Patient Intake Form

Date of 1st appt. _____

Name:	Age: Ht.	Wt.
Street	Birthdate:	Sex:
City	Occupation:	Referred by:
State Zip	Phone: **Home**	**Work**
Physician:	**Cell**	**Emerg. #**
Main Problem:	Email (optional):	
Other Concurrent Therapies		Onset:

Past Medical History (include date):

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other.

Surgeries:

Significant Trauma (auto accidents, falls, etc.)

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological,etc.)

Exercise:

Comments:

Average daily diet:

Morning *Afternoon* *Evening*

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Family Medical History: ___Diabetes ___Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___ Seizures ___ Asthma ___Allergies ___Alcoholism ___ Other _____

Notes _____

GENERAL

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen
☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily
☐ Cravings ☐ Localized weakness ☐ Poor coordination ☐ Change in appetite
☐ Sudden energy drop at _____ (time) ☐ Peculiar tastes/smells _____
☐ Strong thirst (cold/hot drinks) _____ ☐ Bleed or bruise easily (where) _____

SKIN AND HAIR

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Change in hair/skin texture ☐ Purpura ☐ Other hair or skin problem _____

HEAD, EYES, EARS, NOSE, AND THROAT

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glassses
☐ Eye strain ☐ Eye pain ☐ Poor vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Blurry vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Nose bleeds ☐ Sinus problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ Copius saliva
☐ Teeth problems ☐ Jaw clicks ☐ Grinding teeth ☐ Facial pain
☐ Gum problems ☐ Spots in eyes ☐ Recurrent sore throats _____/month
☐ Sores on lips or tongue ☐ Headaches (where and when) _____
☐ Other head or neck problems _____

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest Pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Difficulty in breathing when lying down ☐ Tight chest
☐ Production of phlegm _____what color _____ ☐ Other lung problems

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools _____Frequency
☐ Bad Breath ☐ Rectal pain ☐ Hemorrhoids _____Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____Odor
☐ Pain or cramps ☐ Laxative use:_____ /week; type _____ _____Texture/form

GENITO-URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency
☐ Wake up to urinate How often_____/night; time:_____ ☐ Other G/U problems

PREGNANCY AND GYNECOLOGY

☐ Number pregnancies ☐ Number births ☐ Premature births ☐ Miscarriages
☐ Age at first menses ☐ Period (days) ☐ Duration ☐ Irregular periods
☐ Flow (describe) ☐ Clots Last PAP_____ Last menses _____
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps Menopause _____
☐ Birth control type and duration _____ ☐ Changes in body/psyche prior to menstruation

MUSCULOSKELETAL

☐ Neck pain ☐ Mucscle pains ☐ Back pain(where) ☐ Joint pains(where)
☐ Other joint or bone problems? _____ _____

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Treated for emotional problems ☐ Considered/attempted suicide
☐ Other neurological or psychological problems?

CLASSICAL

Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

Body type: _____
Color: _____
Tone: _____
Odor: _____
Yin/Yang: _____
Firm/Weak: _____
Hot/Cold: _____
Surface/Interior _____

