**New Patient Intake Form**

Name (last, first, m) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prefer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Emails are not shared and will only be used for occasional office announcements and appointment reminders

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confidential Voicemail? □ Yes □ No

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confidential Voicemail? □ Yes □ No

What is your birth sex: □ Male □ Female □ Unknown □ Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What gender do you identify as? □ Male □ Female □ Trans □ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your pronoun? □ He □ She □ Trans □ Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □ Single □ Married □ Separated □ Divorced Number of Children\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you authorize Regional Chiropractor Center to release information to this person?**

**\_\_\_\_Yes \_\_\_\_\_No (If no, we cannot disclose any information)**

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Health Concern**

What is the main reason, or goal, for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies: Do you have a severe allergy to any of the following?**

□ Sulfa □ Penicillin □ Aspirin □ Codeine □ Latex □ Sulfites □ Cats

□ Dogs □ Mold □ Dust □ Bees □ Pollen □ Wheat □ Shellfish

□ Peanuts □ Eggs □ Milk □ Soy Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions: Do you currently have or have a history of the following? Check all that apply**

Adrenal Disorder Anemia Anxiety Arthritis/Joint Disorder

Asthma Cancer COPD Depression

Diabetes Mellitus Digestive Problem Heart Disease Hyperlipidemia

Hypertension Inflammatory Bowel Disease Irritable Bowel Syndrome

Kidney Disease Liver Disease Stroke Thyroid Disease

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

**Tobacco Use:** □ Never Smoker □ Former Smoker □ Passive Smoke Exposure (Second Hand)   □ Current Smoker

**Type of tobacco used:**

□ Cigarettes □ Cigars □ Pipe □ Vape Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Packs/Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a current tobacco user: Are you ready to quit?   □ Yes □ No

Do you drink alcohol? □ Yes □ No

Drinks/Week: Glasses of Wine\_\_\_\_\_\_\_\_\_\_\_\_ Cans of Beer\_\_\_\_\_\_\_\_\_\_ Shots of Liquor \_\_\_\_\_\_\_\_\_\_\_\_

**Medications: What medications/supplements are you currently taking? List for what conditions, dosage and frequency**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications/Supplements** | **Dose** | **Frequency** | **Conditions** |
|  |  |  |  |
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**Family History: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had the following conditions.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Relative | Living? If no, cause of death and age | Diabetes Mellitus | Hypertension | Cancer | Thyroid disorders | Other |
| Mother |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |
| MaternalGFather |  |  |  |  |  |  |
| Maternal GMother |  |  |  |  |  |  |
| PaternalGFather |  |  |  |  |  |  |
| Paternal GMother |  |  |  |  |  |  |

**Review of System: Please circle if you experience any of the following in the last 6 months**

|  |  |  |
| --- | --- | --- |
| **Constitutional** |  |  |
| Fatigue | Fever | Undesired weight gain |
| General weakness | Chills | Undesired weight loss |
| Catches cold easily | Night sweats | Poor Appetite |
| Cold hands or feet | Sweat easily |  |
| Slow wound healing  | Feeling hot/flushed  |  |

|  |  |  |
| --- | --- | --- |
| **Eyes** |  |  |
| Changes in vision | Watery, red, itchy eyes | Glaucoma |
| Eye pain | Dry eyes | Cataracts |
| Double vision | Poor night vision | Floaters |

|  |  |  |
| --- | --- | --- |
| **Ears** |  |  |
| Changes in hearing | Ear discharge | Ringing in the ear |
| Ear pain  | Ear infection |  |

|  |  |  |
| --- | --- | --- |
| **Nose** |  |  |
| Nose bleeds | Congestion | Decrease sense of smell |
| Nasal discharge | Nasal Polyps |  |

|  |  |  |
| --- | --- | --- |
| **Mouth/Throat** |  |  |
| Sore throat | Hoarseness | Bleeding gum |
| Ulcer of mouth or lips | Lump in throat | Difficulty swallowing  |
| Swollen glands | Excessive mucus production |  |

|  |  |  |
| --- | --- | --- |
| **Cardiovascular** |  |  |
| Chest pain/tightness | Irregular heartbeat | Leg swelling |
| Blood clots | Varicose/spider vein |  |

|  |  |  |
| --- | --- | --- |
| **Respiratory**  |  |  |
| Snoring | Cough | Wheezing |
| Shortness of breath |  |  |

|  |  |  |
| --- | --- | --- |
| **Musculoskeletal** |  |  |
| Painful joints | Joints swelling | Muscle cramp/spasm |
| Muscle pain | Muscle weakness |  |

|  |  |  |
| --- | --- | --- |
| **Neurological** |  |  |
| Headache | Numbness/tinging | Tremors |
| Dizziness | Fainting | Seizures |
| Difficulty concentrating | Speech difficulty | Facial asymmetry |
| Poor memory | Loss of balance |  |

|  |  |  |
| --- | --- | --- |
| **Endocrine** |  |  |
| Cold intolerance/sensitivity | Excessive thirst | Large volume/amount of urine |
| Heat intolerance/sensitivity | Excessive hunger  |  |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal** |  |  |
| Abdominal pain  | Nausea | Constipation |
| Gas/bloating | Vomiting | Diarrhea  |
| Acid Reflux  | Belching/hiccups | Blood in stool |
| Poor digestion | Ulcers | Loss of bowel control |

