

# Healing Care Acupuncture

1030 Xenia Avenue  
Yellow Springs, OH 45387

937.532.5773  
www.HealingCareAcupuncture.com

## Patient Intake Form

Please help me to provide you with the best possible care by taking the time to fill out this form as accurately as you can.  
All information provided is confidential. Please feel free to ask if you have any questions. Thank you.

Name \_\_\_\_\_ Date \_\_\_\_\_ Gender: F  M  Married  Single  Other   
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ Mobile Phone (\_\_\_\_) \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_ Referred by \_\_\_\_\_  
Main reason you are seeking acupuncture \_\_\_\_\_  
Have you been given a diagnosis for this problem? \_\_\_\_\_ What was the diagnosis? \_\_\_\_\_  
How long have you had this problem? \_\_\_\_\_  
What kinds of treatments have you tried? \_\_\_\_\_  
Have you been treated by acupuncture before? \_\_\_\_\_

### Family History

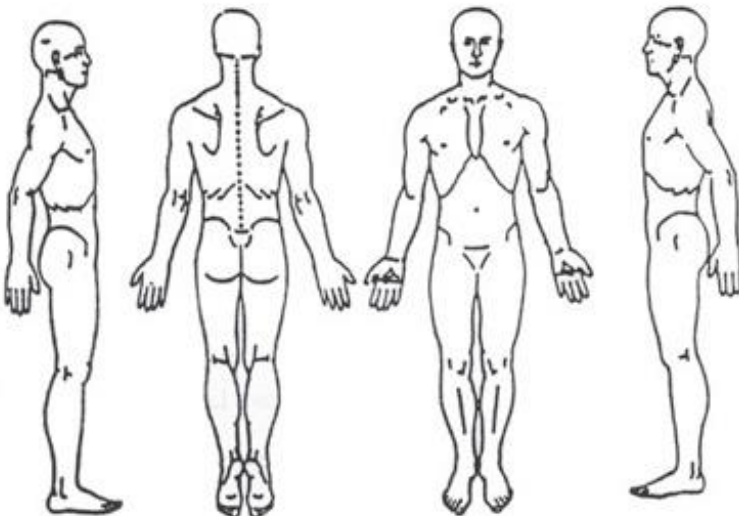
Mother's Side \_\_\_\_\_  
Father's Side \_\_\_\_\_  
Siblings \_\_\_\_\_  
If any of the above is deceased, what was the cause? \_\_\_\_\_

### Personal Lifestyle Habits

Coffee/Tea (cups per day) \_\_\_\_\_ Cigarettes (packs per day) \_\_\_\_\_  
Soda (regular or diet) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_  
Exercise (how often) \_\_\_\_\_ Drug use (recreational) \_\_\_\_\_  
Current Predominant Emotion \_\_\_\_\_ Stress level: Low:  Moderate:  High:   
Best time of year \_\_\_\_\_ Energy level: Low:  Moderate:  High:

Please indicate on the diagram any type of pain or injury and describe \_\_\_\_\_

**Circle all that applies:** Sharp Numb Dull Stabbing Aching Burning **Better with:** Heat Cold Pressure



Please describe any medical devices or implants and indicate on the diagram

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Past Medical History

Please indicate/describe all that applies if you have experienced in the Past (P) and Currently (C) any of the following:

### Significant Illnesses

- AIDS/HIV
- Alcoholism
- Allergies (medications, foods, latex) \_\_\_\_\_
- Bleeding disorders \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes
- Fibromyalgia
- Hepatitis Type \_\_\_\_
- Herpes Type \_\_\_\_
- High cholesterol
- Multiple Sclerosis
- Rheumatic fever
- Stroke
- STD \_\_\_\_\_
- Thyroid disorders
- Tuberculosis
- Other \_\_\_\_\_

### General

- Insomnia/Poor sleep
- Dreams-disturbed sleep
- Difficulty falling asleep
- Difficulty staying asleep
- Hours of sleep \_\_\_\_\_
- Fatigue
- Recent weight loss/gain
- Strongly like cold drinks
- Strongly like hot drinks
- Tendency to be cold
- Tendency to be warm
- Sweat easily
- Night sweats
- Chills
- Fever
- Sudden energy drops
- Peculiar tastes or smell
- Other \_\_\_\_\_

### Head and Neck

- Headaches
- Migraines
- Stiff neck
- Swollen glands
- Other \_\_\_\_\_

### Ears

- Hearing aids
- Hearing loss: L\_ R\_ Both\_
- Ringing: L\_ R\_ Both\_
- Earache
- Ear infection
- Ear drainage
- Other \_\_\_\_\_

### Eyes

- Glasses/contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts
- "Lazy" eye
- Itchy eyes
- Dry eyes
- Excessive tearing
- Eye pain
- Eye strain
- How often checked? \_\_\_\_\_
- Other \_\_\_\_\_

