New Patient Intake Form

Today's Date____/____/____

Name **SS#** **Birthdate / /**
Marital Status **Age**
Address **❑M ❑ F** **Ht** **Wt**

City, State, Zip
Home Phone **Work Phone** **Occupation**
Emergency Contact Name & Phone
Referred by
Reason for visit today **Have you had acupuncture before? ❑ Yes ❑ No** **Chinese herbal medicine? ❑ Yes ❑ No**
How long have you had this condition?
Is it getting worse? **Does it bother your: ❑ Sleep ❑ Work ❑ Other (what?)**
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? ❑ Yes ❑ No **If yes, for what?**
Who is your physician? **Physician's Phone**
Other concurrent therapies

Family Medical History

❑ Allergies ________________ ________________
❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism
❑ Cancer ________________ ________________
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Seizures
❑ Stroke

Your Past Medical History

Illnesses: ____
____
____

Surgeries: ____
____
____

Significant Trauma (i.e Motor Vehicle Accidents, Falls,etc.): ________________
____
____

Do you have or have you ever had, any infectious disease? _______ If so, please describe: ________________
____
____

Medicines: Include prescription, over the counter drugs, vitamins, herbs. etc. taken within the last three months.
____
____
____

Average or typical Blood Pressure _________ / _________ Average Pulse Rate: ________________
Allergies: ____
____
____

Personal Medical History

Significant Illnesses

- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV (AIDS)
- ☐ Allergies
- ☐ Asthma
- ☐ Seizures
- ☐ Heart Disease
- ☐ Weight Problem
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Addictive Disorders
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other: ____________

Gynecology & Pregnancy (females only)

- ☐ Irregular period
- ☐ Clots
- ☐ Light Flow
- ☐ Heavy Flow
- ☐ PMS
- ☐ Duration of Flow _____
- ☐ Painful Periods
- ☐ Age of First Menses
- ☐ Date of Last Menses
- ☐ Last PAP
- ☐ # of Pregnancies______
- ☐ # of Births __________
- ☐ Miscarriages, # of _____
- ☐ Abortions # of ________
- ☐ Premature Births # _____
- ☐ Difficult Births ________
- ☐ Fertility Problems
- ☐ Breast Lumps
- ☐ Vaginal Discharge
- ☐ Vaginal Sores

Please check if you have experienced any of the following in the last 3 months.

General:

- ☐ Poor Appetite
- ☐ Fevers
- ☐ Fatigue
- ☐ Tremors
- ☐ Cravings
- ☐ Headaches
- ☐ Localized Weakness
- ☐ Insomina
- ☐ Strong Thirst
- ☐ Poor Balance
- ☐ Chills
- ☐ Sudden Energy Drop
- ☐ Peculiar Tastes or Smells
- ☐ Bleeding
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Joint Pain
- ☐ Hearing Loss
- ☐ Sweat Easily
- ☐ Change in Appetite
- ☐ Night Sweats
- ☐ Depression
- ☐ Emotional Changes
- ☐ Bruising Easily

Skin & Hair:

- ☐ Rashes
- ☐ Eczema
- ☐ Recent Moles
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in Hair Texture
- ☐ Change in Skin Texture
- ☐ Dandruff
- ☐ Hives
- ☐ Ulcers
- ☐ Acne
- ☐ Psoriasis

ENT + Head & Eyes:

- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Gum Problems
- ☐ Night Blindness
- ☐ Facial Pain
- ☐ Color Blindness
- ☐ Eye Pain
- ☐ Glasses
- ☐ Sinus Problems
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Jaw Click
- ☐ Earaches
- ☐ Glaucoma
- ☐ Poor Vision
- ☐ Cataracts
- ☐ Concussions
- ☐ Poor Hearing
- ☐ Migraine
- ☐ Eye Strain
- ☐ Grinding of Teeth
- ☐ Floaters
- ☐ Spots in Front of Eyes
- ☐ Nose Bleeds
- ☐ Recurrent Sore Throat
- ☐ Sores on Lips
- ☐ Mouth Ulcers
- ☐ Toothache

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Coughing Blood
- ☐ Bronchitis
- ☐ Phlegm
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Easily Winded
- ☐ Painful Breathing

