PATIENT INTAKE FORM

Name _____ Date _____

NOW: ☐ PREGNANT ☐ PACEMAKER ☐ AIDS ☐ HEPATITIS ☐ BLOOD TRANSFUSION

FAMILY HISTORY:

☐ Abuse ☐ AIDS ☐ Alcoholism ☐ Allergies ☐ Asthma ☐ Cancer ☐ Diabetes
☐ Drugs ☐ Heart Disease ☐ High Blood Pressure ☐ Respiratory Diseases ☐ Seizures
☐ Stroke ☐ Other _____

YOUR PAST MEDICAL HISTORY/ILLNESSES:

☐ Aids ☐ Alcoholism ☐ Arthritis ☐ Asthma ☐ Auto Immune Disease ☐ Bronchitis ☐ Cancer
☐ Chronic Fatigue Syndrome ☐ Chronic Lung Disease ☐ Diabetes ☐ Drugs ☐ Heart Disease
☐ Hepatitis ☐ Hernia ☐ High Blood Pressure ☐ Kidney Disease ☐ Organ Transplant ☐ Pneumonia
☐ Rheumatic Fever ☐ Seizures/Epilepsy ☐ Sexually Transmitted Diseases (STD)_____
☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers ☐ Vaccine Reaction ☐ Whooping Cough

SURGERIES: (Please include dates)

1. _____
2. _____
3. _____

TRAUMATIC INJURY: (Please include dates)

Car accident _____
Falls _____
Other _____

ALLERGIES:

Drugs _____
Chemicals _____
Food _____
Others _____

CURRENT MEDICATIONS:

OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:

Chemical: _____ Acid/Alkalines: _____
Heavy Metals: _____ Physical Labor: _____
Electrical: _____ Psychological: _____

HABITS/EXCESSIVE USAGE:

☐ alcohol ☐ chocolate ☐ cigarettes ☐ coffee ☐ cola ☐ drugs ☐ exercise ☐ food ☐ salt
☐ sex ☐ sugar ☐ tea ☐ other _____

CHIEF COMPLAINT / REASON FOR COMING IN: _____

GENERAL

- ☐ poor appetite
- ☐ change in appetite
- ☐ large appetite
- ☐ cravings
- ☐ weight gain
- ☐ weight loss
- ☐ fevers
- ☐ chills
- ☐ sweating
- ☐ night sweats
- ☐ sweats easily
- ☐ headache
- ☐ insomnia
- ☐ hours of sleep _____
- ☐ easy to fall asleep
- ☐ heavy sleeper
- ☐ light sleeper
- ☐ dream disturbance
- ☐ hard to fall back asleep
- ☐ tremors/shaking
- ☐ dizziness
- ☐ poor coordination
- ☐ vertigo
- ☐ edema
- ☐ bleeds easily
- ☐ bruises easily
- ☐ fatigue/tired
- ☐ sudden drop in energy

Are you taking:
- ☐ Aspirin
- ☐ Blood Thinners
- ☐ Vitamins
- ☐ Herbs
- ☐ Supplements

Energy level: ☐ high ☐ moderate ☐ low
Thirsty, desires: ☐ hot ☐ cold ☐ room temp. ☐ no desire
Coldness: ☐ hands ☐ feet ☐ back
Heat: ☐ hands ☐ feet ☐ solar plexus ☐ abdomen ☐ whole body
Stiffness: ☐ joints ☐ back ☐ limbs
Intolerance to: ☐ hot ☐ cold ☐ wind ☐ fan ☐ A/C
Pain: ☐ upper back ☐ lower back ☐ upper limbs ☐ lower limbs ☐ whole body
Rate the pain: Scale 1-10 (10 worst) _____

SKIN AND HAIR

- ☐ rashes
- ☐ eczema
- *skin:* ☐ dry ☐ moist
- ☐ sores
- ☐ ulcers
- ☐ herpes
- ☐ psoriasis
- ☐ eruptions
- ☐ discharge
- ☐ pimples/acne
- ☐ bruises
- ☐ hives
- ☐ itching
- ☐ sweating
- ☐ change in skin texture
- ☐ dandruff
- ☐ loss of hair
- ☐ balding
- ☐ thinning of hair
- ☐ change in hair
- ☐ other hair problems: _____
- ☐ other skin problems: _____

