Acupuncture For Life
2032 N. Broad St., Suite 3
Lansdale, PA 19446
267-575-0592

Patient Intake Form

Name (last, first) _____ Date _____
Address _____
City / State / Zip _____
Home phone _____ Work Phone _____Cell Phone _____
Email _____Occupation _____Birth Date _____
Emergency contact _____(name & phone)Referred by
_____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed
___ Caregiver for dependent ___ Children _____

Have you ever had acupuncture? _____ If yes, when/where? _____

For what condition? _____

Are you currently under the care of a physician? _____If so, who, and for what condition(s)?_____
_____

Main reason(s) for seeking acupuncture?
_____
_____
_____

Are you working with an attorney for your condition? Yes or No

How long have you experienced symptoms? _____

Your condition is improved by: _____

Your condition is aggravated by:_____
_____
_____
List all current medications, prescribed or over the counter
_____
_____
_____
_____
List all current vitamins, herbs and other supplements
_____
_____
_____

Significant illnesses (please check all that apply)

___ Cancer
___ Diabetes
___ Hepatitis
___ Heart Disease
___ Stroke
___ Seizures
___ HIV / AIDS
___ Pneumonia
___ Tuberculosis
___ Multiple sclerosis
___ Thyroid
___ Asthma
___ Stomach Ulcers
___ Obesity
___ Depression
___ Shingles
___ Chronic Fatigue
___ Rheumatic Fever
___ High Blood Pressure
___ STD's
___ Other _____

Please list any surgeries you've had including dates _____
_____
_____
_____

Please list any Allergies _____
_____
_____

Please list any major emotional or physical traumas you've experienced
_____
_____
_____

Lifestyle (please check all that apply, and note frequency of use)

___ Tobacco
___ Alcohol
___ Recreational drugs
___ Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency:
_____
_____
_____

Dietary preferences

___ Vegetarian
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners
___ Fast food/ burgers/ fries
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___ Ice chewing
___ Extreme thirst
___ Thirst with no desire to drink

General symptoms

___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other _____

Digestion

___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ GERD
___ Nausea
___ Vomiting
___ Bulimia
___ Anorexia
___ Irritability or low energy between meals
___ Other _____

How many meals per day? _____ How many snacks per day? _____

Intestinal

___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Anal fissures
___ Rectal prolapse
___ Intestinal pain/cramping
___ Incomplete evacuation
___ IBS
___ Colitis
___ Crohn's Disease
___ Gout
___ Celiac Disease
___ Gallstones
___ Other _____

Sleep

___ Falls asleep easily
___ Lie in bed with eyes open
___ Wake as specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or Frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat

___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth___ Excess saliva
___ Sinus problems
___ Swollen glands
___ Earaches
___ Difficulty swallowing
___ Headaches
___ Tinnitus / ringing
___ Nosebleed
___ Bleeding gums
___ Post-nasal drip
___ Sore throat
___ Deafness

Cardiovascular / respiratory

___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath
___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough (color of phlegm?)
___ Other _____

Skin / hair

___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____

Musculoskeletal

___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion
___ Disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Fibromyalgia
___ Other _____

Neuropsychological

___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10
no stress moderate stress extremely stressed

Rate your stress level regarding:

Work _____
Health _____
Love _____
Money _____
Family _____
The future _____

Genito-urinary

___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Bladder prolapse
___ Decreased libido / sexual desire
___ Other _____

<u>Men only</u>
___ Enlarged prostate/prostatitis
___ Prostate cancer
___ Testicular cancer
___ Testicular pain or swelling
___ Erectile dysfunction
___ Impotency
___ STD's _____

<u>Women only</u>
Age menses began _____ Age menses ended (if applicable)_____
Date of last ob/gyn exam _____
Hysterectomy? ___ partial ___ full

___ Hormone replacement therapy
___ Live births
___ Miscarriage
___ Abortions
___ Infertility
___ Birth control pills
___ Breast cancer
___ Ovarian cysts
___ Fibroids
___ Endometriosis
___ Candida / yeast
___ Vaginal discharge
___ Vaginal odor
___ Vaginal sores
___ Herpes
___ Human Papilloma Virus positive
___ Uterine prolapse
___ STD history (chlamydia, PID, etc)
___ Fibrocystic breast

Period lasts _____ days Usual number of days in cycle _____
Headaches ___ before menstrual cycle ___ during cycle ___ after cycle

___ Pain at ovulation
___ Cramps / low back pain
___ Acne associated with period
___ Constipation associated with period
___ Diarrhea associated with period
___ Depression or irritability with period
___ Bleeding outside of normal menstrual cycle
___ No period / skipped cycles
___ Irregular cycle

Menstrual flow is:
___ Clotting
___ Brownish
___ Watery, thin and bright red
___ Normal red
___ Flooding and trickling
___ Stop and start flow

If you have been evaluated for infertility, what was your diagnosis?
_____
_____

New Patient Informed Consent

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Acupuncture is NOT a substitute for conventional medical diagnosis and treatment. Techniques commonly employed in the application of acupuncture: Acupuncture needling – treatment will consist of the insertion of sterile disposable needles at specific sites on the body. Stimulation of said needles may be by manipulation, electrical stimulation or the application of warming substances (moxa) on the needle itself. Auxiliary / Associated therapies – massage, acupressure, cupping, gua sha, assisted stretching, and topical application of liniments There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, psycho-pharmaceuticals and illegal drugs.

I, _____, certify that I have read and understood the statements above
(Print Patient Name)
statement. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

Patient Signature: _____ Date:_____

Payment and Cancellation Policies

Payment is by check, charge or cash. Make checks payable to Acupuncture For Life Full payment is expected at the time the services are rendered. A $20 charge for the first check returned by the bank. If a second check is returned, subsequent payments must be money order or cash. HCFA forms for insurance reimbursement are available for $10. If you must cancel your appointment, call as soon as possible to give the Acupuncturist a chance to rebook your time slot. You must call before 5pm the day before your appointment or else you will be charged in full for your cancelled appointment. Exceptions can be made for medical emergencies. If you are an infertility patient and you start your period the day of your appointment, cancel it. You will not be charged for canceling your appointment but please give at least a few hours notice if you can. If Acupuncture For Life must cancel your session for any reason, you will be called by 5pm the day before. If you live alone and have no voice mail or answering machine or other way of contacting you, we will try until 10:00 the evening before your appointment to reach you. If you miss an appointment, you will be charged for it. Payment is expected either at the next appointment or by mail. If for some reason the Acupuncturist misses your appointment, you will, of course, not be charged for it and your rescheduled appointment will be at no charge. In the event of severe winter weather (not flurries), the 5pm cancellation policy is temporarily suspended. Please call Acupuncture For Life as soon as possible if you cannot make your appointment because of the weather. Leave a message on the machine if you have to. The Acupuncturist will do likewise if we can't make your appointment because of the weather. If you have an appointment and you don't call and you don't show up, you will be charged for your appointment regardless of the weather.

I, _____, certify that I have read and understood the statements above
(Print Name)
and agree to abide by them.

Patient Signature: _____ Date:_____

Acupuncturist Signature_____ Date:_____