**New Patient Intake Form**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Male [ ] Female**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, and Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact & Phone: Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth-date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had acupuncture before? [ ] Yes [ ] No Chinese Herbal Medicine? [ ] Yes [ ] No**

**Are you under the care of a physician now? [ ] Yes [ ] No**

**If yes, what for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is your physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician/s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other concurrent therapies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long have you had this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it getting worse? [ ] Yes [ ] No**

**Does it bother your: [ ] Sleep [ ] Work [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What seemed to be the initial cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What seems to make it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What seems to make it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is there any litigation pending? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Medical History**

|  |
| --- |
| **[ ] Allergies [ ] Alcoholism [ ] Heart Disease [ ] Seizures [ ] Asthma [ ] Diabetes [ ] High Blood Pressure**  **[ ] Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Arteriosclerosis [ ] Cancer [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Your Past Medical History**

(Check any of the following conditions you currently have, or have had in the past.)

|  |
| --- |
| **[ ] AIDS / HIV [ ] Chicken Pox [ ] Herpes [ ] Polio [ ] Tuberculosis**  **[ ] Alcoholism [ ] Diabetes [ ] High Blood Pressure [ ] Rheumatic Fever [ ] Typhoid Fever**  **[ ] Allergies [ ] Emphysema [ ] Measles [ ] Scarlet Fever [ ] Ulcers**  **[ ] Appendicitis [ ] Multiple Sclerosis [ ] Epilepsy [ ] Seizures [ ] Venereal Disease**  **[ ] Arteriosclerosis [ ] Goiter [ ] Mumps [ ] Stroke [ ] Whopping Cough**  **[ ] Asthma [ ] Gout [ ] Pacemaker [ ] Surgeries (list) [ ] Other: (specify)**  **[ ] Birth Trauma (yours) [ ] Heart Disease [ ] Pleurisy [ ] Thyroid Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ] Cancer [ ] Hepatitis [ ] Pneumonia [ ] Major Trauma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Your Daily Nutritional Intake**

|  |
| --- |
| **Appetite : [ ] Coffee [ ] Artificial Sweetener [ ] Salty Foods [ ] Thirst for Water (# glasses per day) [ ] Low [ ] High [ ] Soft Drinks [ ] Sugar**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Average Daily Menu**

|  |
| --- |
| **Morning Snack Noon Snack Evening Snack**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_** |

**Pharmaceuticals Taken in Last 3 Months**

|  |
| --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**General Symptoms**

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| --- |
| **[** ] Bleed or Bruise easily [ ] Heavy Appetite [ ] Poor Appetite  [ ] Bodily Heaviness [ ] Heavy Sleep [ ] Poor Circulation  [ ] Chills [ ] Insomnia / Disturbed Sleep [ ] Recent Weight Loss / Gain [ ] Cold hands or Feet [ ] Lack of Strength [ ] Shortness of Breath  [ ] Dream-disturbed sleep [ ] Muscle cramps [ ] Strongly like cold drinks  [ ] Fatigue [ ] Night Sweats [ ] Strongly like hot drinks  [ ] Fever [ ] Peculiar taste \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Vertigo / Dizziness  (describe) |

**Head. Eyes, Nose, Throat**

|  |
| --- |
| [ ] Blurred Vision [ ] Excessive saliva [ ] Headaches [ ] Recurrent sore throat [ ] Teeth problems  [ ] Cataracts [ ] Eye pain [ ] Itchy eyes [ ] Red eyes [ ] TMJ  [ ] Concussion [ ] Eye strain [ ] Lumps in throat [ ] Ringing ears [ ] Other head or neck  [ ] Dry mouth [ ] Facial pain [ ] Migraines [ ] Sinus problems problems:  [ ] Earaches [ ] Glasses [ ] Night blindness [ ] Sores on lip or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Enlarged thyroid [ ] Glaucoma [ ] Nose bleeds [ ] Spots in eyes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Grinding teeth [ ] Poor hearing [ ] Swollen glands [ ] Poor vision \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Excessive phlegm [ ] Gum problems  Color of phlegm \_\_\_\_\_\_\_\_\_ |

**Respiratory**

|  |
| --- |
| [ ] Asthma/ Wheezing [ ] Color of phlegm\_\_\_\_\_\_\_\_ [ ] Pneumonia Other respiratory Problems: [ ]  [ ] Cough [ ] Coughing blood [ ] Shortness of breath \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Wet [ ] Dry [ ] Difficulty breathing [ ] Tight chest \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Thick [ ] Thin when lying down [ ] Difficult inhalation? Exhalation? |

