

Bloom Acupuncture Chicago
New Patient Intake Form

Date _____
Name _____ DOB _____
Address _____ City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____ Email _____
At which place(s) do I have permission to contact you? Cell / Home / Email
Emergency Contact _____ Relationship _____
Occupation _____ Height _____ Weight _____
Name of your Physician _____
Who referred you to this office? _____
1. What brought you here today? _____

2. When did you first notice any problems related to your chief complaint and what symptoms did you notice? _____

3. Describe what has happened from the first symptoms until today. _____

4. What previous medical workups, diagnosis, and treatment have you had for this problem? How have these been helpful or not? _____

5. Please list any allergies to drugs or medications: _____

6. What medications or supplements are you currently taking?
Medication **Dose** **How long have you been taking it?**

7. Other illnesses, surgeries, injuries:

<u>Illnesses</u>	<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. Other illnesses, surgeries, injuries:

Illnesses

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injuries/Trauma

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Family History

- ☐ Allergies
 ☐ Diabetes
 ☐ Emotional Difficulties
 ☐ Glaucoma
 ☐ Heart Problems
 ☐ Stroke
☐ Cancer
☐ Seizure Disorders
☐ Tuberculosis
☐ Thyroid Problems
☐ Hypertension/High BP

Please check any conditions or symptoms that you presently have or have had in the past:

	<u>Presently Have</u>	<u>Had in Past</u>		<u>Presently Have</u>	<u>Had in Past</u>
Cough	☐	☐	Pneumonia	☐	☐
Cough with blood	☐	☐	Sputum/Phlegm	☐	☐
Shortness of breath	☐	☐	Asthma	☐	☐
Bronchitis	☐	☐	Lack of perspiration	☐	☐
Seasonal Allergies	☐	☐	Excessive perspiration	☐	☐
Chronic colds	☐	☐			
Nasal or sinus congestion	☐	☐	Nose bleeds	☐	☐
Sinus infections	☐	☐	Nasal Polyps	☐	☐
Loss of smell	☐	☐			
Irregular heartbeat	☐	☐	Chest pains	☐	☐
Poor circulation	☐	☐	Heart attack	☐	☐
Dizziness	☐	☐	Low blood pressure	☐	☐
Palpitations	☐	☐	*High blood pressure	☐	☐
Fainting spells	☐	☐	*treatment _____		

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>		<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Indigestion	☐	☐	Abdominal cramping	☐	☐
Nausea	☐	☐	Diarrhea	☐	☐
Vomiting	☐	☐	Constipation	☐	☐
Vomiting with blood	☐	☐	*Laxative use	☐	☐
Gas	☐	☐	*Product _____		
Bloating	☐	☐	Alternating diarrhea & constipation	☐	☐
Belching	☐	☐	Rectal Pain	☐	☐
Acid regurgitation	☐	☐	Hemorrhoids	☐	☐
Poor appetite	☐	☐	Blood in Stool	☐	☐
Excessive appetite	☐	☐	Bowel movements every _____ days		
			_____ number of bowel movements/day		
Frequent urination	☐	☐	Burning on urination	☐	☐
Excessive urination	☐	☐	Difficulty urinating	☐	☐
Nighttime urination	☐	☐	Painful urination	☐	☐
Unable to hold urine	☐	☐	Blood in urine	☐	☐
Kidney stones	☐	☐	Sexually transmitted diseases	☐	☐
Bladder infections	☐	☐			
Muscle pain	☐	☐	*Joint pain	☐	☐
Muscle weakness	☐	☐	*Where _____		
Muscle spasms	☐	☐	Neck pain	☐	☐
Back pain (lower)	☐	☐	Knee pain	☐	☐
Back pain (middle)	☐	☐	*Numbness	☐	☐
Back pain (upper)	☐	☐	*Where _____		
Pain down leg(s)	☐	☐			
Wear glasses	☐	☐	Eye tiredness / strain	☐	☐
Blurred vision	☐	☐	Seeing spots	☐	☐
Double vision	☐	☐	Sensitivity to light	☐	☐
Cataracts	☐	☐	Eye dryness	☐	☐
Glaucoma	☐	☐	Eye redness	☐	☐
Eyes feel swollen	☐	☐	Eye itchiness	☐	☐
Pressure in the eye	☐	☐	Eye tearing	☐	☐
Eye pain	☐	☐			
Hearing difficulties	☐	☐	Loss of balance	☐	☐
Ringings in the ears	☐	☐	Ear infections	☐	☐
Ear pain	☐	☐			

