PATIENT INTAKE FORM

This is a confidential questionnaire to help us determine the best treatment plan for you. If you have any questions, please feel free to ask. Thank you.

Last First Middle

Name _____Date: _____

Address _____S.S. #_____

Email: _____Home Phone: _____ Work Phone _____

Age: _____ Date of Birth: _____Marital Status M __ S __ D __ W__ Sex M/F____

Occupation _____Employer:_____

Emergency Contact _____Phone_____

Who should we thank for referring to this office? How did you hear about us?_____

Have you received acupuncture therapy before? Y N (date)_____(Acupuncturist)_____

What are your main complaints that brought you to this office? Please provide a brief history.

#1_____

#2_____

Do you have any other health conditions that are causing you worry or discomfort?

_____

List all major accidents, surgeries, or hospitalizations (including date or age).

_____

_____

List any medications and supplements you are currently taking (indicating a reason).

_____

Do you have any known allergies, and to what?_____

_____

When and where were you last seen by a medical doctor?

Name of physician: _____ Date: _____

Reason for visit: _____ Diagnosis _____

In your family, have you or anyone else had following diseases? If yes, please indicate the relationship to you.

_____Cancer _____Tuberculosis _____Diabetes _____Hypertension _____HIV Positive _____Hepatitis

Do you have any of the following conditions or problems?

____ digestion _____fatigue _____ menstruation ____hypertension ____ heart

____ constipation _____ diarrhea _____ bleed easily ____ menstruation ____ urinary tract

____ dizziness or fainting _____ infectious diseases _____ sexually transmitted disease

____ easily anxious or nervous _____ high blood pressure _____ high cholesterol

____other_____

What type of care do you desire?

_____ temporary relief of symptoms/pain control.

_____ eradication of tendencies causing your condition.

_____ balanced optimum health-care, elimination of root cause of problem, if possible.

_____ maintenance care/ balance to stay in good health.

How would you classify your condition?

_____ minor ____ severe/worsening

_____ involved ____ serious

On a scale of 1-10, how would you rate how your health problem affects your life?
(1 is no problem, 10 is major problem) _____

What other therapies have you tried for this condition?

_____.

Lab results: (please include copies, if available._____

_____.

List one adjective/word to describe your life _____.

Please indicate the use and frequency of the following?

tobacco _____

coffee/black tea _____

alcohol _____

non-medical drugs _____

exercise _____

How do you feel about the following areas of your life? Please check the Appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spiritually						

PATIENT PROFILE (for all patients)

Indicate with a one (1) any condition that you sometimes experience, two (2) for those which occur often, and three (3) for symptoms that are a major concern.

Water Element
__ Hearing loss
__ Dizziness
__ Low back pain
__ Neck pain
__ Sinus congestion
__ Edema
__ Dark under eyes
__ Emotional instability
__ Aversion to cold
__ Hair thinning/loss
__ Premature aging
__ Frequent urination
__ Kidney stones
__ Perspire easily
__ Weak legs/knees
__ Asthmatic cough
__ Rapid weight change
__ Loose teeth/loss
__ Reduced sexual energy
__ Thyroid problems
__ Diabetes
__ Excess fear_
__ Hearing problems

Wood Element
__ Headaches
__ Migraines
__ Ringing in ears
__ Poor eyesight
__ Eye infection
__ Dry eyes
__ Eczema
__ Shingles
__ Herpes simplex
__ Warts
__ Nervousness
__ Convulsions
__ Spasms
__ Irritability
__ Constipation
__ Hemorrhoids
__ Hepatitis
__ Ulcer
__ Vomiting
__ Gallstones
__ Indecisive
__ Fullness below ribs
__ Shoulder tension
__ Neck tension
__ Insomnia 11pm-3am