|  |  |  |
| --- | --- | --- |
| **Genitourinary**  |  |  |
| Difficulty/painful urination | Urinary retention | Pain in your side |
| Increase/urgency in urination | Nighttime urination | Pain with sex |
| Blood in urine | Dribbling urination | Pelvic pain |
| Urine incontinence/leakage | Bedwetting | Genital sores |

|  |  |  |
| --- | --- | --- |
| **Psychiatric**  |  |  |
| Depression, sadness | Stress | Hallucinations |
| Anxiety/panic attacks | Fear | Hyperactivity |
| Irritability/anger | OCD | Suicidal ideation |
| Post-partum | Apathy, lack of interest |  |

|  |  |  |
| --- | --- | --- |
| **Woman’s Health** |  |  |
| Painful menses | Vaginal sores | Endometriosis |
| Pain between menses | Vaginal dryness | PCOS |
| Irregular menses | Facial hair growth | Ovarian cysts |
| Nipple discharge | Breast lump | Uterine fibroids |
| Low libido | Painful, swollen, or fibrocystic breast | Infertility |

Date of last period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal? □ Yes □ No

Date of last mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last pap smear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now or could you be pregnant? □ Yes □ No

|  |  |  |
| --- | --- | --- |
| **Men’s Health** |  |  |
| Pain or difficulty obtaining or maintaining erection  | Pain or difficulty with ejaculation | Prostate disease  |
| Pain or mass in testicle | Premature ejaculation | Low libido  |

|  |  |  |
| --- | --- | --- |
| **Sleep** |  |  |
| Trouble falling asleep | Nightmares | Typical bedtime: \_\_\_\_\_\_\_\_\_ |
| Trouble staying asleep | Sleep talking/walking | Typical wake time: \_\_\_\_\_\_\_\_  |
| Excessive dreaming | Tired upon waking | Hours/night: \_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Additional Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acupuncture Informed Consent**

I hereby consent to be treated with East Asian Medicine by a licensed acupuncturist at Regional Chiropractor Center. I understand treatment may include, but not limited to, Acupuncture, Electro-Acupuncture, Chinese Herbal Medicine, Cupping, Tui Na, Gua Sha, Moxibustion, and Nutritional counseling.

**Acupuncture:** I have been informed that acupuncture is a generally safe method of treatment. I understand that acupuncture is performed by the insertion of sterile needles through the skin. I am aware it may have some side effects, including bruising, minor bleeding, minor pain or discomfort, dizziness or fainting, or numbness and tingling near the needling sites that may last a few days. Acupuncture is used to treat the underlying cause of the body’s dysfunction or illness, to treat pain, and to treat the body’s physiological functions. Acupuncture works with different systems of the body (e.g., nervous, musculoskeletal, cardiovascular, immune, gastrointestinal, etc.) to provide optimal function.

**Moxibustion:** The application of heat to the skin at certain points or area on the body.

* **Indirect Moxibustion:** the application of heat near the skin
* **Direct Moxibustion:** The application of heat directly to the skin. I am aware this is not intended to be a painful experience. I understand that if I receive direct moxibustion as part of therapy, there is risk of mild burning or scarring from its use.

**Cupping:** I understand that cupping is used to treat muscle pain. It is used to increase circulation and break up adhesion in muscle. I understand that cupping can cause bruising and mild bleeding.

**Chinese Herbs/Nutrition:** I understand that Chinese herbs may be recommended to me as part of the treatment. I understand that I am not required to take these substances. However, if I choose to take them, I understand that herbs prescribed need to be taken as recommended by my acupuncturist. I am aware that certain adverse side effects may result from taking these herbs and I will notify my acupuncturist of any unanticipated or unpleasant effects. These side effects may include, but not limited to: nausea, vomiting, abdominal pain or discomfort, headache, change in bowel movement, rashes, hives, tingling of the tongue, and possible aggravation of symptoms. I understand that some herbs and supplement are inappropriate for pregnancy and I will promptly notify my acupuncturist if I am pregnant.

**Tui-Na/Acupressure:** I understand I may also be given Tui-Na, which is a type of massage or acupressure as part of the treatment. I am aware that certain adverse side effects may result from this treatment: These include, but not limited to bruising, sore muscles or aches, and possible aggravation of symptoms.

**Electro-Acupuncture:** I understand that I may be asked to be treated with electro-acupuncture using a transcutaneous electrical nerve stimulations (TENs) machine that would be attached to the needles. Even though this method is generally painless, I am aware that certain adverse side effects may result. These may include, but not limited to pain or discomfort, electrical shock, and possible aggravation of symptoms.

By voluntarily signing below, I show that I have carefully read, or have had read to me, the above consent to treatment. I have been told abouts the risks and benefits of East Asian Medicine and understand all of the above information. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to the above procedures, realizing no guarantees have been given to me by Regional Chiropractor Center regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. I hereby acknowledge that I am financially responsible for services rendered and consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (In case of minor, parent or guardian must sign)

**Notice of Privacy Policy**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

**USES AND DISCLOSURES OF HEALTH INFORMATION**
The following describes how information about you may be used in this office:

* **Treatment Services:** We may use or disclose your health information to all of our staff members, your physicians, and/or other health care providers taking care of you.
* **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
* **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
* **Legal Requirements:** We may use or disclose your health information when required to do so by law.
* **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
* **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
* **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services.
* **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
* **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
* **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_