New Patient Intake Forms Today's Date:___ /____ /____

Name_____ Marital Status_____ Birthday ___/___/____ Age ____

Adress_____

Email:_____Occupation_____

Home #:_____Cell #:_____

Reason for visit today:_____

Have you had Acupuncture before?_____ Chinese Herbal Medicine?_____

How long have you had this condition? _____Is it getting worse?_____

What seems to be the initial cause?_____

What makes it better?_____ What makes it worse?_____

Does it bother your: Sleep Work Other (specify)_____

Are you under the care of a physician now? Yes No If yes, for what? _____

Physician's Name:_____

Other current therapies:_____

Family Medical History:

Allergies	**Cancer (type) _____**	**Depression**	**Heart Disease**
Arteriosclerosis	**Diabetes (type)_____**	**High Blood Pressure**	
Asthma	**Seizures**	**Stroke**	**Alcoholism/Drugs**

Your Past Medical History: (Circle Any You Have Had In The Past)

HIV/AIDs	**Emphysema**	**Multiple Sclerosis**	**Stroke**
Alcoholism	**Epilepsy**	**Mumps**	**Shingles**
Allergies	**Goiter**	**Pacemaker**	**Thyroid Disorders**
Appendicitis	**Gout**	**Pleurisy**	**Tuberculosis**
Arteriosclerosis	**Heart Disease**	**Pneumonia**	**Typhoid Fever**
Asthma	**Hepatitis (Type:)**	**Polio**	**Ulcers**
Birth Trauma	**Herpes (Type:)**	**Rheumatic Fever**	**Venereal Disease**
Chicken pox	**High Blood Pressure**	**Scarlet Fever**	**Whooping Cough**
Diabetes (Type:)	**Measles**	**Seizures**	**Covid**

Cancer Type:_____Treatment:_____

List of Surgeries:

_____

_____

_____

List of Medications and Vitamins:

How Are Your Dietary Habits? Good Fair Poor

Do You Exercise Routinely? Yes No

Your Lifestyle: Alcohol- Tobacco- Marijuana- Drugs-Stress- Occupational Hazards

Emotion: Anxious/Fear Stable Worried Depressed Grief Irritable Easy Stressed Exuberant
Considered/Attempted Suicide: Yes /No Seeing a therapist: Yes /No

Energy: Best: AM/Afternoon/PM Worst: AM/PM
Overall Energy: Low 1 2 3 4 5 6 7 8 9 10 High

Hot/Cold: Hands/Feet/Body: Hot Cold Warm Sweaty Night Sweats
Pain: Burning Gripping Moving Pulling Distending Aching Empty Heavy
Thirst: Never Usual Always Fluid Intake adequate Yes No Prefers drinking liquids: Cold Hot
Appetite Normal Excessive Poor None Craves: Sweet/Sour/Biller/Salty/Spicy
Sleep Restful Interrupted Restless Vivid Dreams
Difficult: Falling asleep Staying asleep Waking up

Cardiovascular:

High Blood Pressure Low Blood Pressure Chest Pain Tachycardia Phlebitis Fainting
Blood Clots Difficulty Breathing Heart Palpitations Irregular Heartbeat/Afib

Gastrointestinal:

Nausea/Vomiting Diarrhea/Constipation Hemorrhoids Itchy or Burning Anus
Acid regurgitation/Heartburn Gas/Bloating Indigestion Strong Appetite Food Allergies
Hiccup Stomachache/Ulcer Bad Breath Rectal Pain Anal Fissures
Bowel movements: Frequency _____Texture _____Form_____
Laxative? Yes No If so how frequent and what kind? _____
Date of Colonoscopy_____ Date of Endoscopy _____

Circle The Appropriate Response

Respiratory:

Shortness of breath Asthma/Wheezing Difficult to inhale/exhale Cough COPD

Musculoskeletal:

Neck Shoulder Upper Back Lower Back Muscle Limited range of Motion

Genitourinary:

Pain on urination Frequent Urination Urgent Urination Blood in Urine
Unable to Hold Urine Incomplete Urination Wake to Urinate Bedwetting
Kidney Stone Venereal Disease Increased/Decreased Libido Impotence

Head/Eyes/Ears/Nose/Throat:

Glasses (age___) Eye Strain/Pain Red Eyes Itchy Eyes Spots in Eyes
Poor Vision Blurred Vision Glaucoma/Cataracts Night Blindness
TMJ Facial Pain Grinding Teeth Teeth/Gum Problems Sores Lips/Tongue Dry Mouth
Excessive Saliva Sinus Problems Allergies Nose Bleeds Post Nasal Drip
Recurrent Sore Throat Swollen Glands Enlarged Thyroid
Ringing in Ears(High or Low Pitch) Poor Hearing Hearing Aids Earache
Headaches/Migraines (Front/Top/Side/Back/Whole Head/Band-Type) Concussions

Skin and Hair:

Acne Rashes Hives Eczema/Psoriasis Dandruff Hair Loss Thinning Hair

Neuropsychological:

Depression Anxiety Irritability Easily Stressed Dizziness Tremors Seizures Spasms
Numbness Tics Poor Memory Confused Abuse Survivor
Considered/Attempted Suicide Yes/No Are you seeing a Therapist Yes/No

Gynecology:

Age Menses Began _____ Length of Cycle _____ Last Menstrual Cycle _____
Cramps/Clots/PMS/Painful/Irregular/Absent # of Pregnancies_____
Age at Menopause _____

Notes:

Consent for Communication and/or Disclosure

Can this office leave telephone voice-mail message concerning scheduling? Yes No

Can this office send text message to you regarding appointments? Yes No

Can this office e-mail you? Yes No

Please Print the names of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**

Please list family member or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY.

Name:	**Phone:**

Financial Policy

The following is a statement of our Financial Policy, which we require all patients to read and sign below before any treatment. Full payment is due at time of service. We accept credit card, cash and check.

Regarding Insurance

At this time our office is not accepting insurance.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Help us to serve you better by keeping scheduled appointments. By respecting this policy you are allowing other clients the opportunity to utilize available appointments if they become open. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read, understand and agree to this Financial Policy. A photocopy of this form shall be considered as effective as the original.

Signature of Patient or Responsible Party **Date:**

Acupuncture & Herbs, ***feeling well naturally***

Dr. Andrea Murphy, AP, DOM

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, homeopathy, Gua Sha, Acupuncture injection therapy. I will immediately notify the Acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional supplement.

I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles, and maintains a clean and safe environment, at all times.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herb and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify the Acupuncturist if I am or become pregnant.

While I do not expect the Acupuncturist to be able to anticipate all possible risks and complications of treatment, I wish to rely on the Acupuncturist to exercise judgment during the course of treatment which the Acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

All my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had a opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: **Date:**