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

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____-____-____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____