HealthFocus Acupuncture and Oriental Medicine
5030 Sadler Place, Suite 202 • Glen Allen, VA 23060 • (804) 467-1355

PATIENT INTAKE FORM

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Although some of the questions may seem unrelated to your condition, these details allow us to create a customized treatment plan especially for you. All your information will be confidential. Please feel free to ask if you have any questions. *Thank you.*

Contact Information

Full Name _____ Date _____

Gender ❑ Female ❑ Male _____ Date of birth _____ Age _____

Marital Status ❑ single ❑ married ❑ divorced ❑ widowed _____ # of children _____

Street Address _____

City _____ State _____ Zip _____

Main phone# _____ Alternate phone# _____

E-mail address _____ Allow contact by e-mail? ❑ Yes ❑ No

Emergency contact name _____ phone# _____

Family physician _____ Ever tried acupuncture before? ❑ Yes ❑ No

How did you find out about our clinic? _____

Present Health

Main concern _____

What diagnosis, if any, have you received for this problem _____

_____ How long have you had this problem _____

To what extent does this problem interfere with daily activities _____

_____

What kind of treatment have you tried _____

Anyone in your immediate family with similar/same problem _____

Pacemaker or electrical implant ❑ Yes ❑ No

Bleeding disorder or take blood thinners ❑ Yes ❑ No

Recent foreign travel ❑ Yes ❑ No

Significant trauma (falls, auto accidents, or sports injuries)

Surgeries or hospitalizations

Allergies (drugs, chemicals, food, or environmental)

Medications, vitamins, OTC, herbs, etc

Social History

Occupation

Do you usually work ❑ indoors ❑ outdoors

Occupational stress (chemical, physical, psychological)

Height

Weight now

Weight 1 year ago

Do you smoke ❑ Yes ❑ No

per day

How many years

Do you drink alcohol ❑ Yes ❑ No

How much per day

Do you drink caffeine ❑ Yes ❑ No

How much per day

Exercise regularly ❑ Yes ❑ No

If yes, briefly describe routine

Medical History & Family History - Select "S" for Self; Select "F" for Family

Alcohol or drug abuse	❑S	❑F	Thyroid disease	❑S	❑F	Epilepsy or seizures	❑S	❑F
Anemia	❑S	❑F	Digestive disorders	❑S	❑F	STD	❑S	❑F
Emotional disorder	❑S	❑F	Heart disease	❑S	❑F	Lyme disease	❑S	❑F
Arthritis	❑S	❑F	Low blood pressure	❑S	❑F	Measles or Mumps	❑S	❑F
Asthma	❑S	❑F	High blood pressure	❑S	❑F	Rheumatic fever	❑S	❑F
COPD	❑S	❑F	High cholesterol	❑S	❑F	Stroke	❑S	❑F
Tuberculosis	❑S	❑F	Hepatitis	❑S	❑F	Kidney disease	❑S	❑F
Cancer	❑S	❑F	Liver disease	❑S	❑F	HIV or AIDS	❑S	❑F
Diabetes	❑S	❑F	Gallbladder disease	❑S	❑F	Autoimmune disorder	❑S	❑F

Circle any symptoms you have experienced in the last 3 months. Where applicable, fill in the blanks.

General

Recent weight change	Fever	Night sweats	Chronic infections
General weakness	Chills	Poor sleep	Favorite season _____
Fatigue	Bruise or bleed easily	Slow wound healing	Worst season _____
Sudden energy drop	Sweat easily	Frequent colds	

Skin, Hair, and Nails

Dry skin	Psoriasis	Sores	Dandruff
Rashes	Acne	Warts	Hair loss
Itching	Purpura	Change in skin texture	Other _____
Hives	Change in mole size/color	Change in hair	
Eczema	Ulcerations	Change in nails	

Head and Neck

Headache	Glaucoma	Vertigo	Sores on lips or tongue
Migraine	Night blindness	Nasal stuffiness	Neck pain
Facial pain	Spots in front of eyes	Sinus problems	Neck stiffness
Dizziness	Eye pain	Nosebleeds	Swollen glands
Poor vision	Eye discharge	Sore throat	Goiter
Wear glasses/contacts	Hearing loss	Jaw clicks or pops	Limited range of motion - neck
Blurry vision	Ringing in ears	Grinding teeth	
Double vision	Earaches	Dental problems	Other _____
Cataracts	Ear discharge	Bleeding gums	

Musculoskeletal

Muscle pain/soreness	Elbow pain	Foot/ankle pain	Joint sprain
Muscle weakness	Hand/wrist pain	Decreased range of motion	Swollen joints
Back pain	Hip pain	Joint disorders	Other _____
Shoulder pain	Knee pain		

Neurological

Poor memory	Unsteady gait	Abnormal sensations	Paralysis
Changes in speech	Loss of balance	Numbness	Tremors
Changes in mood	Lack of coordination	Tingling	Other _____

Cardiovascular

Chest pain or pressure	Irregular heartbeat	Swelling or edema	Varicose veins
Palpitations	Rapid heartbeat	Blood clots	Other _____