### Nose, Throat, and Mouth

- Sinus problems
- Hay fever/allergies
- Frequent colds
- Frequent sore throat
- Difficulty swallowing
- Sores on lips, tongue, mouth
- Nosebleed
- Dry nose
- Nasal drainage
- Nasal congestion
- Hoarseness
- Thirst
- Excessive saliva
- Facial pain
- Dry mouth
- Dental problems
- Grinding teeth
- Other \_\_\_\_\_

### Skin

- Hives
- Rashes
- Eczema
- Dry skin
- Itching
- Bruise easily
- Acne
- Other \_\_\_\_\_

### Respiratory

- Difficulty breathing
- Difficulty when reclining
- Asthma
- Chronic cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Pneumonia
- Other \_\_\_\_\_

### Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Cold hands and feet
- Swollen hands and feet
- Swollen ankle
- Phlebitis
- Varicose veins
- Anemia
- History of heart disease
- Heart murmur
- Other \_\_\_\_\_

### Gastrointestinal

- Cravings \_\_\_\_\_
- Bad breath
- Nausea
- Indigestion
- Stomach pain
- Abdominal pain
- Gallbladder problems
- Hernia
- Diarrhea
- Loose stools
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Bloating
- Gas
- Hiccups
- Acid reflux
- Hemorrhoids
- Bloody stool
- Bowel movements  
\_\_\_\_ x per day
- Other \_\_\_\_\_

### Musculoskeletal

- Joint pain/swelling \_\_\_\_\_
- Arthritis
- Muscle cramps
- Muscle weakness
- Muscle soreness
- Herniated disc
- Osteoporosis
- Pain (see diagram)
- Injury (see diagram)
- Other \_\_\_\_\_

**Neurological**

- \_\_\_ Concussions
- \_\_\_ Fainting
- \_\_\_ Dizziness
- \_\_\_ Seizures
- \_\_\_ Tremors
- \_\_\_ Numbness or tingling
- \_\_\_ Paralysis
- \_\_\_ Poor coordination/balance
- \_\_\_ Vertigo
- \_\_\_ Poor memory
- \_\_\_ Other \_\_\_\_\_

**Mental/Emotional**

- \_\_\_ Depression
- \_\_\_ Mood swings
- \_\_\_ Irritability
- \_\_\_ Easily angered
- \_\_\_ Panic attacks
- \_\_\_ Difficulty relaxing
- \_\_\_ Difficulty making decisions
- \_\_\_ Loneliness
- \_\_\_ Sadness
- \_\_\_ Sensitive
- \_\_\_ Shyness
- \_\_\_ Nervousness
- \_\_\_ Frequent crying
- \_\_\_ Frequent worrying
- \_\_\_ Compulsive behaviors
- \_\_\_ Difficulty focusing
- \_\_\_ Hopelessness
- \_\_\_ Suicidal thoughts
- \_\_\_ Frustration
- \_\_\_ PTSD
- \_\_\_ Other \_\_\_\_\_

**Urinary**

- \_\_\_ Pain with urination
- \_\_\_ Frequent/urgent urination
- \_\_\_ Incomplete urination
- \_\_\_ Incontinence
- \_\_\_ Bedwetting
- \_\_\_ Waking to urinate \_\_\_ x night
- \_\_\_ Blood in urine
- \_\_\_ Cloudy urine
- \_\_\_ History of UTI
- \_\_\_ Bladder infections
- \_\_\_ Kidney problems
- \_\_\_ Other \_\_\_\_\_

**Male Genital**

- \_\_\_ Fertility problems
- \_\_\_ Impotence
- \_\_\_ Premature ejaculation
- \_\_\_ Nocturnal emission
- \_\_\_ Groin pain
- \_\_\_ Pain/itching of genitalia
- \_\_\_ Prostate problems
- \_\_\_ Increased libido
- \_\_\_ Decreased libido
- \_\_\_ Other \_\_\_\_\_

**Gynecology (Women Only)**

- \_\_\_ Fertility problems
- \_\_\_ Currently pregnant
- \_\_\_ # of Pregnancies
- \_\_\_ # of Live births
- \_\_\_ # of Caesarian births
- \_\_\_ # of Miscarriages
- \_\_\_ # of Abortions
- \_\_\_ Menopause
- \_\_\_ Bearing down sensation
- \_\_\_ Last menstrual period \_\_\_\_\_
- \_\_\_ Birth control \_\_\_\_\_
- \_\_\_ PMS
- \_\_\_ Missed/Irregular periods
- \_\_\_ Menstrual cramps
- \_\_\_ Excessive blood flow
- \_\_\_ Menstrual blood clots
- \_\_\_ Breast tenderness
- \_\_\_ Abnormal pap smear
- \_\_\_ Vaginal infections
- \_\_\_ Vaginal pain/itching
- \_\_\_ Vaginal dryness
- \_\_\_ Uterine fibroids
- \_\_\_ Ovarian cysts
- \_\_\_ Endometriosis
- \_\_\_ Breast lumps, cysts
- \_\_\_ Increased libido
- \_\_\_ Decreased libido
- \_\_\_ Other \_\_\_\_\_