Cardiovascular:

- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Chest Pain
- ☐ Cold Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Swelling of Feet
- ☐ Palpitations
- ☐ Cold Hands or Feet
- ☐ Swelling of Hands
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Shortness of Breath
- ☐ Difficulty Breathing

Gastrointestinal:

- ☐ Nausea
- ☐ Belching
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Bloating
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Parasites
- ☐ Blood in Stools
- ☐ Black Stools
- ☐ Bad Breath
- ☐ Intestinal Gas
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Gastric Ulcers

Genito-Urinary:

- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Genital Sores
- ☐ Urgent Urination
- ☐ Impotence
- ☐ Kidney Stones
- ☐ Scanty Urination
- ☐ Unable to Hold Urine
- ☐ Discolored Urine
- ☐ Frequent Urination
- ☐ Frequent Night Urination

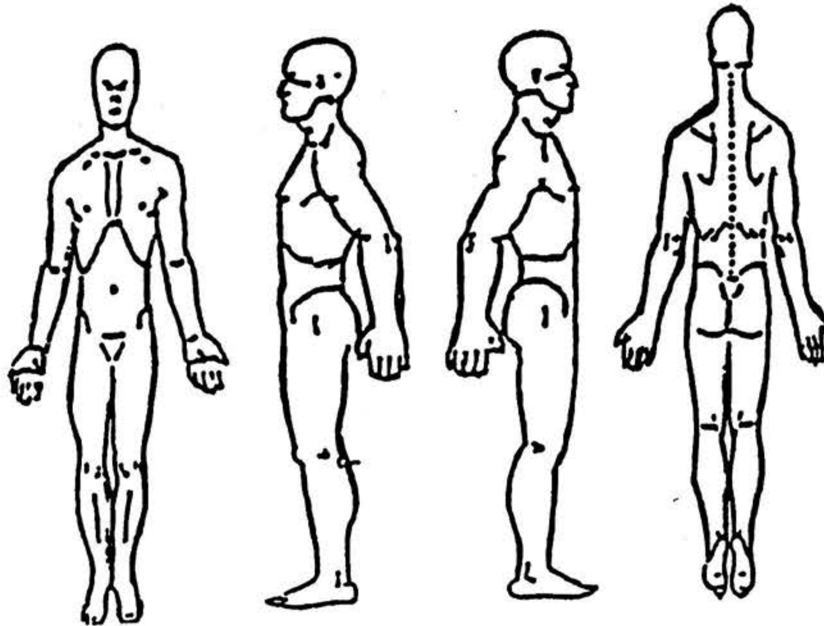
Neuro-Psychological

- ☐ Seizures
- ☐ Dizziness
- ☐ Stress
- ☐ Disorientation
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Poor Memory
- ☐ Migraines
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Easily Angered
- ☐ Loss of Balance
- ☐ Mood Swings
- ☐ Irritable
- ☐ Headache

Musculo-Skeletal

- ☐ Neck Pain
- ☐ Scoliosis
- ☐ Hip Pain
- ☐ Recent Sprains
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Arthritis
- ☐ Weak Joints
- ☐ Joint Pain
- ☐ Knee Pain
- ☐ Muscle Weakness
- ☐ Injuries
- ☐ Muscle Spasms
- ☐ Muscle Cramping
- ☐ Muscle Soreness
- ☐ Foot/Ankle Pain
- ☐ Hand/Wrist Pain

Please Circle Areas of Pain or Injure.
Please be prepared to describe the type and quality of pain.



Current Emotional Health____________ Current Predominant Emotion:______________

Current Quality of Life:______________ Stress Level:____________________

Favorite Time of Year:____________________ Worst::__________________

Do you have a regular exercise program:______________________________

Please describe:_____________________________________

Your Diet

Please indicate amount of consumption

☐ Coffee___________ ☐ Alcohol_____________ ☐ Tea___________

☐ Soft drinks _________ ☐ Tobacco_____________ ☐ Water__________

Average Daily Menu

Morning	Snack
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Noon	Snack
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Evening	Snack
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Earth Medicine LC

