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:

Illnesses Year	**Illness**	**Treatment/Medications**	**Outcome**

7. Other illnesses, surgeries, injuries:

Illnesses

Year	Illness	Treatment/Medications	Outcome

Surgeries

Year	Illness	Treatment/Medications	Outcome

Injuries/Trauma

Year	Illness	Treatment/Medications	Outcome

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:

	Presently Have	Had in Past		Presently Have	Had in Past
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_____		

	Presently Have	Had in Past
Indigestion	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomiting with blood	☐	☐
Gas	☐	☐
Bloating	☐	☐
Belching	☐	☐
Acid regurgitation	☐	☐
Poor appetite	☐	☐
Excessive appetite	☐	☐
Frequent urination	☐	☐
Excessive urination	☐	☐
Nighttime urination	☐	☐
Unable to hold urine	☐	☐
Kidney stones	☐	☐
Bladder infections	☐	☐
Muscle pain	☐	☐
Muscle weakness	☐	☐
Muscle spasms	☐	☐
Back pain (lower)	☐	☐
Back pain (middle)	☐	☐
Back pain (upper)	☐	☐
Pain down leg(s)	☐	☐
Wear glasses	☐	☐
Blurred vision	☐	☐
Double vision	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Eyes feel swollen	☐	☐
Pressure in the eye	☐	☐
Eye pain	☐	☐
Hearing difficulties	☐	☐
Ringing in the ears	☐	☐
Ear pain	☐	☐

	Presently Have	Had in Past
Abdominal cramping	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
*Laxative use	☐	☐
*Product_____		
Alternating diarrhea & constipation	☐	☐
Rectal Pain	☐	☐
Hemorrhoids	☐	☐
Blood in Stool	☐	☐
Bowel movements every_____days		
_____number of bowel movements/day		
Burning on urination	☐	☐
Difficulty urinating	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐
Sexually transmitted diseases	☐	☐
*Joint pain	☐	☐
*Where_____		
Neck pain	☐	☐
Knee pain	☐	☐
*Numbness	☐	☐
*Where_____		
Eye tiredness / strain	☐	☐
Seeing spots	☐	☐
Sensitivity to light	☐	☐
Eye dryness	☐	☐
Eye redness	☐	☐
Eye itchiness	☐	☐
Eye tearing	☐	☐
Loss of balance	☐	☐
Ear infections	☐	☐

	Presently Have	Had in Past		Presently Have	Had in Past
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 Have	Had in Past		Presently Have	Had in Past
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 difficulities 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
3166 North Lincoln Ave., Ste. 410A Chicago, IL 60657