CAM Center of Haegrstown
Julie Sutton, L.Ac.
89 West Lee Street
Hagerstown, MD 21740
Phone 301-797-3737 Fax 301-302-7802

PATIENT INTAKE FORM

DATE: _____

NAME: _____
Last First Middle

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

EMAIL: _____

PREFERRED CONTACT PHONE #: _____ SECONDARY PHONE #:_____

DATE OF BIRTH: _____ AGE: _____ GENDER (Please circle): M / F

IN CASE OF EMERGENCY CONTACT NAME: _____PHONE: _____

YOUR OCCUPATION: _____EMPLOYER:_____PHONE:_____

MARITAL STATUS: M S W D NAME OF SPOUSE: _____ NUMBER OF CHILDREN: _____

NAME OF PARENT/GUARDIAN (if patient is a minor):_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

REASON(S) FOR TODAY'S VISIT: _____

☐ YES, I HAVE BEEN TREATED BY ACUPUNCTURE BEFORE. DATE OF LAST TREATMENT _____

☐ YES, I AM CURRENTLY UNDER A PHYSICIAN'S CARE FOR: _____

NAME OF PHYSICIAN: _____ PHONE: _____

☐ YES, I AM CURRENTLY TAKING PRESCRIPTION DRUGS. PLEASE LIST BELOW:

DRUG NAME & DOSAGE	**FOR WHAT PURPOSE/CONDITION**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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☐ YES, I AM CURRENTLY TAKING SUPPLEMENTS AND/OR VITAMINS. PLEASE LIST BELOW:

SUPPLEMENT/VITAMIN NAME & AMOUNT	FOR WHAT PURPOSE/CONDITION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

☐ YES, I HAVE AN INFECTIOUS DISEASE. PLEASE DESCRIBE: _____

☐ YES, I HAVE ALLERGIES. PLEASE INDICATE BELOW:

- ○ FOODS: _____
- ○ MEDICATIONS: _____
- ○ BITES / STINGS: _____
- ○ SEASONAL: _____
- ○ ANIMALS: _____
- ○ OTHER: _____

FAMILY MEDICAL HISTORY: (Please check if any of the following applies to any blood relatives)

☐ AIDS	☐ ASTHMA	☐ HEART DISEASE	☐ SEIZURES
☐ ALCOHOLISM	☐ CANCER	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ALLERGIES	☐ DIABETES, TYPE I OR II	☐ MENTAL ILLNESS	☐ OTHER: _____

DESCRIBE THE FOLLOWING FAMILY MEMBER'S HEALTH:

MOTHER:		LIVING		DECEASED		UNKNOWN
FATHER:		LIVING		DECEASED		UNKNOWN
SIBLINGS:		LIVING		DECEASED		UNKNOWN
GRANDPARENTS:		LIVING		DECEASED		UNKNOWN
CHILDREN:		LIVING		DECEASED		UNKNOWN

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PERSONAL HEALTH HISTORY: (Please check if any of the following apply)

- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ASTHMA
- ☐ ARTERIOSCLEROSIS
- ☐ BIRTH TRAUMA (YOURS)
- ☐ CHILDHOOD FEVERS
- ☐ CHILDHOOD ILLNESSES
- ☐ DIABETES, TYPE I OR II
- ☐ EMPHYSEMA
- ☐ ENDOCRINE DISORDER
- ☐ EPILEPSY
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ MULTIPLE SCLEROSIS
- ☐ THYROID DISEASE

☐ MAJOR SURGERIES (Please list all with approximate dates): _____

_____

☐ SIGNIFICANT TRAUMA (auto accidents, falls, etc. Please list with approximate date of injury): _____

_____

CURRENT SYMPTOMS: (Please check if any of the following apply)

