New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone Mobile Phone SS# Date of Birth

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐Yes ☐No

Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐Yes ☐No Who and what for? _____

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for? _____

Insurance Information

Insurance Company Phone Date Called

ID # Co-Pay $ Covered %

Visit # Deductible Amount

Contact Name

Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

☐ Work ☐ Standing ☐ Sexually ☐ Other
☐ Sleep ☐ Emotional ☐ Recreation
☐ Walking ☐ Relationships ☐ Bending
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this?

Are you interested in:

☐ Pain Relief ☐ Holistic Health ☐ Stress Relief ☐ Other
☐ Preventative Care ☐ Stretching/Yoga ☐ Herbal Therapy
☐ Oriental Nutrition ☐ Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you
have been or are currently involved in:

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what?

Do you take medication? Yes No If so, what types and how often?

Do you take supplements? Yes No If so, what types and how often?

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? Do you have a low point during the day? ☐ Yes ☐ No When?

What are your indulgences?

What are your hobbies/pleasures?

Female Concerns

Date of last menstruation Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long?

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge

Other

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other:
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

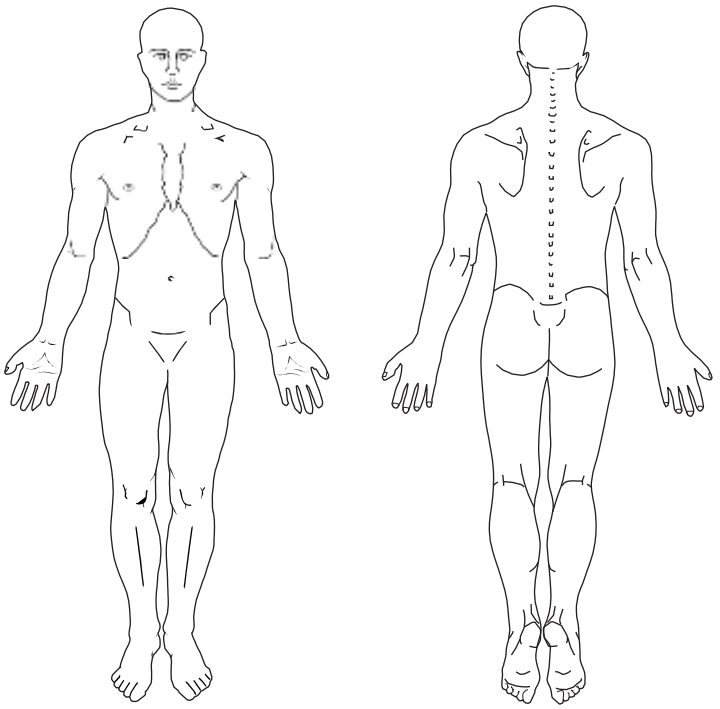
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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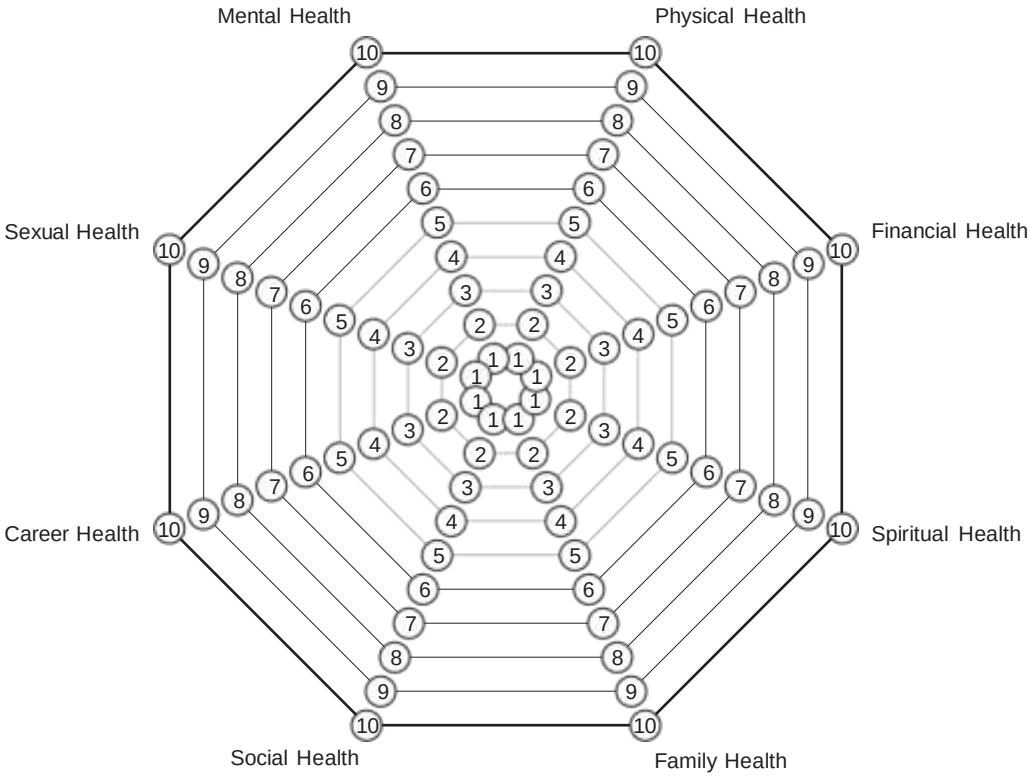
Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied

5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Consent to Oriental Medical Health Care/Terms of Acceptance

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at CostaCoast Sprinters, LLC (CCS) who now or in the future treat me while employed by, working or associated with or substituting for CCS, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping, guasha and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

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. 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 CCS.

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