4680 Westview Terrace
Santa Fe, NM 87507

Client Name____ Date____________________

Name of Primary Insurance Company____

Name of Employer If Group Insurance____

Name of Primary Insured____

Primary Insured SSN________________________________ D.O.B.______________________

Relationship to Client: Self____ Father_____ Mother_____ Spouse_____ Other______

Name of Secondary Insurance Company____

Name of Employer If Group Insurance____

Name of Primary Insured____

Primary Insured SSN________________________________ D.O.B.______________________

Relationship to Client: Self____ Father_____ Mother_____ Spouse_____ Other______

Employer Assistance? Yes_____ No_____ Name of Insurance Carrier_______________

Public Payor? Yes _____ No _____ Name of Payor____________________________

ASSIGNMENT AND RELEASE OF BENEFITS

I the undersigned, certify that I (or my dependent) have insurance with ______________________ and assign insurance payments to Earth Medicine LC for services rendered. I understand that I am responsible for charges if not paid for by insurance. Earth Medicine LC will make every effort to secure payment from your insurance company. But in the event payment is not received within 90 days of services rendered you will be billed for the balance due. I hereby authorize the provider here said to release information necessary to my insurance carrier or public payer to secure payment of benefits. I authorize this by the use of my signature below.

______________________________ ______________________________

Print Name of Client If Minor, Print Name of Parent/Guardian

______________________________ ______________________________

Signature of Client If Minor, Signature of Parent/Guardian

Consent for Treatment

METHOD OF TREATMENT AND PURPOSE

Oriental medicine, including Chinese, Japanese, Korean, and Vietnamese variations is a healing philosophy that promotes well being. By the insertion of fine needles (acupuncture) or applied pressure (acupressure) at specific points on the skin. The application of heat close to skin surface (indirect moxabustion) can also be used. In using these modalities the human body's energy is stimulated to rebalance itself and correct neurological, organic, or functional disorders. In this way, internal diseases may be treated, or the perception of pain modified, to help normalize physiological functions. Other treatment methods include, but are not limited to tui na massage, gua sha friction stimulation, cupping, electrical stimulation, heat therapies (moxabustion and infrared heat lamp) exercise, prescription of herbal formulas and dietary advice.

SIDE EFFECTS

Acupuncture's most commonly reported side effect is the feeling of calm and relaxation. While some people feel tranquil, others may report increased energy soon after treatment. Please understand however, that although limited certain adverse effects may possibly result from insertion of needles.

These include, but are not limited to local bruising, minor bleeding, fainting, brief pain or discomfort, infection, broken needle and temporary aggravation of symptoms existing prior to acupuncture treatment.

Persons with a bleeding disorder, a pacemaker device, infectious disease, metal plates or rods in body, pregnant or suspect that they are pregnant must inform the practitioner of these conditions prior to any treatment. I understand I must report to the practitioner any effects I experience after receiving acupuncture/ acupressure or any other treatment method.

HERBAL PRESCRIPTIONS

Herbal formulas are a very important and useful component of Oriental Medicine. They are able to address issues of an ailment that the other therapies can not. The practitioner (*Inez Jones*) may suggest supplements and/or herbal formulas in tea, capsule or pill form. These substances are not in any way intended to replace medications prescribed by a medical doctor.

SIDE EFFECTS

Side effects of herbs may include but are not limited to change in bowel movements, temporary abdominal discomfort, and possible aggravation of pre-existing symptoms. If you experience any problems while taking herbs, stop taking immediately and phone the practitioner.

I understand the above treatments and risks, and that I always have a choice as to whether I participate in a suggested therapy.

Printed Name: ______________________________

Signed: ______________________________ Date: ____________________

Notice of Privacy Practices Concerning Your
Protected Health Information

Any information provided to me by patients, regarding their health history or health care is filed in a locked file cabinet and held in the strictest confidence. The information provided used for the sole purpose of assisting you in your treatment. I, Inez Jones D.O.M. am the only person with access to your personal health information. Your personal health information can be forwarded to insurance companies, other health care practitioners or attorneys only with your consent, at your specific request.

Patient rights include access to copies of your health care information as well as the right to amend information which you do not wish to share. If you have any concerns relating to your protected health information, please discuss them with Inez Jones.

I have read and understood this Notice of Privacy Practice Policy, as stated above.

Signed: ______________________________ Date: _______________