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>		<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Bad taste in mouth	☐	☐	Sore tongue	☐	☐
Bad breath	☐	☐	Numbness in tongue	☐	☐
Mouth sores/ulcerations	☐	☐	Grinding teeth	☐	☐
Changes in the skin color	☐	☐	Dandruff	☐	☐
Skin bruising	☐	☐	Eczema	☐	☐
Skin rashes	☐	☐	Psoriasis	☐	☐
Skin acne	☐	☐	Skin ulcerations	☐	☐
Body hair changes	☐	☐			
Sudden weight loss	☐	☐	Sudden weight gain	☐	☐
Diabetes	☐	☐	Thyroid disorder		
Anxiety	☐	☐	Problems with alcohol/drug use	☐	☐
Depression	☐	☐	Psychological crisis	☐	☐
Irritability	☐	☐	Psychoactive medications	☐	☐
Hot tempered	☐	☐	if yes, which ones? _____		
Stress	☐	☐	Emotional difficulties	☐	☐
Fevers	☐	☐	Seizures	☐	☐
Chills	☐	☐	Concussion	☐	☐
Cold intolerance	☐	☐	Headache	☐	☐
General chilliness	☐	☐	Shaking / tremors	☐	☐
Cold hands and feet	☐	☐	Cysts / tumors	☐	☐
Heat intolerance	☐	☐	Edema / water retention	☐	☐
General warmth	☐	☐	Night sweating	☐	☐
Fatigue	☐	☐	Insomnia	☐	☐
Anemia	☐	☐	if yes, difficulty falling asleep / staying asleep?		
Poor memory	☐	☐	Nightmares	☐	☐

Smoking: How much per day? _____

Alcohol: How much per day? _____

Nutrition

What do you typically eat for the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Exercise

What is your daily activity level related to your occupation?

- ☐ Sedentary (mostly sitting) ☐ Somewhat active ☐ Moderately active
☐ Very active (moving around or up most of the time) ☐ Heavy duty (lifting, moving things)

In what kind of physical activities (exercise, sports) do you participate? Intensity level? How often per week? How long each time? _____

Miscellaneous:

How much water do you drink per day? _____

How many caffeinated products (coffee, tea, carbonated pop) do you drink per day?

Snacks: _____

Male Patients – please fill out the following section

Please check any conditions or symptoms that you presently have or had in the past

	Presently <u>Have</u>	Had in <u>Past</u>		Presently <u>Have</u>	Had in <u>Past</u>
Prostate enlargement	☐	☐	Premature ejaculation	☐	☐
Prostatitis	☐	☐	Impotence	☐	☐

Female Patients – please fill out the following section

Pregnancy:

Are you pregnant? Y N Not sure

Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), and/or abortions (A). Whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum, etc.)

Year

_____	_____
_____	_____
_____	_____
_____	_____

Menstruation

Age of onset _____ Last Menstrual Period (first day) _____

Date of last Pap exam ____/____/____ Result _____

Length of usual period _____ days Length between periods _____

Regularity:

☐ regular ☐ irregular ☐ usually early by ____ days ☐ usually late by ____ days ☐ varies between being early or late

Flow is: ☐ even ☐ uneven ☐ heavy ☐ light

Color is: ☐ pale ☐ pink ☐ light red ☐ red ☐ deep red ☐ purplish ☐ brown

Consistency is: ☐ thin ☐ thick ☐ clotted

Discomfort with Period

☐ lower abdominal distention	☐ before	☐ during	☐ after menstruation
☐ lower back soreness	☐ before	☐ during	☐ after menstruation
☐ cramping	☐ before	☐ during	☐ after menstruation
☐ other _____			

Premenstrual Syndrome (PMS)

☐ irritability ☐ bloating ☐ mood swings ☐ breast tenderness
☐ other _____

Vaginal Discharge

☐ No ☐ Yes If yes, color and amount: _____

Menopause

Age of onset _____ Any difficulties/symptoms? _____

Uterine bleeding (not related to periods)? No Yes Color _____ Amount _____
☐ comes on suddenly ☐ all the time

Bloom Acupuncture Chicago Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist, Beth Kathan, L.Ac., and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including local bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration. Burns and/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 this clinic uses sterile disposable needles, maintains clean needle technique, and a safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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, although some may be toxic in large individual doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic channels of the same name.

I acknowledge that Beth Kathan, L.Ac, is not and does not profess to be a Western-trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does she give any substances by injection. I acknowledge that the practitioner has completed academic training at an accredited school of Acupuncture and Chinese Medicine, is National Board Certified (NCCAOM), and a Licensed Acupuncturist (L.Ac). in the state of Illinois. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and have had the opportunity to ask questions. This consent covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient _____ Date _____
(or patient representative)

BETH KATHAN, L.Ac., M.S.T.O.M.
BLOOM ACUPUNCTURE CHICAGO
1647 North Clybourn, Chicago, IL 60614