HEAD, EYES, EARS, NOSE, MOUTH & THROAT

Head
- ☐ dizziness
- ☐ migraine
- *Headaches:*
  - ☐ frontal
  - ☐ temporal
  - ☐ vertex
  - ☐ occipital
- ☐ head injury
- ☐ facial pain
- ☐ facial paralysis
- ☐ sinus problems

other: _____

Eyes (R/L)
- ☐ cataract/ glaucoma
- ☐ eye pain
- ☐ twitching
- ☐ floaters/spots
- ☐ poor vision
- ☐ blurry vision
- ☐ night blindness
- ☐ itchiness
- ☐ glasses/contacts
- ☐ red eyes

other: _____

Ears (R/L)
- ☐ loss of hearing
- ☐ discharge
- ☐ earaches
- ☐ poor hearing
- ☐ itchiness
- *Ringing in ears:*
  - ☐ loud ☐ soft
  - ☐ high pitch
  - ☐ low pitch
- ☐ inflammation
- ☐ tenderness

other: _____

Nose
- ☐ loss of smell
- ☐ good sense of smell
- ☐ nose bleeds
- ☐ allergies
- ☐ nasal discharge
- *color:* ☐ yellow ☐ white ☐ clear ☐ green
- *amount:* ☐ scanty ☐ mod ☐ heavy ☐ thick ☐ thin

other: _____

Mouth
- ☐ grind teeth
- ☐ drooling
- ☐ excess saliva
- ☐ dry mouth
- ☐ gum disease
- ☐ bad breath
- ☐ gum bleeding
- ☐ gum swelling
- ☐ taste in mouth
- ☐ ulcers
- ☐ sores

other: _____

Throat
- ☐ dry throat
- ☐ hoarseness
- ☐ recurrent sore throat
- ☐ loss of voice
- ☐ difficulty swallowing
- ☐ lump in throat
- ☐ frequent tonsilitis

other: _____

CARDIOVASCULAR

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ dizziness
- ☐ fainting
- ☐ palpitations
- ☐ chest pain
- ☐ cold hands/feet
- ☐ swelling hands/feet
- ☐ irregular heart beat
- ☐ insomnia
- ☐ difficulty in breathing
- ☐ shortness of breath
- ☐ dream disturbance
- ☐ poor memory
- ☐ mania/delirium
- ☐ coma
- ☐ loss of consciousness

other: _____

RESPIRATORY

- ☐ pneumonia
- ☐ bronchitis
- ☐ asthma
- ☐ coughing blood
- ☐ wheezing

cough: how long? _____
☐ dry ☐ croup ☐ rapid ☐ other
phlegm: ☐ thin ☐ thick ☐ clear ☐ white ☐ yellow ☐ green
☐ tightness in chest

- ☐ shortness of breath
- ☐ fullness in chest

difficulty breathing:
☐ sitting ☐ lying down
☐ other chest discomfort

GASTROINTESTINAL

☐ food allergies	☐ taste in mouth	☐ loose stools	☐ difficult stools	☐ tenderness in abdomen
☐ vomiting	☐ belching	☐ bloody/black stools	☐ mucus in stools	☐ fullness in abdomen
☐ cramping	☐ bad breath	☐ ulcers	☐ hemorrhoids	☐ burning in abdomen
☐ gas	☐ hiccup	☐ increased appetite	☐ hernia	☐ like/dislike pressure
☐ abd/stomach pain	☐ constipation	☐ poor appetite	☐ rectal pain	☐ like/dislike cold
☐ nausea	☐ diarrhea	☐ hungry-no desire to eat	☐ rectal bleeding	☐ like/dislike warmth

GENITO-URINARY

☐ burning /painful urine	☐ poor stream/scanty urine	☐ diminished sex drive	☐ discharge
color: ☐ cloudy ☐ pale	☐ dribbling urine	☐ increased sex drive	☐ history of kidney stones
☐ dk yellow ☐ pink/red	☐ unable to urinate	☐ impotency	☐ history of bladder infections
☐ unable to hold urine	☐ frequent urination	☐ genital itching	☐ history of prostate problems
☐ wakes up to urinate	☐ urgency to urinate	☐ genital sores/pain	☐ history of STD

MUSCULO-SKELETAL

☐ joint pain	*upper limbs:*	☐ pain ☐ swelling ☐ tenderness	☐ burning ☐ stiffness	☐ weakness	☐ numbness	☐ tingling
☐ joint swelling	*lower limbs:*	☐ pain ☐ swelling ☐ tenderness	☐ burning ☐ stiffness	☐ weakness	☐ numbness	☐ tingling
☐ joint stiffness	*back:*	☐ pain ☐ swelling ☐ tenderness	☐ burning ☐ stiffness	☐ weakness	☐ numbness	☐ tingling
☐ sciatica	*neck:*	☐ pain ☐ swelling ☐ tenderness	☐ burning ☐ stiffness	☐ weakness	☐ numbness	☐ tingling

NEUROPHYSIOLOGICAL

☐ history of emotional problems	☐ melancholy	☐ joyful	☐ tremors/shaking
☐ depression	☐ grieving	☐ giddy	☐ convulsions
☐ anxiety	☐ easy to anger	☐ over-thinking	☐ coma
☐ easily stressed	☐ irritability	☐ talkative	☐ concussion
☐ confusion/foggy	☐ restlessness	☐ silent	☐ paralysis
☐ lack of clarity	☐ emotional	☐ extrovert	☐ trauma at birth
☐ moody	☐ frequent sighing	☐ introvert	☐ vaginal delivery ☐ cesarean
☐ fear/fright	☐ over-worried	☐ poor memory	☐ considered/attempted suicide
☐ hyper	☐ bad-tempered	☐ seizures	☐ unable to focus
			☐ phobia _____