- ☐ HEADACHES
- ☐ VISION PROBLEMS
- ☐ JAW / TEETH PAIN
- ☐ EAR PAIN
- ☐ SINUS PAIN / PROBLEMS
- ☐ THROAT PAIN / PROBLEMS
- ☐ BREATHING DIFFICULTIES
- ☐ CHEST PAIN
- ☐ CHILLS
- ☐ FEVER
- ☐ INDIGESTION
- ☐ INSOMNIA
- ☐ NERVOUSNESS
- ☐ GOUT
- ☐ URINATION DIFFICULTIES
- ☐ INFERTILITY
- ☐ IMPOTENCE
- ☐ MUSCULAR PAIN
- ☐ JOINT DYSFUNCTION / PAIN
- ☐ HIGH / LOW BLOOD PRESSURE
- ☐ DEPRESSION
- ☐ OVERLY EMOTIONAL
- ☐ ANXIETY
- ☐ FATIGUE
- ☐ DIZZINESS
- ☐ WEIGHT LOSS
- ☐ WEIGHT GAIN
- ☐ CONSTIPATION / DIARRHEA
- ☐ SKIN DISORDERS
- ☐ PMS
- ☐ MENSTRUAL DISORDERS
- ☐ MENOPAUSAL PROBLEMS
- ☐ EXCESS THIRST
- ☐ LACK OF THIRST
- ☐ SPONTANEOUS SWEATING
- ☐ NIGHT SWEATING
- ☐ LACK OF SWEATING

☐ OTHER: _____

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LIFE STYLE: (Please check if any of the following apply)

- ☐ LIVE ALONE
- ☐ LIVE WITH SPOUSE / SIGNIFICANT OTHER
- ☐ LIVE WITH ROOMMATE(S)
- ☐ LIVE WITH PARENTS
- ☐ LIVE WITH CHILDREN
- ☐ ENJOY YOUR WORK
- ☐ ENJOY YOUR HOME
- ☐ ENJOY YOUR SOCIAL LIFE
- ☐ WORK 1ST SHIFT
- ☐ WORK 2ND SHIFT
- ☐ WORK 3RD SHIFT
- ☐ WORK INCONSISTENT HOURS
- ☐ MANAGE OWN BUSINESS
- ☐ UNEMPLOYED
- ☐ STUDENT FULL TIME
- ☐ STUDENT PART TIME
- ☐ HAVE FAMILY SUPPORT
- ☐ HAVE FINANCIAL SUPPORT
- ☐ ENJOY HOBBIES
- ☐ RELIGIOUS
- ☐ SPIRITUAL CONNECTION

DIET AND PERSONAL HABITS: (Please check if any of the following apply)

- ☐ USE TOBACCO
- ☐ FORMER TOBACCO USER
- ☐ DRINK ALCOHOL
- ☐ USE OF RECREATIONAL DRUGS
- ☐ EXERCISE REGULARLY
- ☐ VEGETARIAN / VEGAN
- ☐ HEALTHY DIET
- ☐ CONSUME A LOT OF FRIED FOOD
- ☐ CONSUME A LOT OF SWEETS
- ☐ CONSUME A LOT OF DAIRY
- ☐ CONSUME A LOT OF RED MEAT

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Please check if you experience any of the following on a regular basis:

HEAD, EYES, EARS, NOSE, THROAT:

- ☐ HEADACHES
- ☐ MIGRAINES
- ☐ CONCUSSIONS
- ☐ HEAVINESS OF HEAD
- ☐ FACIAL PAIN
- ☐ FACIAL NUMBNESS
- ☐ GLASSES / CONTACTS
- ☐ NIGHT BLINDNESS
- ☐ EYE STRAIN
- ☐ EYE PAIN
- ☐ RED EYES
- ☐ ITCHY EYES
- ☐ SPOTS IN EYES
- ☐ SPOTS IN VISION
- ☐ BLURRED VISION
- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ EAR RINGING
- ☐ HEARING LOSS
- ☐ EARACHES
- ☐ RINGING IN EARS
- ☐ NOSEBLEEDS
- ☐ SINUS PROBLEM
- ☐ SINUS DRAINAGE
- ☐ THROAT DRAINAGE
- ☐ THROAT TICKLE
- ☐ SORE THROAT
- ☐ SWOLLEN GLANDS
- ☐ LUMP IN THROAT
- ☐ ENLARGED THYROID
- ☐ TEETH REMOVED
- ☐ NUMEROUS CAVITIES
- ☐ TEETH GRINDING
- ☐ TMJ
- ☐ GUM PROBLEMS
- ☐ LIP SORES
- ☐ MOUTH SORES
- ☐ EXCESSIVE SALIVA

RESPIRATORY:

- ☐ DIFFICULTY BREATHING
- ☐ SHORTNESS OF BREATH
- ☐ TIGHT CHEST
- ☐ ASTHMA
- ☐ WHEEZING
- ☐ PNEUMONIA
- ☐ CHRONIC COUGH
- ☐ ACUTE COUGH
- ☐ PLEURISY
- ☐ PHLEGM / CONGESTION
- ☐ RATTLING SOUND WITH BREATH
- ☐ CAN'T SLEEP LYING DOWN