**Cardiovascular**

|  |
| --- |
| [ ] Blood clots [ ] Fainting [ ] Low blood pressure [ ] Tachycardia  [ ] Chest pain [ ] High blood pressure [ ] Heart Palpitations  [ ] Difficulty Breathing [ ] Irregular heartbeat [ ] Phlebitis |

**Gastrointestinal**

|  |
| --- |
| [ ] Acid regurgitation [ ] Bloody stools [ ] Hemorrhoid [ ] Burning anus Bowel movements:  [ ] Anal fissures [ ] Nausea [ ] Vomiting [ ] Constipation Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Nausea [ ] Vomiting [ ] Bad breath [ ] Rectal pain Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Black stools [ ] Diarrhea [ ] Itchy anus [ ] Mucous in stools Texture / Form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Bloating [ ] Gas [ ] Laxative use Odor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Hiccough [ ] Intestinal pain or cramping [ ] Other |

**Musculoskeletal**

|  |
| --- |
| [ ] Joint pain [ ] Low back pain [ ] Rib pain  [ ] Limited range of motion [ ] Muscle pain [ ] Upper back pain  [ ] Limited use [ ] Neck / shoulder pain Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Skin and Hair**

|  |
| --- |
| [ ] Acne [ ] Eczema [ ] Hives [ ] Rashes  [ ] Change in hair / skin texture [ ] Fungal infections [ ] Itching [ ] Ulcerations  [ ] Dandruff [ ] Hair loss [ ] Psoriasis [ ] Other |

**Neuropsychological**

|  |
| --- |
| [ ] Abuse survivor [ ] Depression [ ] Numbness (where?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Tics  [ ] Anxiety [ ] Easily stressed [ ] Poor memory [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Considered suicide [ ] Irritability [ ] Seizures [ ] Seeing a therapist? |

**Genitourinary**

|  |
| --- |
| [ ] Bedwetting [ ] Impotence [ ] Nocturnal emissions [ ] Urgent urination  [ ] Blood in urine [ ] Incomplete urination [ ] Pain on urination [ ] Venereal disease  [ ] Decreased libido [ ] Premature ejaculation [ ] Wake to urinate  [ ] Frequent urination [ ] Unable to hold urine [ ] Kidney stones |

**Gynecology**

|  |
| --- |
| Age menses began\_\_\_\_\_\_ #Live births\_\_\_\_\_\_\_ Age at menopause\_\_\_\_\_\_\_ Date last period began\_\_\_\_\_\_\_ [ ] Painful periods Length of cycle\_\_\_\_\_\_\_ # Pregnancies\_\_\_\_\_\_ Breast lumps\_\_\_\_\_\_ Date of last PAP\_\_\_\_\_\_ [ ] PMS [ ] Clots\_\_\_\_\_\_  Duration of flow\_\_\_\_\_\_\_\_ #Premature births\_\_ [ ] Irregular periods [ ] Vaginal discharge [ ] Vaginal odor or sores |

**Other**

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| **OKLAHOMA HEALING ARTS INSTITUTE** |

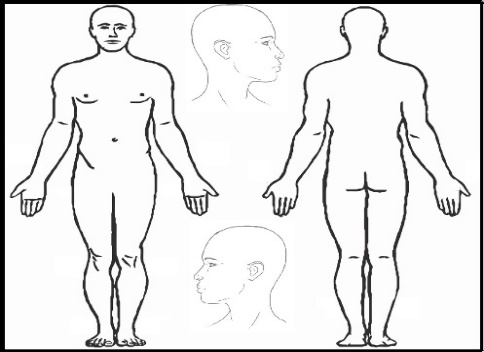
**3516 N.W. 50th, Okc, OK 73112 Phone 405-662-2650 PATIENT EVALUATION / TREATMENT – PROGRESS – NOTES / DOCUMENTATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Last First**

**Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate precisely the area of your symptoms using “XXX” on the figures below**

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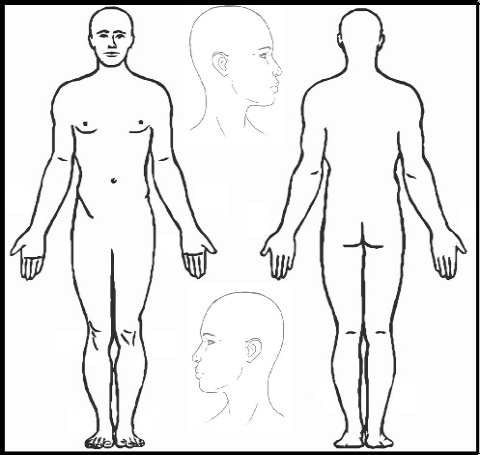
**Significant Medical History Current Medications Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_& Supplements**

