NEW PATIENT INTAKE FORM

Today's Date_____/_____/_____

Name **SS#** **Birthdate** / /

Marital Status **Age**

Address ❑ M ❑ F **Ht** **Wt**

Email

City, State, Zip **Occupation**

Home Phone **Work** **Cell**

Emergency Contact's Name & Phone

Referred by

Reason for visit today **Have you had acupuncture before?** ❑ Yes ❑ No **Chinese herbal medicine?** ❑ Yes ❑ No

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

Health Insurance Info:

Insurance Co. Name **Policy #**

Address **Phone**

City, State, Zip

Medicare Info:

Insurance Co. Name **Policy #**

Address **Phone**

City, State, Zip

Family Medical History

❑ Allergies (list) _____ _____

❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism

❑ Cancer (type) _____
❑ Depression

❑ Diabetes (Type:)
❑ Heart disease
❑ High blood pressure

❑ Seizures
❑ Stroke

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
❑ Stroke
❑ Surgery (list) _____ _____ _____
❑ Thyroid disorders
❑ Major trauma (Car, fall, etc--list) _____ _____ _____
❑ Tuberculosis
❑ Typhoid fever
❑ Ulcers
❑ Venereal disease
❑ Whooping cough
❑ Other (Specify) _____ _____ _____ _____

Your Diet

Appetite ❑ Low ❑ High

❑ Coffee/Tea
❑ Soft Drinks/Fruit Juices

Protein Intake ❑ Low ❑ High

❑ Artificial Sweeteners

❑ Sugar
❑ Salty foods

Thirst for water: # glasses per day: _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in the last 2 months:

Vitamins/supplements taken in the last 2 months:

Practitioner Use Only

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 or 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

Length of cycle (day 1 to day 1)

- ❑ Duration of flow
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge (color)_____
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps

Pregnancies_____
Live births_____
Premature births_____
Age at menopause_____

Date of last PAP

Date last period began

Other

CONSENT TO TREATMENT

BLOSSOM HEALTH

I, (patient) _____, hereby authorize Sharon Pruss, L.Ac., to administer treatment of acupuncture and other techniques relevant to my diagnosis. I have the right to refuse any form of treatment.

Treatment may include but is not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using conventional heat lamp or "moxibustion" (burning *Artemesia Vulgaris* herb). With any heat treatment, there may be a risk of burning.
3. Massage technique of *gua sha*. This technique may cause redness on the skin at the site of treatment. Slight bruising and tenderness may persist after the treatment.
4. The placement of suction (vacuum) cups on the skin. These cups may produce a red or purple mark on the skin at the site of cup placement. Slight bruising or tenderness may remain after the treatment.
5. Electrical stimulation of the needles may be used, producing a tapping sensation at the needles' location.
6. The use of press-tacks, press-balls, magnets, intradermal needles, non-insertive needles, and other various techniques that can be applied and used in the office. There is a possibility that these could cause irritation of the skin.

- I have been informed that I have the right to refuse any form of treatment.
- I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment.
- I also understand that there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to treatment.
- I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks with treatment--including, but not limited to, local bruising, slight bleeding, fainting, temporary pain and discomfort, and nausea. Very rare risks might be a punctured lung and infection.
- I understand that an emotional response to the treatment(s) can occur in some patients.
- I do not expect the acupuncturist to be able to anticipate and explain all risks and possible complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.
- I understand that no guarantee can be made concerning the results of treatment.

Signature of Patient or Legal Guardian:

_____

Printed Name of Patient: _____ Date _____

Blossom Health
Sharon Pruss, L.Ac.
310.621.4553

SUMMARY OF PATIENT PRIVACY POLICY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

This notice is to inform you that we are in compliance with the law concerning privacy of your health information, HIPAA. This is a short summary; the full length explanation of HIPAA is available to you upon request. If you are concerned about how we may use your information, please read the long version called, "Notices of Privacy Practices." By signing this form, you acknowledge the understanding of this Notice.

We, at this clinic, do not share your protected health information (PHI) with anyone other than with an entity that you agree to share information with. By signing this form, you agree to allow us to use your information for pertinent reasons: products and services, healthcare operations, and billing for payment of products and services. These reasons are fully described in the "Notices of Privacy Practices." This type of information includes your name, social security number, birth date, address, insurance company, phone numbers, your health history questionnaire, and any and all related medical charting with regards to products or services we provide to you.

Patients can request to have anyone accompany them in the room during treatment. The patient then acknowledges that personal health information may be shared with this person. We do not share your PHI with anyone else in the clinic other than those listed here or pertinent staff of the clinic for the purpose of clinic operations.

We have the right to contact you by phone, mail, or email if you list this information in your consent form. This contact could be regarding scheduling, promotions, or other pertinent reasons of the clinic, but we will not give PHI to anyone else as a result of these types of contact.

_____ _____

Signature Date