**Surgeries (type and date)**

- \_\_\_\_\_
- \_\_\_\_\_
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**Trauma, Injuries (type and date)**

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**Medications, Supplements, and Vitamins (dosage and for what condition)**

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**Other information**

- \_\_\_\_\_
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- \_\_\_\_\_
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**Acupuncture Clinic Fees**

First Visit Clinic Fee  
 Traditional Chinese Medicine  
 Diagnosis and Treatment \$125.00

Follow-up Visit Clinic Fee  
 Treatment \$90.00

All payments are due at time of service. Accepted payments include cash, checks, and credit cards.

**Appointment Reminders**

Healing Care Acupuncture understands that it is not always possible to keep scheduled appointments. In order to help reduce Late Cancellation or No Show, please indicate how you would like to be reminded of your appointment:

- Phone Call: \_\_\_\_\_
- Text: \_\_\_\_\_
- Email: \_\_\_\_\_

\_\_\_\_\_

Signature of Patient or Legal Representative

\_\_\_\_\_

Date

# Healing Care Acupuncture

1030 Xenia Avenue  
Yellow Springs, OH 45387

## ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby voluntarily request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of an acupuncturist to be performed by *Sharmine N. Lynch, L.Ac.*, representing Healing Care Acupuncture, on me (or on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Gua-Sha, and supplemental techniques.

I understand that acupuncture is a generally safe method of treatment, but that it may have some side effects that include, but are not limited to, unusual dizziness or fainting, temporary bruising, pain or discomfort, soreness, swelling, bleeding, numbness or tingling near the needling sites that may last a few days. Burns, blistering, or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify the acupuncturist if I am or become pregnant or if I am in the process of trying to become pregnant.

While I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, to be in my best interest.

I understand that acupuncture is not a substitute of conventional medical diagnosis and treatment and that I have the opportunity to discuss the nature and purpose of acupuncture and treatments with the practitioner at any time during my care. I understand that there is no implied or stated guarantee of cure or improvement of my condition.

I understand the acupuncturist may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that scheduling an appointment reserves a time specifically for me, and that consequently, a minimum of 24 hour notice is required to reschedule or cancel an appointment. If I do not call or show up, I will be responsible for the missed session fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent for treatment, acknowledge the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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's Name (Please Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient's Representative (If Applicable)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Patient's Representative (If Applicable)

\_\_\_\_\_  
Date

## Healing Care Acupuncture

1030 Xenia Avenue  
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**FOR PATIENT REVIEW REGARDING DIAGNOSTIC EXAM  
PLEASE SIGN ONE OF THE TWO OPTIONS LISTED BELOW:**

### Option 1:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

---

Patient's Signature

Date

### Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

---

Patient's Signature

Date

---

Licensed Acupuncturist Signature

Date

# Healing Care Acupuncture

1030 Xenia Avenue  
Yellow Springs, OH 45387

## Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

### *Safeguards in place at our office include:*

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

### *Types of information that we gather and use:*

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call during regular business hours at 937-532-5773.

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Signature of Patient or Legal Representative

---

Date

---

Printed Name and Relationship to Patient

## Healing Care Acupuncture

1030 Xenia Avenue  
Yellow Springs, OH 45387  
937.532.5773

### Acknowledgment of Receipt of Privacy Practices

I consent to the use or disclosure of my identifiable health information by *Healing Care Acupuncture* for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Healing Care Acupuncture* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *Healing Care Acupuncture* is not required to agree to the restrictions that I may request. However, if *Healing Care Acupuncture* agrees to a restriction that I request, the restriction is binding upon *Healing Care Acupuncture*.

I have the right to revoke this consent, in writing, at any time except to the extent that *Healing Care Acupuncture* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review *Healing Care Acupuncture's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at [www.HealingCareAcupuncture.com](http://www.HealingCareAcupuncture.com). This Notice of Privacy Practices also describes my rights and the duties of my practitioners and *Healing Care Acupuncture* with respect to my identifiable health information.

*Healing Care Acupuncture* reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship to Patient

## Acupuncture Treatment Patient Referral Form

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Patient \_\_\_\_\_ D.O.B. \_\_\_\_\_

Condition to be treated \_\_\_\_\_

Primary  
Diagnosis \_\_\_\_\_

ICD-10 Diagnosis \_\_\_\_\_ ICD-10 Code \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

ICD-10 Diagnosis \_\_\_\_\_ ICD-10 Code \_\_\_\_\_

Instructions or Precautions (if any): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Referring Physician or Specialist \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Signature \_\_\_\_\_

Please return this form to:

Att: Sharmine Lynch, L.Ac.

Healing Care Acupuncture  
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(937) 532-5773  
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