GYNECOLOGY AND PREGNANCY [Last Menstrual Period _____ Last PAP _____]

☐ no. of pregnancies ___	☐ age at first menses _____	☐ fibroids	*color:* ☐ lt. red ☐ red
☐ no. of live births ____	☐ length of period _____	☐ abd. Bloating/fullness	☐ dk red ☐ dk purple
☐ no. of miscarriages ___	☐ number of days in cycle __	☐ pain with stools	*clots:* ☐ large ☐ small
☐ no. of premature births _____	☐ early menstrual cycle (less than 21 days)	☐ mood change before period	*vaginal discharge:*
		☐ body change before period	☐ odor ☐ no odor
☐ no. of abortions _____	☐ late menstrual cycle	*menstrual pain/cramps:*	☐ watery ☐ thick
☐ infertility	(less than 35 days)	☐ before ☐ during ☐ after	☐ curdy ☐ itchy
☐ pain during intercourse	☐ irregular menstrual cycle	☐ days of heavy flow _____	*color:* ☐ clear ☐ white
☐ uterine prolapse	☐ *menopause:* ☐ pre ☐ post	☐ endometriosis	☐ yellow ☐ bloody
birth control pills:	☐ age at menopause _____	*flow:* ☐ thick ☐ thin	☐ vaginal burning/itching
type _____	☐ history of ovarian cysts	*amount:* ☐ scanty ☐ mod	☐ vaginal pain
how long? _____	☐ history of uterine problems	☐ heavy ☐ very heavy	☐ vaginal sores

BREAST

☐ history of breast disease	☐ breast tenderness	*breast discharge:* ☐ clear ☐ white ☐ yellow ☐ green
☐ breast lumps/masses	☐ breast fullness/swelling	☐ black ☐ blood ☐ watery ☐ thin ☐ thick
☐ history of breast cancer	☐ breast pain	other: _____

The Points of Health

PATIENT CONFIDENTIAL INFORMATION

Name _____ (First) _____ (Middle) _____ (Last)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Business Phone _____

Cell Phone _____ Email _____

Age _____ Date of Birth _____ Sex _____

Driver's License No _____ Occupation _____

CASE HISTORY

Chief Complaint _____

Complaint result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other

Date of accident/Injury/Other ____/____/____

Have you seen any other doctor about this condition? _____ If yes, when? _____

Doctor's Name _____

Nearest relative not living with you _____

Relationship _____ Phone _____

In case of emergency, call
Name _____ Phone _____

List the telephone number where you want to receive calls/text messages about appointments and other health care information: _____

Is it ok to leave a message with:(check one) ☐ detailed information ☐ callback number only

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and phone numbers

_____

_____

FINANCIAL ARRANGEMENTS

Method of Payment ☐ Cash ☐ Check ☐ Master Card ☐ Visa ☐ Amex

REFERRAL INFO

How were you referred to the clinic? ☐ Internet Search ☐ Walk-In ☐ Other _____

☐ Relative/Friend _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____

(parent's signature if patient is minor)

The Points of Health

Amy E. White, A.P.

Voluntary Informed Consent to Treatment

I voluntarily consent to participate in therapy performed at The Points of Health and/or by Amy E. White, Acupuncture Physician. I understand that the scope of treatment may include acupuncture, electric-stimulation acupuncture, auricular acupuncture, acupressure, acupoint injection therapy, cupping, micro point stimulation, moxabustion, heat therapy, tuina, gua sha, ear seeds, herbal formulas, and/or supplements consisting of Chinese herbs, nutraceuticals and homeopathics. I understand that I may refuse any of these treatments.

I understand that any of the above modalities may be contraindicated during the following conditions: pregnancy, a prevailing condition of stress, when fatigued, on an empty stomach, or in a weakened state.

I understand that under certain conditions nausea, dizziness, or fainting may occur. I also understand that bruising, hematomas, bleeding, temporary soreness, or the possible aggravation symptoms prior to treatment and following the treatment may occur.

I have not withheld any information regarding my medical history and unless stated otherwise, I assert that I am in stable health and I am fully aware of what I am signing. No guarantees or assurances have been made concerning the results of this treatment or procedure.

Signature_____ Date____-____-____

CANCELLATION POLICY

I agree to cancel or reschedule appointments with a minimum of 24 hours notice. I understand that if I fail to give ample notice or no show, each occurrence will result in a $35 fee.

Signature:_____ Date____-____-____

The Points of Health

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Patient:

X_____ _____ _____

Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:

☐ Accepted _____ _____ _____

☐ Denied Signature Title Date