CARDIOVASCULAR:

- ☐ HYPERTENSION (HIGH BLOOD PRESSURE)
- ☐ HYPOTENSION (LOW BLOOD PRESSURE)
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ SLOW HEART RATE
- ☐ RAPID HEART RATE
- ☐ IRREGULAR HEART RATE
- ☐ PACEMAKER
- ☐ FAINTING
- ☐ EDEMA (SWELLING)

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GASTROINTESTINAL:

- ☐ NAUSEA
- ☐ VOMITING
- ☐ VOMITING BLOOD
- ☐ ACID REGURGITATION / REFLUX
- ☐ GAS / FLATULENCE
- ☐ HEMORRHOIDS
- ☐ RECTAL PAIN / ITCHING
- ☐ FISSURES
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ BLOOD IN STOOL
- ☐ INTESTINAL PAIN
- ☐ POOR APPETITE
- ☐ BLOATING

URINARY:

- ☐ PAIN WITH URINATION
- ☐ FREQUENT URINATION
- ☐ URGENT URINATION
- ☐ INCOMPLETE URINATION
- ☐ BED WETTING
- ☐ FREQUENT UTI'S
- ☐ BLOOD IN URINE
- ☐ KIDNEY STONES

MUSCULO-SKELETAL:

- ☐ MUSCLE WEAKNESS
- ☐ MUSCLE CRAMPS
- ☐ MUSCLE SPASMS
- ☐ MUSCLE ATROPHY
- ☐ JOINT PAIN
- ☐ JOINT INSTABILITY
- ☐ LIMITED RANGE OF MOTION
- ☐ ARTHRITIS
- ☐ GENERAL ACHES
- ☐ CHRONIC PAIN (LONG-TERM)
- ☐ ACUTE PAIN (SHORT-TERM)

NEUROLOGICAL:

- ☐ FAINTING / SYNCOPE
- ☐ DROWSINESS
- ☐ TREMOR
- ☐ STROKE / CVA / TIA
- ☐ DIZZINESS
- ☐ LOSS OF BALANCE
- ☐ CONVULSIONS
- ☐ SEIZURES
- ☐ VERTIGO
- ☐ POOR MEMORY
- ☐ PARALYSIS
- ☐ NUMBNESS

NEUROPHYSIOLOGICAL:

- ☐ DEPRESSION
- ☐ IRRITABLE
- ☐ EASILY STRESSED
- ☐ EASILY FRUSTRATED
- ☐ WORRY EASILY - ANXIETY
- ☐ UNRESOLVED GRIEF
- ☐ FRIGHTENED EASILY
- ☐ POOR MEMORY

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SKIN AND HEAR:

- ☐ RASHES / HIVES
- ☐ PSORIASIS
- ☐ HAIR LOSS
- ☐ ULCERATIONS
- ☐ ACNE
- ☐ THIN, SLOW GROWING NAILS
- ☐ ECZEMA
- ☐ ITCHING
- ☐ SKIN CHANGES
- ☐ FUNGAL INFECTION
- ☐ DANDRUFF