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| |  | | --- | | **I consent to treatment by Scott Rigsbee and other Practitioners at Oklahoma Healing Arts Institute. I understand that they are not medical doctors, but practitioners of natural healing arts and they do not diagnose disease but work to correct Imbalances in the body.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient Signature**  **Date\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_** |   **Name your condition in the space below: Please circle current pain level:**  **(Main problem today) Better Worse**    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Areas of Therapy Practitioners Notes**

|  |  |
| --- | --- |
| ***Needle***  ***Count*** | |
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|  |  |
|  |  |
|  |  |
| ***Needle Count -Total*** |  |

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**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_**

**Acupuncture Affiliates Oklahoma Healing Arts Institute 3516 N.W. 50th Street, Okc, OK 73112 Phone (405) 779-5605** [**okhealingarts@gmail.com**](mailto:okhealingarts@gmail.com)

|  |  |  |  |
| --- | --- | --- | --- |
| Per Session | Modalities | Office Visit | Fee |
| 1 | **Acupuncture** |  |  |
| 1 |  | New Patient-Initial Session | 75 |
| 1 |  | Patient-Complex | 75 |
| 1 |  | Patient-Moderate | 50 |
| 1 |  | New Patient-Brief | 35 |
| 1 |  | Established Patient-Complex | 55 |
| 1 |  | Established Patient-Moderate | 50 |
| 1 |  | Cupping | 25 |
| 1 |  | Instructor / Intern. TX | 50 |
|  | **Chinese Medicine** |  |  |
| 1 |  | Chinese Internal Medicine |  |
| 1 |  | Western Herbal Medicine |  |
|  | **Herbal Medicine/**  **Supplementation** |  |  |
| 1 |  | Consult-Brief | 25 |
| 1 |  | Consult-Moderate | 35 |
| 1 |  | Consult-Complex | 45 |
|  | **Bodywork** |  |  |
| 1 |  | Tui Na (Chinese Bodywork) | 75 |
| 1 |  | Massage-Integrative | 120 (2 hour) |
| 1 |  | Massage-Lymphatic/Regional | 120 First 50 there after |
|  |  | Shiatsu (Japanese Bodywork) | 85 |
| 1 |  | Aroma Wrap | 65 |
| 1 |  | Massage-Myofascial-Trigger Point | 65 |
| 1 |  | Massage-Medical | 85 |
| 1 |  | Massage-Chinese Stone Therapy | 60 |
| 1 |  | Foot Reflexology | 50 |
|  |  | Chair Massage | $1.00 per min |
|  | **Nutritional Counseling** |  |  |
| 1 |  | Complex | 150 |
| 1 |  | Moderate | 95 |
| 1 |  | Brief | 55 |
|  | **Integrative Nutrition Health Coach** | 1 Session | 75 |
|  | **Empowerment Guru** | 1 Session | 50 |
| 1 | **Ionic Foot Bath (Detox)** | Per Session | 15 |
| 1 | **Zyto Scan** | Per Session | 20 |
| Our Financial Policies:  We accept: Cash, Check and Credit Cards A charge $35 will be required for all Insufficient Check or Credit Card Payments  **We do not submit Insurance Claims**. You are responsible for payment at time of service.  You are responsible to deal with your Insurance Company for reimbursement. We will provide a receipt at time of service, **KEEP THIS RECIEPT FOR YOUR RECORDS. ADDITIONAL COPIES are $10 for the first, PAYABLE in advance. You’re Insurance Company reserves the right to deny payment for your care.**  **\*\*Rx Dispensary: Effective February 1, 2016) Call at least 72 hours in advance: (405-662-2650) a and leave your order on voicemail with: (1) Date & Time of call; (2) Name & Phone number;**  **(3) Rx (If RX is to be mailed. Giver your current shipping address with Zip Code; (3)Rx Name,**  **(4)(Credit Card Number with your House Number or**  **PO Box Number & Zip Code (No Delivery to PO Box) \*\* Allow 3 days to 2 weeks for delivery. 72 hours office minimum.**  **Shipments are packaged and mailed on Tuesday only. RECOMMENDATION: Do not deplete your supply. An order may require 1-2 weeks to reach you.**  THANK YOU! | | | Service Fee\_\_\_\_\_\_\_\_\_\_  Fee Total \_\_\_\_\_\_\_\_\_\_\_  Product(s)\_\_\_\_\_\_\_\_\_\_\_  Tax\_\_\_\_\_\_\_\_\_\_\_  Grand Total \_\_\_\_\_\_\_\_\_  Payment\_\_\_\_\_\_\_\_\_\_\_\_  CA\_\_\_\_CK\_\_\_\_CC\_\_\_  CK #  \_\_\_\_\_\_\_\_\_\_\_\_ |

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ PRACTITIONER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_