**Healing acupuncture of Family Integrative Health**

**Jennifer Yen LAC. B.S, M.A.C**

**New Patient Intake Form**

**Patient Information**

First Name: Middle Initial: Last Name:

Sex: Date of Birth:

Primary Phone: Email:

Primary Address:

Primary Insurance company: ID number: Name:

Emergency Contact / Phone:

**General Medical Questionnaire**

Please list any past medical problems you have had or continue to have (e.g. diabetes, hypertension, etc.). Please include any significant injuries?

Please give previous hospitalizations or surgeries with approximate dates:

| Surgery/Hospitalization | Year | Complications |
| --- | --- | --- |
|  |  |  |

Provide any medical conditions present in any **first-degree** (parents, siblings, children) relatives:

**Social History**

Do you smoke?

Ever smoked?

If yes, how many years?

Packs/day avg:

Do you drink alcohol?

If yes, drinks/week:

Any other drug use?

What is your current work situation?

**Medication Allergies** (if none, write “none”) **Reaction (hives, rash, throat swelling, etc.)**

**Current Medications (include supplements)**

| Medication | Dose/ Freq | Medication | Dose/ Freq |
| --- | --- | --- | --- |
| NA |  |  |  |

**Reason for visit:**

How long has this been a problem?

Describe the pain (ache, sharp, burning, etc.) Provide context of how this started:

What treatments have you tried?

What makes the problem better?

What makes the problem worse?

Additional Information:

**Review of Systems**

Please Highlighted with underline on the figures below, the location of your discomfort, if applicable

Please indicate all of the following that you have experienced in the last **4 weeks***. Please high lighten with yellow color*

**Constitutional** □ Fever □ Fatigue □ Sleep Problems □ Chills/Sweats □ Weight changes (specify) \_\_\_\_\_\_\_\_ □ Other:

**Head, Eyes, Ears, Nose, Throat** □ Visual disturbances □ Runny nose □ Dizziness □ Decreased hearing □ Sinus pain/pressure □ Ringing in ears □ Itchy eyes □ Congestion □ Earache □ Eye pain □ Flu-like symptoms □ Other:

**Cardiovascular** □ Chest pain/pressure □ Leg pain when walking □ Leg swelling □Palpitations □ Exercise intolerance □ Other:

**Respiratory** □ Shortness of breath □ Chest congestion □ Wheezing □ Cough □ Coughing sputum □ Other

**Gastrointestinal**  Abdominal pain , Constipation □ Rectal pain □ Blood in stool □ Diarrhea □ Bowel incontinence □ Vomiting □ Black stools □ Other: □ Nausea □ Heartburn

**Neurological** □ Headache □ Poor coordination □ Fainting □ Dizziness □ Burning sensation □ Seizures □ Abnormal balance or gait □ Numbness/tingling □ Other:

**Musculoskeletal** □ Joint pain □ Back pain □ Muscle weakness □ Joint swelling □ Muscle cramps □ Other: □ Neck pain □ Muscle pain

**Genitourinary** □ Urinary frequency □ Pain with urination □ Testicular pain/swelling □ Incontinence □ Frequent nighttime urination □ Other: □ Urinary Urgency □ Erectile dysfunction

**Integumentary** □ Rash □ Wound/Laceration □ Skin Cancer □ Boil/abscess □ Skin infection □ Other:

**Psychiatric** □ Depression □ Anxiety □ Other:

**Hematologic/Lymphatic** □ Easy bruising □ Easy bleeding □ Other: □ Swollen Lymph nodes

**Endocrine** □ Excessive thirst □ Hot/cold intolerance □ Other:

**Patient Financial Obligation Agreement**: I understand that all payments are due at the time of service. I agree, to be financially responsible and make full payment for all charges. I understand that if I elect to make full payment at the time of encounter, that I will be given an opportunity to directly submit charge information to my insurance company. I understand that this is my personal responsibility and do not hold Family integrative health responsible for performing this action on my behalf nor do I hold them responsible for any charges that are not reimbursed by my insurance company.

**Notice of Privacy Practices: Acknowledgement of Receipt**

I acknowledge that I was provided with a copy of Family Integrative Health & Urgent Care Notice of Privacy Practices (NOPP). □ Received □ N/A (only if you received the notice from us previously)

**Authorization to transmit information**

I authorize the staff of Family Integrative Health & Urgent care and Privia EHR to transmit any required information either electronically or in paper form to my insurance entities for the purposes of receiving payment for services rendered on my behalf.

**Consent Form :** 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, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 or Legal Guardian Name (Print):

Patient or Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acupuncturist** Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_