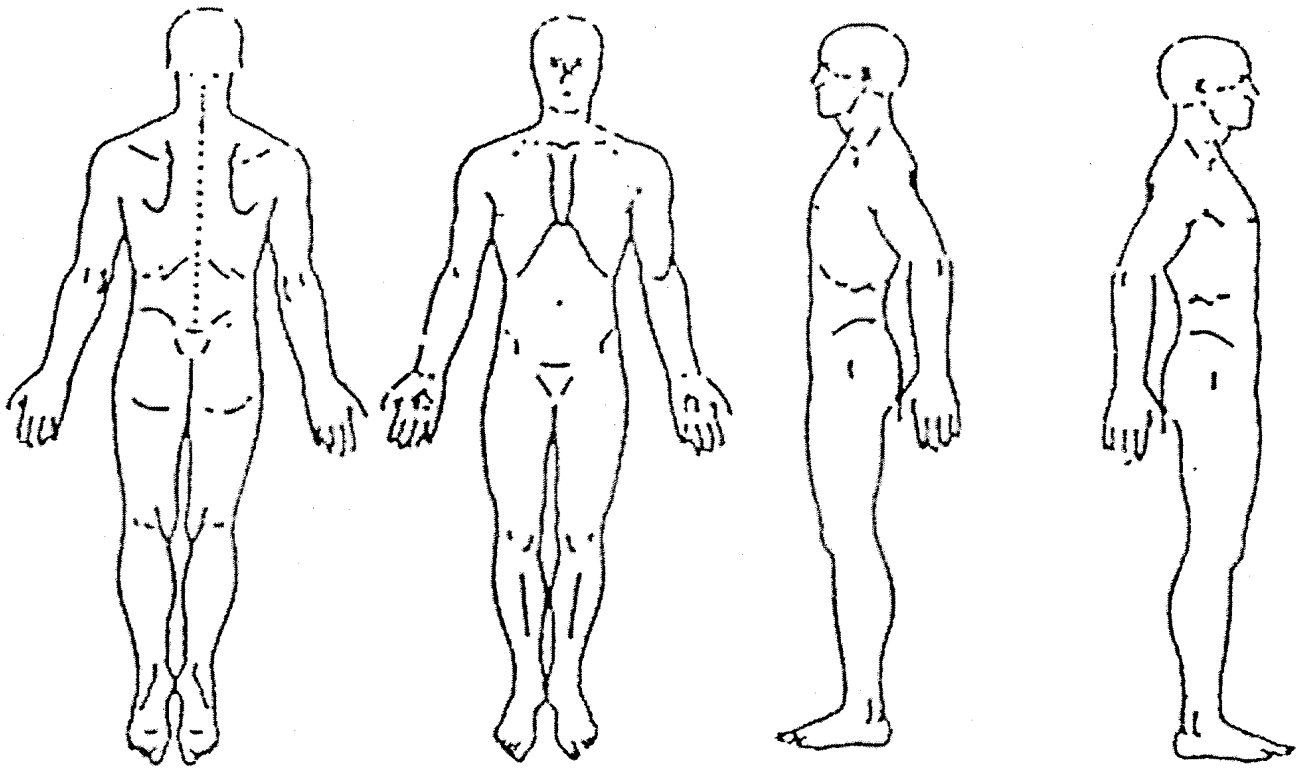
VITALITY AND IMMUNITY SYSTEM:

- ☐ FREQUENT COLDS
- ☐ LOW ENERGY
- ☐ TENDER / ACHY ALL OVER
- ☐ FREQUENT FLU
- ☐ LETHARGIC
- ☐ CHRONIC MENTAL CLOUDINESS
- ☐ MENTAL CLOUDINESS
- ☐ SLOW WOUND HEALING
- ☐ INABILITY TO ADAPT

GYNELOGICAL:

- ☐ PREGNANT
- ☐ MENOPAUSAL
- ☐ POST MENOPAUSAL
- ☐ COULD BE PREGNANT
- ☐ HEAVY MENSES
- ☐ NURSING
- ☐ PAIN WITH MENSTRUATION

****** Please <u>MARK</u>** any areas of pain on the diagram located on this form ****



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CONSENT FOR TREATMENT: I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF ACUPUNCTURE TREATMENTS AND OTHER COMPLEMENTARY MEDICINE PROCEDURES INCLUDING VARIOUS MODES OF PHYSIO-THERAPY ON ME (OR ON THE PATIENT NAMED BELOW, FOR WHOM I AM LEGALLY RESPONSIBLE) BY JULIE SUTTON, L.Ac.

I UNDERSTAND THAT METHODS OF TREATMENT MAY INCLUDE, BUT ARE NOT LIMITED TO ACUPUNCTURE, MOXIBUSTION, CUPPING, CHINESE OR WESTERN HERBAL MEDICINE, SUPPLEMENT RECOMMENDATIONS, AND NUTRITIONAL COUNSELING.

ACUPUNCTURE IS A SAFE TREATMENT INVOLVING THE INSERTION OF TINY, STERILE NEEDLES THROUGH THE SKIN, TO ATTEMPT TO NORMALIZE PHYSIOLOGICAL FUNCTIONS, MODIFY THE PERCEPTION OF PAIN, AND TREAT CERTAIN DISEASES OR DYSFUNCTIONS OF THE BODY. ACUPUNCTURE CAN OCCASIONALLY CAUSE SLIGHT BLEEDING, BRUISING OR TINGLING NEER THE NEEDLING SITES THAT MAY LAST A FEW DAYS. I WILL REPORT TO THE ACUPUNCTURIST ANY DIZZINESS OR LIGHT-HEADEDNESS THAT OCCURS DURING OR AFTER AN ACUPUNCTURE TREATMENT.

