Unified Health GROUP

ACUPUNCTURE NEW PATIENT INTAKE FORM

(CONFIDENTIAL PATIENT INFORMATION)

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Today's Date_____/_____/_____ S/S#_____-_____-_____

First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone _____Cell Phone_____ Email _____

Sex: ❒ Female ❒ Male Birth Date_____/_____/_____

FAMILY MEDICAL HISTORY

❒ Allergies (list) _____ _____
❒ Arteriosclerosis
❒ Asthma
❒ Alcoholism
❒ Cancer (type) _____
❒ Depression
❒ Diabetes (Type:)
❒ Heart Disease
❒ High Blood Pressure
❒ Seizures
❒ Stoke

YOUR PAST MEDICAL HISTORY

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

❒ AIDs/HIV
❒ Alcoholism
❒ Allergies
❒ Appendicitis
❒ Arteriosclerosis
❒ Asthma
❒ Birth Trauma (your own birth)
❒ Cancer
❒ Chicken Pox
❒ Diabetes (Type:)
❒ Emphysema
❒ Epilepsy
❒ Goiter
❒ Gout
❒ Heart Disease
❒ Hepatitis (Type:)
❒ Herpes (Type:)
❒ High Blood Pressure
❒ Measles
❒ Multiple Sclerosis
❒ Mumps
❒ Pacemaker (Date:)
❒ Pleurisy
❒ Pneumonia
❒ Polio
❒ Rheumatic Fever
❒ Scarlet Fever
❒ Seizures
❒ Stoke
❒ Surgery
❒ Thyroid Disorders
❒ Major Trauma (Car, fall, etc-list) _____ _____
❒ Tuberculosis
❒ Typhoid Fever
❒ Ulcers
❒ Venereal Disease
❒ Whooping Cough
❒ Other (Specify) _____ _____

CURRENT MEDICATIONS:

Name	Dose	Frequency

PAST SURGICAL HISTORY:

Approximate Date	Type of Operation

YOUR LIFESTYLE

❒ Alcohol
❒ Tobacco
❒ Marijuana
❒ Drugs
❒ Stress
❒ Occupational Hazards

Regular Exercise:
Type_____ Frequency_____
Type_____ Frequency_____

GENERAL SYMPTOMS

❒ Poor Appetite
❒ Heavy Appetite
❒ Strongly Like Cold Drinks
❒ Strongly Like Hot Drinks
❒ Recent Weight Loss/Gain
❒ Poor Sleep
❒ Heavy Sleep
❒ Dream-Disturbed Sleep
❒ Fatigue
❒ Lack of Strength
❒ Bodily Heaviness
❒ Cold Hands or Feet
❒ Poor Circulation
❒ Shortness of Breath
❒ Fever
❒ Chills
❒ Night Sweats
❒ Sweat Easily
❒ Muscle Cramps
❒ Vertigo or Dizziness
❒ Bleed or Bruise Easily
❒ Peculiar Taste (Describe) _____

HEAD, EYES, EARS, NOSE, THROAT

❒ Glasses (What age:)
❒ Eye Strain
❒ Eye Pain
❒ Red Eyes
❒ Itchy Eyes
❒ Spots in Eyes
❒ Poor Vision
❒ Blurred Vision
❒ Night Blindness
❒ Myopia or Presbyopia
❒ Glaucoma
❒ Cataracts
❒ Teeth Problems
❒ Grinding Teeth
❒ TMJ
❒ Facial Pain
❒ Gum Problems
❒ Sores on Lips/Tongue
❒ Dry Mouth
❒ Excessive Saliva
❒ Sinus Problems
❒ Excessive Phlegm
Color:
❒ Recurrent Sore Throat
❒ Swollen Glands
❒ Lumps in Throat
❒ Enlarged Thyroid
❒ Nosebleeds
❒ Ringing in Ears (high or low?)
❒ Poor Hearing
❒ Earaches
❒ Headaches
❒ Migraines
❒ Concussions
Other head or neck problems:_____