STOP

COMMENTS

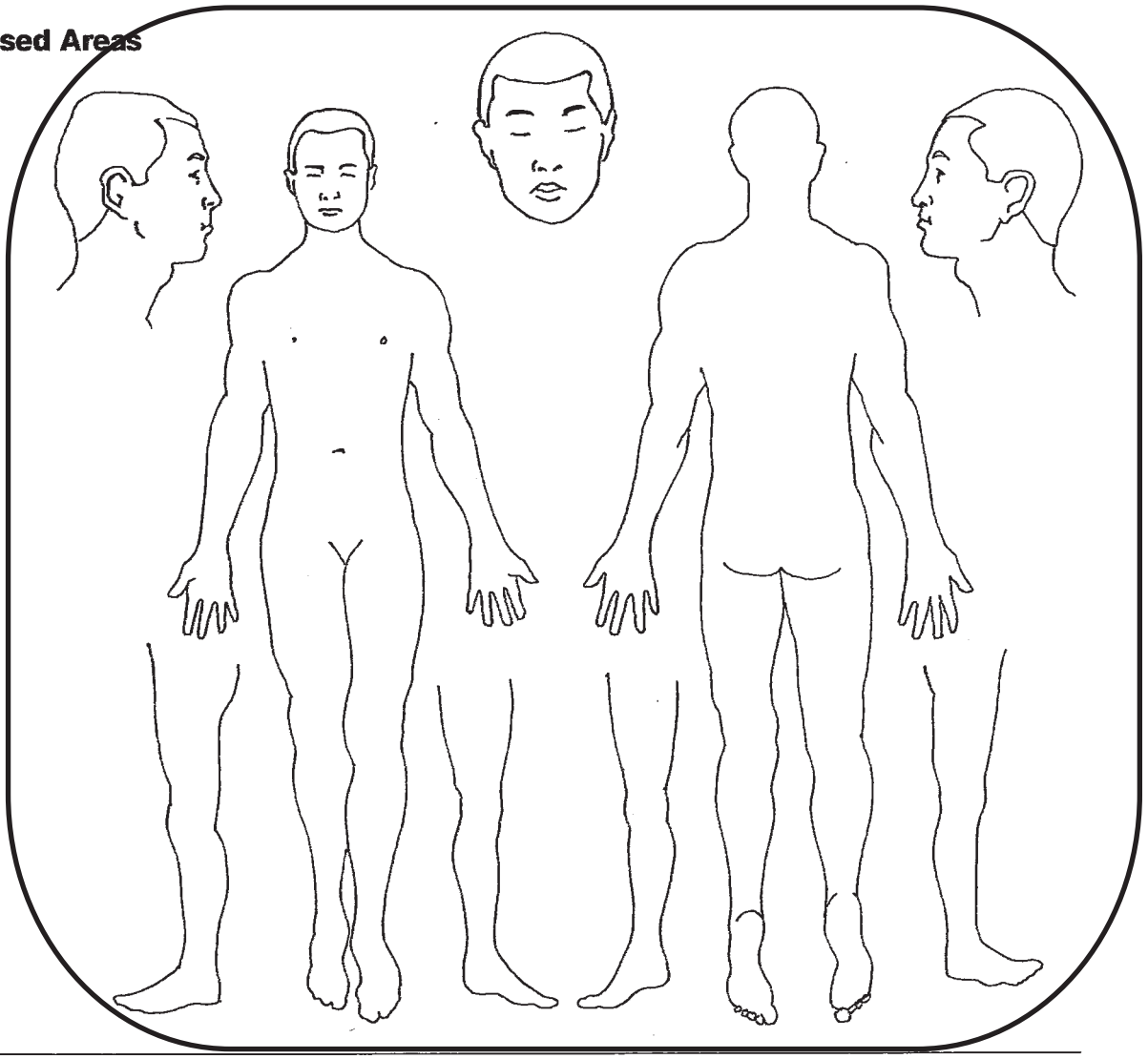
Point Palpation

	HT	SI	PC	TW	LU	LI	SP	ST	KI	BL	LV	GB
	CV-14	CV-4	CV-15(17)	CV-5	LU-1	ST-25	LV-13	CV-12	GB-25	CV-3	LV-14	GB-24
Left												
Right												
	BL-15	BL-27	BL-14	BL-22	BL-13	BL-25	BL-20	BL-21	BL-23	BL-28	BL-18	BL-19
Left												
Right												

Painful or Distressed Areas

Fill out circled section *only.*

Please mark painful or distressed areas on these figures, including areas not related to your chief complaint.



Assessment

Objective Symptoms _____

Subjective Symptoms _____

General Diagnosis _____

Treatment Strategy _____

We want you to know:

Chinese Medicine is a system of medicine based on traditional Asian principles and methods and *is not meant to replace Western medical treatment.*

It is not necessary to discontinue Western medical therapies in order to receive Acupuncture or Chinese herbs. Adjusting the dosages of prescribed pharmaceutical medications must be done under the advice of the prescribing physician.

No claims are made about curing your condition.

Any Western medical diagnosis must be performed by a licensed physician. You will be advised to seek more appropriate treatment when necessary. In that event you assume full responsibility for consulting with your physician.

Cancellation Policy: Mystic River Acupuncture is a specialized practice with time set aside for individualized care and attention for each client. Appointments must be canceled 24 hours in advance, or you will be billed for the missed appointment.

Payment is expected at time of service, unless other arrangements are made in advance. *I understand that I am responsible for payment of all fees.*

There is a **$25.00 charge** (or more if the bank charges us more) for any check returned to our office by the bank, payable at once, in addition to the face amount of the check.

****

I have read and understand all the information stated above.

I hereby certify that all information I have given on these forms is true and complete, to the best of my knowledge. In addition, *I will advise my Acupuncturist of any changes in my medical condition.*

_____	_____	_____
printed name	*signature*	*date*

Mystic River Acupuncture
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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Mystic River Acupuncture is in compliance with HIPAA regulations assuring your medical privacy. We never release medical records without permission. Your records are available to you upon request. The staff of Mystic River Acupuncture, such as receptionists and therapists who have access to your records, obtain only the information they need to perform their jobs. They are aware of HIPAA regulations and understand the importance of patient confidentiality.

Please read and sign the following so that we may remain in compliance with the HIPAA regulations. Thank you very much for your cooperation.

****

I understand that:

My medical records are kept confidential, and are sent to third parties, such as attorneys, insurance companies, or doctors, only upon my consent to release.

No consultation concerning my case will be made with any other party, including members of my family, without my written permission.

Unless I request otherwise, Mystic River Acupuncture staff may contact me at any of the phone numbers or addresses I provide for them. Phone messages for me may be left on an answering machine; via voice mail; or with whomever answers the phone.

Mystic River Acupuncture has permission to release my records and discuss my case with representatives of the third party responsible for payment, such as my health insurance company.

_____ _____ _____

printed name *signature* *date*

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