MOXIBUSTION CONSISTS OF BURNING AN HERB FROM THE MUGWORT PLANT CALLED MOXA. YOUR ACUPUNCTURIST WILL BURN THIS HERB DIRECTLY ON THE SKIN ON CERTAIN ACUPUNCTURE POINTS, ON TOP OF A NEEDLE OR HOOVERING JUST ABOVE THE SKIN. THERE ARE MINIMAL TO NO RISKS IN THIS TECHNIQUE. SHOULD A MILD BURN OCCUR, EXPECT FOR ALL TO BE RESOLVED IN 3-5 DAYS.

CUPPING INVOLVES A LOCALIZED SUCTION PRODUCED BY A SMALL PLASTIC OR GLASS CUP. THERE IS A POSSIBILITY OF LOCAL BRUISING FROM THE SUCTION WHICH USUALLY RESOLVES WITHIN 3-7 DAYS.

THE HERBS AND NUTRITIONAL SUPPLEMENTS (WHICH ARE FROM PLANT, ANIMAL AND MINERAL SOURCES) THAT HAVE BEEN RECOMMENDED ARE TRADITIONALLY CONSIDERED SAFE IN THE PRACTICE OF CHINESE MEDICINE. I UNDERSTAND THAT SOME HERBS MAY BE INAPPROPRIATE DURING PREGNANCY. IF I EXPERIENCE ANY GASTROINTESTINAL UPSET OR ALLERGIC REACTIONS TO THE HERBS, I WILL INFORM THE ACUPUNCTURIST.

FINANCIAL RESPONSIBILITY: THE UNDERSIGNED AGREES THAT IN CONSIDERATION FOR THE SERVICES TO BE RENDERED TO THE PATIENT, HE/SHE HEREBY INDIVIDUALLY OBLIGATES HIMSELF/HERSELF TO PAY THE ACCOUNT OF JULIE SUTTON, L.Ac. IN ACCORDANCE WITH THE REGULAR RATES AND TERMS.

RELEASE OF INFORMATION: THE UNDERSIGNED DOES HEREBY AUTHORIZE JULIE SUTTON, L.Ac. TO RELEASE ANY AND ALL INFORMATION REGARDING THE PATIENT'S MEDICAL HISTORY AND TREATMENT ADMINISTERED DURING OUTPATIENT TREATMENT, TO ANY PHYSICIAN OR HOSPITAL OR TO ANY INSURANCE COMPANY, EMPLOYER, LEGAL COUNSEL OR OTHER ORGANIZATION RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS MEDICAL EXPENSES. THE UNDERSIGNED CONSENTS TO ALLOW MESSAGES TO BE LEFT ON THE PERSONAL PHONE NUMBERS PROVIDED BY THE PATIENT ON THE INTAKE FORM REGARDING FUTURE APPOINTMENTS.

ASSIGNMENT OF INSURANCE BENEFITS: THE UNDERSIGNED AUTHORIZES, WHERE HE/SHE AS AGENT OR AS PATIENT, DIRECT PAYMENT TO JULIE SUTTON, L.Ac. OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO OR ON BEHALF OF THE UNDERSIGNED FOR ACUPUNCTURE SERVICES. IT IS THE UNDERSIGNED'S RESPONSIBILITY TO SUPPLY THE OFFICE WITH A REFERRAL IF REQUIRED BY HIS/HER INSURANCE AND IF NOT SUPPLIED THE UNDERSIGNED WILL BE RESPONSIBLE FOR PAYMENT. IT IS UNDERSTOOD BY THE UNDERSIGNED THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: THE UNDERSIGNED HAS REVIEWED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND A COPY WAS PROVIDED TO ME, IF REQUESTED.

BY SIGNING THIS FORM, I ADMIT THAT THE CONTENTS OF THIS FORM HAVE BEEN FULLY EXPLAINED TO ME AND I DO UNDERSTAND THE CONTENTS OF THIS FORM.

SIGNATURE (PATIENT, PARENT, or GUARDIAN) X_____DATE_____

Relationship (circle one): Self Parent Guardian

PRINT PATIENT NAME _____ DATE OF BIRTH _____