Fire Element
__ Dry scalp
__ Skin rash
__ Cysts/tumor
__ Ear infection
__ Sore throat
__ Lymph swelling
__ Hot palms/soles
__ Heart palpitations
__ Aversion to heat
__ Bitter taste in mouth
__ Gum problems
__ Nose bleed
__ Facial redness
__ Itch/burn skin
__ Thirst
__ Vivid dreaming
__ Dark urine
__ Night sweats
__ Excess Joy

Other
__ Fatigue
__ Arthritis
__ Sciatica
__ Nerve pain
__ Cold hands/feet
__ Bursitis/tendonitis

Metal Element
__ Bronchitis
__ Asthma
__ Weak breath
__ Cough
__ Sinus problem
__ Allergies
__ Nose infection
__ Grief/Weeping
__ Skin problems

Earth Element
__ Underweight
__ Indigestion
__ Flatulence
__ Food allergy
__ Stomach ache
__ Ulcer
__ Diarrhea
__ Anemia
__ Halitosis
__ Mouth sores
__ Heartburn
__ Big appetite
__ Weak appetite
__ Abd. bloating
__ Excess worry
__ Obsessive
__ Acid reflux

FOR WOMEN ONLY (check all that apply)

Are you pregnant?____ # children___ # miscarriage___ # abortion___
Pregnancy complications? _____
Any menstrual difficulties?_____

Menstrual cycle:
__ Irregular
__ Painful
__ Excess/Defic. bleeding
__ Water retention
__ Dark/light color
__ Painful breast
__ Heavy clots
__ Feel better before menstrual flow
__ Feel better after menstrual flow

Vaginal discharge
__ Liquid
__ Yellow
__ Thick
__ Bad odor
__ White
__ Other

Gynecology History
__ Ovaries _____
__ Tubes _____
__ Vagina _____
__ Breast _____
__ Other _____

Any other comments _____.

FOR MEN ONLY (check all that apply)

__ Reduced sexual energies
__ Premature ejaculation
__ Seminal emission
___Other _____
__ Pain with urination
__ Prostate problems
__ Impotence
__ Groin pain
__ Infertility

12709 Poway Rd. #205
Poway, CA 92064
Ph: (858) 254-4781
Fax: (858) 668-7110

Acupuncture Healthcare Specialists

RESPONSIBILITY AGREEMENT WITH CONSENT TO TREATMENT AND STATEMENT OF FINANCIAL POLICY

I. I acknowledge and understand that I am responsible for the total charges for all of the services rendered to me or any member of my family. I hereby agree to pay my account as services are provided.

2 I understand that all new patients are required to pay for their initial visit in full until becoming an established member of the practice or until insurance coverage is verified if acupuncture is a covered medical service by my insurance company. In certain circumstances, I can bill my insurance company myself and will be provided all necessary forms by this office. In other circumstances, the office will bill for me and I agree to make the necessary co-payment at each visit. If, for any reason, my insurance company does not pay for any portion of my bill, I agree to make arrangements for prompt payment of the bill.

3 In the event timely payment is not made on this account and the injury for which treatment has been obtained was caused by a third party, the undersigned hereby grants Kelly McConville, L.Ac. a lien on any recovery, whether by settlement, judgment or otherwise, received from or paid on behalf of the third party, including any uninsured motorist proceeds. Further, the undersigned agrees to notify Kelly McConville, L.Ac. in writing within thirty (30) days of any such claim. Nothing herein shall he deemed as excusing payment in full by the undersigned as required by this agreement. This lien is in addition thereto and is intended as security for payment.

4 I understand that an appointment commits the physician's time to me and unless 24 hours advanced notice is given, I am financially responsible for canceled or missed appointments.

5. I hereby consent to acupuncture and related holistic treatments and evaluations rendered to me (or my child if a minor) by the above named provider.

6. I hereby consent to receive new patient or referral acknowledgement via postcard mailing.

7. If my email account is provided to the practitioner, I hereby consent to receive monthly newsletters.

_____
Print Name

_____ _____
Patient's signature Date