New Patient Intake Form

Today's Date ____/____/____

Name

Marital Status: _____

Birthdate / /

Age _____

Address _____

☐ Male ☐ Female

_____

Ht _____ Wt _____

Email

Occupation

Home Phone Work Cell

Referred by

Reason for visit today

Have you had acupuncture before?

Chinese herbal medicine?

How long have you had this condition?

Is it getting worse? Does it bother your ☐sleep ☐work ☐other (specify)?

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

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

Physician's name: Physician's phone:

Other concurrent therapies:

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
	☐ Asthma		☐ Heart Disease	☐ Stroke
	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	

Your Past Medical History:

☐ AIDs/HIV	☐ Emphysema	☐ Mumps	☐ Cancer type:	☐ Tuberculosis
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker (Date:)	treatment:	☐ Typhoid fever
☐ Allergies	☐ Goiter	☐ Pleurisy		☐ Ulcers
☐ Appendicitis	☐ Gout	☐ Pneumonia		☐ Venereal disease
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Surgery (list)	☐ Whooping cough
☐ Asthma	☐ Hepatitis (Type:)	☐ Rheumatic fever		☐ Other
☐ Birth Trauma	☐ Herpes (Type:)	☐ Scarlet fever		
(your own birth)	☐ High Blood Pressure	☐ Seizures	☐ Major trauma (car,fall, pls list)	
☐ Chicken Pox	☐ Measles	☐ Stroke		
☐ Diabetes (Type:)	☐ Multiple Sclerosis	☐ Thyroid disorders		

Your Diet:

Appetite	☐ Low	☐ Coffee/Tea	☐ Artificial	☐ Sugar	Protein Intake	☐ Low	Thirst for water:
	☐ High	☐ Soft Drinks/ Fruit Juices	Sweeteners	☐ Salty foods		☐ High	# glasses per day:

Pharmaceuticals (name and dosage):

Vitamins/Supplements (name and dosage):

Your Lifestyle:

☐ Alcohol ☐ Marijuana ☐ Stress
☐ Tobacco ☐ Drugs ☐ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms:

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands or feet	☐ Night sweats	☐ Peculiar taste (Describe)
☐ Like cold drinks	☐ Dream-disturbed sleep	☐ Poor circulation	☐ Sweat easily	_____
☐ Like hot drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps	_____
☐ Weight loss/gain	☐ Lack of strength	☐ Fever	☐ Vertigo/dizziness	_____

Head, Eyes, Ears, Nose, Throat

☐ Glasses (age?)	☐ Night blindness	☐ Gum problems	☐ Recurrent sore throat	☐ Headaches
☐ Eye strain	☐ Myopia/Presbyopia	☐ Sores on lips/tongue	☐ Swollen glands	☐ Migraines
☐ Eye pain	☐ Glaucoma	☐ Dry mouth	☐ Lumps in throat	☐ Concussions
☐ Red eyes	☐ Cataracts	☐ Excessive saliva	☐ Enlarged thyroid	Other head or neck problems
☐ Itchy eyes	☐ Teeth problems	☐ Sinus problems	☐ Nosebleeds	_____
☐ Spots in eyes	☐ Grinding teeth	☐ Excessive phlegm	☐ Ringing in ears	_____
☐ Poor vision	☐ TMJ	Color:	☐ Poor hearing	_____
☐ Blurred vision	☐ Facial pain		☐ Earaches	

Respiratory

☐ Difficulty breathing wh- lying down	☐ Tight chest	☐ Cough	☐ Color of phlegm:	☐ Coughing up blood
	☐ Asthma/wheezing	Wet or Dry? _____	_____	☐ Pneumonia
☐ Shortness of Breath	☐ Difficult Inhale? Exhale?	Thick or thin? _____		

Cardiovascular

☐ High blood pressure	☐ Low blood pressure	☐ Chest pain	☐ Tachycardia	☐ Phlebitis
☐ Blood clots	☐ Fainting	☐ Difficulty breathing	☐ Heart palpitations	☐ Irregular heartbeat/ Afib

Gastrointestinal

☐ Nausea	☐ Diarrhea	☐ Intestinal pain/cramps	Bowel movements:	
☐ Vomiting	☐ Constipation	☐ Burning anus		
☐ Acid regurgitation	☐ Black stools	☐ Rectal pain	Frequency_____	Texture/form_____
☐ Gas	☐ Bloody stools	☐ Anal fissures		
☐ Hiccup	☐ Mucous in stools	☐ Laxative use	Color_____	Odor_____
☐ Bloating	☐ Hemorrhoid	What kind?		
☐ Bad breath	☐ Itchy anus	How often?		

Musculoskeletal

☐ Neck/shoulder pain	☐ Upper back pain	☐ Joint pain	☐ Limited range of motion	☐ Other
☐ Muscle pain	☐ Low back pain	☐ Rib pain	☐ Limited use	_____

Skin and Hair

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/skin texture	Other (Specify)
☐ Hives	☐ Psoriasis	☐ Itching	☐ Fungal infections	_____
☐ Ulcerations	☐ Acne	☐ Hair Loss		_____

Neuropsychological

☐ Seizures	☐ Poor memory	☐ Irritability	☐ Considered/attempted	Other (Specify)
☐ Numbness	☐ Depression	☐ Easily stressed	suicide	_____
☐ Tics	☐ Anxiety	☐ Abuse survivor	☐ Seeing a therapist	_____