RESPIRATORY

❒ Difficulty Breathing When Lying Down
❒ Shortness of Breath
❒ Tight Chest
❒ Asthma/Wheezing
❒ Difficult Inhalation?___ Exhalation?_____
❒ Cough
Wet or Dry?_____
Thick or Thin?___
Color of Phlegm _____
❒ Coughing Up Blood
❒ Pneumonia

CARDIOVASCULAR

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

GASTROINTESTINAL

❒ Nausea
❒ Vomiting
❒ Acid Regurgitation
❒ Gas
❒ Hiccup
❒ Bloating
❒ Bad Breath
❒ Diarrhea
❒ Constipation
❒ Black Stools
❒ Bloody Stools
❒ Mucous in Stools
❒ Hemorrhoid
❒ Itchy Anus
❒ Intestinal Pain or Cramping
❒ Burning Anus
❒ Rectal Pain
❒ Anal Fissures
❒ Laxative Use
What Kind?_____
How Often?_____
Bowel Movements:
Frequency_____ Texture/Form_____
Color_____ Odor_____

MUSCULOSKELETAL

❒ Neck/Shoulder Pain
❒ Muscle Pain
❒ Upper Back Pain
❒ Low Back Pain
❒ Joint Pain
❒ Rib Pain
❒ Limited Range of Motion
❒ Limited Use
Other (Describe) _____

SKIN AND HAIR

❒ Rashes
❒ Hives
❒ Ulcerations
❒ Eczema
❒ Psoriasis
❒ Acne
❒ Dandruff
❒ Itching
❒ Hair Loss
❒ Change in Hair/Skin Texture
❒ Fungal Infections
Other Hair or Skin Problems_____

NEUROPSYCHOLOGICAL

❒ Seizures
❒ Numbness
❒ Tics
❒ Poor Memory
❒ Depression
❒ Anxiety
❒ Irritability
❒ Easily Stressed
❒ Abuse Survivor
❒ Considered/Attempted Suicide
❒ Seeing a Therapist
Other (Specify) _____

GENITOURINARY

❒ Pain on Urination
❒ Frequent Urination
❒ Urgent Urination
❒ Blood in Urine
❒ Unable to Hold Urine
❒ Incomplete Urination
❒ Venereal Disease
❒ Bedwetting
❒ Wake to Urinate
❒ Increased Libido
❒ Decreased Libido
❒ Kidney Stone
❒ Impotence
❒ Premature Ejaculation
❒ Nocturnal Emission

GYNECOLOGY

❒ Age Menses Began _____	❒ Duration of Flow _____	❒ Vaginal Discharge (color)_____	❒ Breast Lumps # Pregnancies_____	Date of Last PAP _____
Length of Cycle (day 1 to day 1)_____	❒ Irregular Periods ❒ Painful Periods ❒ PMS	❒ Vaginal Sores ❒ Vaginal Odor ❒ Clots	# Live Births_____ # Premature Births____ Age at Menopause____	Date Last Period Began _____

OTHER

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_____

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."***A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.** Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. **Therefore, please be advised that any suggested nutritional, lifestyle or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.**

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also optimize an individual's overall health and wellness.

RELEASE FROM LIABILITY:

I have agreed to receive one or more acupuncture and oriental medical treatments at Unified Health Group and its agents, officers or employees. I acknowledge the possibility that injuries, physical and/or mental changes arising during and/or resulting from engaging in oriental medicine do exist. Injuries and changes, although uncommon include, but are not limited to, abnormal blood pressure, fainting, bruising, bleeding, scarring, puncturing of an organ and, in some instances, death. I am voluntarily participating in an oriental medicine program with knowledge of the dangers involved. I understand and take sole responsibility for any and all injuries and changes that may occur to me. I expressly agree that all treatments and use of all facilities shall be undertaken at my own risk. Unified Health Group, its agents, officers or employees shall not be liable for any claims, demands, injuries, damages, actions or causes of action whatsoever arising out of or connected with the use of any of the services and/or facilities. I hereby expressly release and discharge Unified Health Group from all such claims, demands, injuries, damages, actions or causes of action. Unified Health Group, its agents, officers or employees shall not be responsible or liable for any article lost, stolen or damaged in or about its premises.

I have read and understood the above information.

_____ Date: _____
Signature

_____ Date: _____
Signature of Parent or Guardian if under the age of 18