**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**

|  |
| --- |
| **[** ] 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**

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| --- |
| 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**

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

****

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

**Acupuncture Affiliates Oklahoma Healing Arts Institute 3516 N.W. 50th Street, Okc, OK 73112 Phone (405) 779-5605** **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_