Genitourinary

☐ Pain on urination	☐ Blood in urine	☐ Venereal disease	☐ Increased libido	☐ Impotence
☐ Frequent urination	☐ Unable to hold urine	☐ Bedwetting	☐ Decreased libido	☐ Premature ejaculation
☐ Urgent urination	☐ Incomplete urination	☐ Wake to urinate	☐ Kidney stone	☐ Nocturnal emission

Gynecology

☐ Age menses began	☐ Duration of flow	☐ Vaginal discharge	☐ Breast lumps	Date of last PAP
_____	_____ days	(color)_____	# Pregnancies_____	_____
Length of cycle (day 1-day 1)	☐ Irregular periods	☐ Vaginal sores	# Live births_____	Date last period began
_____	☐ Painful periods	☐ Vaginal odor	# Premature births_____	_____
	☐ PMS	☐ Clots	Age at menopause_____	

PATIENT PROFILE

NAME: _____ **DATE:** _____

It is very important in Chinese Medicine to know how long patient has experienced his/her symptoms. It is essential to indicate time on the symptoms.
Please indicate with one check (X) any conditions that you sometimes experience; use two checks for those which often occur and three (XXX) for symptoms that are a major concern.

WATER ELEMENT
- ____Hearing Loss
- ____Dizziness
- ____Lower Back Pain/Neck Pain
- ____Sinus Congestion
- ____Edema
- ____Rapid Weight Change
- ____Darkness Under the Eyes
- ____Emotional Instability
- ____Aversion to Cold
- ____Pre-Mature Aging
- ____Frequent Urination
- ____Kidney Stones
- ____Perspire very easily
- ____Weakness of the legs/knees
- ____Reduced Sexual Energy
- ____Thyroid Problems
- ____Diabetes
- ____Hair Thinning or Loss
- ____Asthmatic Cough

WOOD ELEMENT
- ____Headache
- ____Migraines
- ____Ulcer
- ____Ringing in the Ears
- ____Indecisiveness
- ____Vomiting
- ____Gallstones
- ____Constipation
- ____Hemorrhoids
- ____Hepatitis
- ____Poor eyesight
- ____Eye Infections
- ____Dry Eyes
- ____Eczema
- ____Shingles
- ____Herpes Simplex
- ____Nervousness
- ____Convulsions/Spasms
- ____Irritability
- ____Painful Menstration
- ____Irregular Menstration

WOOD ELEMENT CONT.
- ____Fullness Below Ribs
- ____Shoulder/Neck Tension
- ____Insomnia 11pm- 3 am
- ____Warts

FIRE ELEMENT
- ____Dry Scalp
- ____Skin Eruptions/Rashes
- ____Cysts/Tumors
- ____Sore Throat/Tonsillitis
- ____Lymphatic Swelling
- ____Hot Palms and Soles
- ____Heart Palpitations
- ____Aversion to Heat
- ____Facial Redness
- ____Itching/Burning Skin
- ____Hot Hands/Feet
- ____Thirst
- ____Dark Urine
- ____Night Sweats
- ____Ear Infections
- ____Headache
- ____Bitter Taste in Mouth
- ____Nose Bleeds
- ____Gum Problems

EARTH ELEMENTS
- ____Indigestion
- ____Strong Appetite
- ____Flatulence
- ____Food Allergy
- ____Stomach Ache/Ulcer
- ____Diarrhea
- ____Anemia
- ____Halitosis
- ____Mouth Sores
- ____Heartburn
- ____Nausea
- ____Abdominal Bloating
- ____Low Body Weight

METAL ELEMENT
- ____Bronchitis
- ____Asthma
- ____Shallow Breathing
- ____Cough
- ____Sinus Congestion
- ____Nasal Infections

OTHER
- ____Fatigue
- ____Arthralgia
- ____Sciatica
- ____Nerve Pain
- ____Cold Hands/Feet
- ____Bursitis

Pain (please describe):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other comments:

_____
_____
_____
_____
_____
_____
_____

Andrea Murphy, DOM

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. 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 checks.

Regarding Insurance:

At this time our office is not set up to file your insurance for you unless you have been in an accident. We will be glad to supply you with all the necessary forms to file with your insurance company. You are responsible for payment of each treatment at the time of treatment.

By signing this document, you are authorizing the release of any information requested by any insurance company, adjuster or attorney that will assist in the payment of a claim.

Usual and customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some, and at times, perhaps all the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

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. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective and the original.

X_____DATE_____

Signature of Patient or Responsible Party

Consent for Communication and/or Disclosure

1. May our Patient Care Coordinator contact you:

   At home? Yes No
   If yes, may we leave the following information on your home voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

   At work? Yes No
   If yes, may we leave the following information on your work voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

2. Please indicate the number you wish us to use to contact you:
   Home:_____ Work:_____ Cell:_____

3. 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 heath care operation):

   o NONE
   Name_____ Phone_____
   Name_____ Phone_____
   Name_____ Phone_____

4. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:
   Name_____ Phone_____

5. Please print the address where you wish billing statements and/or correspondence from our office to be sent.
   o Use my home address
   o Use this one: _____

6. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? Yes No

7. May we send you email messages, such as newsletters and Family Healing Center updates, events and specials?
   Yes, at this email_____ No

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider and give my permission to share the information as indicated with the person(s) named above.

_____

PATIENT SIGNATURE 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 and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

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, cosmetic acupuncture, homeopathy, gua sha, acupuncture injection therapy. I will immediately notify a member of the clinical staff 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, and 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 herbs 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 a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient records and lab reports, but 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 an 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*** _____