Respiratory

Chest pain	Cough	What color? _____	Bronchitis
Shortness of breath	Coughing blood	Difficulty breathing	Pneumonia
Wheezing	Production of phlegm	Difficulty breathing at night	Other _____

Gastrointestinal

Bad breath	Nausea	Hiatal hernia	*Bowel Movements*:
Cravings	Vomiting	Rectal pain	Frequency _____
Peculiar tastes	Loss of appetite	Hemorrhoids	Color _____
Acid reflux	Increase in appetite	Diarrhea	Odor _____
Difficulty swallowing	Weight loss	Constipation	❑ Hard
Increased Thirst	Weight gain	Chronic laxative use	❑ Well-formed or
Decreased Thirst	Abdominal pain/cramps	Black or tarry stools	❑ Loose
Bloating	Ulcer	Blood in stools	Other _____
Belching or Gas	Parasites	Mucus in stools	

Urinary

Frequent urination	Incontinence	Cloudy urination	Urinary tract infection
Urgent urination	Burning urination	Blood in urine	Other _____
Nighttime urination	Painful urination	Kidney stones	

Males Only

Reduced force of urine stream	Decreased libido	Infertility	Genital rashes
Dribbling urination	Excessive libido	Scrotal pain or swelling	Genital warts
Prostate problems	Erectile dysfunction	Penile Discharge	Genital herpes
Inguinal hernia	Premature ejaculation	Genital itching	Other _____

Females Only

Breast pain/discomfort
Breast lump or mass
Nipple discharge
Decreased sex drive
Excessive sex drive
Vaginal dryness
Vaginal infection
Vaginal discharge

Genital pain
Pain during intercourse
Genital itching
Genital rashes
HPV
Genital herpes
Hernia (femoral or inguinal)

Endometriosis
Uterine fibroids
Ovarian cysts
Polycystic Ovarian Syndrome
Infertility
Hot Flashes

Menstruation:
Irregular periods
Painful periods
Moodiness
Clots
Heavy bleeding
Scanty bleeding
Other _____

Age when your menstrual periods began _____
First day of your last period _____
How many days does your period last _____
Length of cycle (day 1 to day 1) _____
Do you practice birth control ❑ Yes ❑ No
If yes, what type and how long _____
_____

*Number of total pregnancies:*_____
Live births_____ Miscarriages_____
Abortions_____ Premature births_____
C-Section_____ Difficult delivery_____
Have you experienced menopause ❑ Yes ❑ No
If yes, at what age _____

IS THERE ANY CHANCE YOU COULD BE PREGNANT NOW? ❑ Yes ❑ No

Please use the space below to include any additional information you would like us to know.

HealthFocus Acupuncture and Oriental Medicine
5030 Sadler Place, Suite 202 • Glen Allen, VA 23060 • (804) 467-1355

INFORMED CONSENT TO ORIENTAL MEDICINE TREATMENT

I hereby request and give consent for myself (or the patient named below for whom I am legally responsible) to be treated by Diane Lowry, a licensed acupuncturist at HealthFocus Acupuncture and Oriental Medicine. I understand that the methods of treatment used in this practice may include, but are not limited to, acupuncture, electrical stimulation, moxibustion, heat or cold therapy, gua sha, cupping, medical qigong, tuina, herbal therapy, dietary supplements, and healthy lifestyle recommendations.

Acupuncture and Oriental Medicine
I understand that the practice of Acupuncture and Oriental Medicine is typically a safe treatment. However, as in the practice of conventional Western medicine, there are some risks to treatment. Potential risks include, but are not limited to, local bruising, swelling, minor bleeding, pain, or discomfort at the needling site that may last a few days. Other uncommon but possible risks include dizziness, fainting, or nerve damage. Potential risks of moxibustion or heat therapy include burns, blistering, or scarring. Temporary redness or bruising that resolves within a few days is a common side effect of gua sha and cupping.

HealthFocus Acupuncture and Oriental Medicine maintains a clean and safe environment. We adhere to a strict hand-washing policy, provide clean table linens for each treatment, swab each acupuncture point with alcohol prior to insertion of the needle, and use only sterile disposable stainless steel needles.

Pregnancy
I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that are contraindicated during pregnancy. Otherwise, Oriental Medicine treatment can be very beneficial in the pregnancy and birthing process.

Herbal Therapy and Dietary Supplements
I understand that herbal and dietary supplements recommended to me by my acupuncturist are safe in the recommended doses. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. Large doses of herbs taken without my practitioner's recommendation may be toxic and some herbs are inappropriate during pregnancy. I am aware that certain adverse side effects may result from taking these substances. Side effects could include, but are not limited to, changes in bowel movement, abdominal pain or discomfort, nausea, vomiting, or the possible aggravation of symptoms existing prior to treatment. I understand that I must stop taking any herbal or dietary supplements and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. I have informed my practitioner of all substances to which I have had allergic reactions.

IN THE EVENT OF A MEDICAL EMERGENCY, CALL 911 IMMEDIATELY.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. 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 at HealthFocus Acupuncture and Oriental Medicine.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient's Name (please print)	Patient's Signature
Print Name of Patient's Representative (if applicable)	Signature of Patient's Representative (if applicable)
Relationship or Authority of Patient's Representative	Date Signed