AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

New Patient **Intake Form**

Name_____ Date_____

Address_____ Birth Date_____ Age_____

_____ M / F Ht._____ Wt._____

City, State, Zip Code

Occupation _____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Email _____

Emergency Contact (Name & Number)_____

Referred by_____

Primary Care Physician _____ Phone _____

Other Health Care Practitioners treating you_____

_____

Chief Complaint (reason for visit)

_____

_____

_____

List all previous treatments for this condition (including medication) _____

_____

_____

_____

Other Medical Problems_____

_____

_____

AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

New Patient **Intake Form**

Name_____ Date_____

Current Medication_____

_____

_____

If receiving chemotherapy, type and regimen _____

_____

_____

_____

_____

Past Medical History: (check all that apply and include medication)

AIDS/HIV_____
Diabetes Mellitus_____
Herpes (oral, genital)_____
Rheumatic Fever_____
Stroke_____
Tuberculosis_____
Chest pain_____
Glaucoma_____
Cancer_____

Asthma_____
Hepatitis (type)_____
High Blood Pressure_____
Pneumonia_____
Seizures_____
Thyroid disorder (type)_____
Ulcers_____
Depression_____

List any previous surgery / major trauma (include dates)_____

_____

_____

Family History: (list major medical conditions)

Father_____

Mother_____

Siblings_____

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New Patient **Intake Form**

Name_____ Date_____

Life Style

Do you smoke? Yes No Cigarettes ___ Pipe___ Cigars ___

# of Years _____ How much?_____ Year quit _____

Do you drink alcohol? Yes No

What type? _____

How much? _____

How often? _____

Do you use street drugs? Yes No

What type? _____

How much? _____

How often? _____

Do you regularly drink coffee? Yes No How many cups per day? _____

Are you under a lot of pressure at work? Yes No Please describe_____

_____

Do you exercise? _____ Type_____ Frequency_____

hours of sleep _____ bed time _____ awaken _____

Diet

Describe your typical diet:

Breakfast_____

_____

_____

Lunch_____

_____

_____

Dinner_____

_____

Name_____ Date_____

Dietary restrictions _____

_____

_____

_____

_____

_____

Food allergies _____

Food cravings _____

Water consumption / day _____

Supplements _____

_____

_____

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continued…

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New Patient **Intake Form**

Name_____ Date_____

GENERAL SYMPTOMS	current	(Please check all that apply)	past
• poor / increased appetite	_____		_____
• weight loss / gain	_____		_____
• fatigue	_____		_____
• irritable / depressed/ anxious	_____		_____
• prefer hot / cold drinks	_____		_____
• sweat easily	_____		_____
• night sweating	_____		_____
• fever / chills	_____		_____
• cold hands & feet	_____		_____
• poor circulation	_____		_____
• numbness & tingling in hands / feet	_____		_____
• muscle cramps / weakness	_____		_____
• bruise easily / bleed	_____		_____
• dry skin	_____		_____
• itchy skin	_____		_____
• rashes / eczema / psoriasis / acne	_____		_____
• headache / migraine	_____		_____
• dizziness / vertigo	_____		_____
• blurred vision	_____		_____
• eye pain / tear / red / itch	_____		_____
• facial pain	_____		_____
• sinus disorder / pain / pressure	_____		_____
• runny nose	_____		_____
• swollen glands	_____		_____
• sore throat	_____		_____
• difficulty swallowing	_____		_____
• decreased hearing	_____		_____
• ringing in ears	_____		_____
• gum / teeth problems	_____		_____
• hair loss	_____		_____
• shortness of breath	_____		_____
• chest tightness	_____		_____
• asthma/ wheezing	_____		_____

continued…

AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

New Patient **Intake Form**

Name_____ Date_____

GENERAL SYMPTOMS cont'd.=	current	(Please check all that apply)	past
• cough	_____		_____
dry/ hacking	_____		_____
color of phlegm	_____		_____
copious/sticky/blood	_____		_____
• environmental allergies	_____		_____
• palpitations	_____		_____
• irregular heart beat	_____		_____
• low blood pressure	_____		_____
• indigestion	_____		_____
• gas / flatulence	_____		_____
• bloating	_____		_____
• belching / burping	_____		_____
• acid regurgitation	_____		_____
• nausea / vomiting	_____		_____
• foul breath	_____		_____
• diarrhea	_____		_____
• loose stools	_____		_____
• constipation	_____		_____
• blood / mucous in stools	_____		_____
• intestinal cramping	_____		_____
• hemorrhoids	_____		_____
• frequent urination	_____		_____
• urgent urination	_____		_____
• blood in urine	_____		_____
• pain / burning urination	_____		_____
• cloudy urination	_____		_____
• incontinence	_____		_____
• night urination	_____		_____
• urinary infections	_____		_____
• neck / shoulder pain	_____		_____
• upper back pain	_____		_____
• lower back pain	_____		_____
• rib pain	_____		_____
• difficulty falling asleep			
time sleep _____			
awake _____			
• awaken at night	_____		_____
• nightmares	_____		_____

AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

New Patient **Intake Form**

Name_____ Date_____

GYNECOLOGY (women):

- date of last pap smear _____ results _____
- date of last menstrual period _____
- length of cycle (regular / irregular) _____
- duration of flow _____
- do you have clots with menstrual flow _____
- menstrual pain / cramping_____ location _____
- PMS
    - breast tenderness _____
    - mood changes (type)_____
    - bloating _____
    - headache _____ location _____
    - low back pain_____
    - food cravings _____
- method of contraception_____
- uterine fibroids _____ type _____
- ovarian cysts_____
- age of menopause _____

UROLOGY (men):

- date of last prostate exam _____ results _____
- urinary frequency _____
- poor stream flow _____
- premature ejaculation _____

Additional information _____

_____

_____

_____

Signature _____ Date _____

Print Name _____

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New Patient **Intake Form**

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month ☐ Past week ☐ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL**_____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL**_____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL**_____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL**_____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL**_____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL**_____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL**_____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL**_____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL**_____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL**_____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL**_____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL**_____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL**_____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL**_____
GRAND TOTAL			**TOTAL**_____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

☐ Yes (1 pt.)

If yes, how many are you currently taking? ____ (1 pt. each)

☐ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?

☐ Cimetidine (2 pts.)

☐ Acetaminophen (2 pts.)

☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

☐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)

☐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)

☐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)

☐ Experience no side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?

☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of

☐ Environmental and/or chemical sensitivities (5 pts.)

☐ Chronic fatigue syndrome (5 pts.)

☐ Multiple chemical sensitivity (5 pts.)

☐ Fibromyalgia (3 pts.)

☐ Parkinson's type symptoms (3 pts.)

☐ Alcohol or chemical dependence (2 pts.)

☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?

☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

GRAND TOTAL: _____

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?

☐ Yes ☐ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?

☐ Yes ☐ No

3. Are you currently on diuretics or blood pressure medication?

☐ Yes ☐ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)

XTT SCORE _____ (High >10; moderate 5-9: Low <4)

URINARY pH _____

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

Comparative Pain Scale

	0	No pain. Feeling perfectly normal.
Minor Does not interfere with most activities. Able to adapt to pain psychologically and with medication devices such as cushions.	**1 Very Mild**	Very light, barely noticeable pain, like a mosquito bite or a poison ivy itch. Most of the time you never think about the pain.
	2 Discomforting	Minor pain, like lightly pinching the fold of the skin between the thumb and first finger with the other hand, using the fingernails. Note that people react differently to this self-test.
	3 Tolerable	Very noticeable pain, like an accidental cut, a blow to the nose causing a bloody nose, or a doctor giving you an injection. The pain is not so strong that you can't get used to it. Eventually, most of the time you don't notice the pain. You have *adapted* to it.
Moderate Interferes with many activities. Requires lifestyle changes but patient remains independent. Unable to adapt to the pain.	**4 Distressing**	Strong, deep pain, like an average toothache, the initial pain from a bee sting, or minor trauma to part of the body, such as stubbing your toe really hard. So strong you notice the pain all the time and cannot completely adapt. This pain level can be simulated by pinching the fold of the skin between the thumb and first finger with the other hand, using the fingernails, and squeezing really hard. Note how the simulated pain is initially piercing, but becomes dull after that.
	5 Very Distressing	Strong, deep, piercing pain, such as a sprained ankle when you stand on it wrong, or mild back pain. Not only do you notice the pain all the time, you are now so preoccupied with managing it that your normal lifestyle is curtailed. Temporary personality disorders are frequent.
	6 Intense	Strong, deep, piercing pain so strong it seems to partially dominate your senses, causing you to think somewhat unclearly. At this point you begin to have trouble holding a job or maintaining normal social relationships. Comparable to a bad non-migraine headache combined with several bee stings, or a bad back pain.
Severe Unable to engage in normal activities. Patient is disabled and unable to function independently.	**7 Very Intense**	Same as 6 except the pain completely dominates your senses, causing you to think unclearly about half the time. At this point you are effectively disabled and frequently cannot live alone. Comparable to an average migraine headache.
	8 Utterly Horrible	Pain so intense you can no longer think clearly at all, and have often undergone severe personality change if the pain has been present for a long time. Suicide is frequently contemplated and sometimes tried. Comparable to childbirth or a severe migraine headache.
	9 Excruciating Unbearable	Pain so intense you cannot tolerate it and demand pain killers or surgery, no matter the side effects or risk. If this doesn't work, suicide is frequent since there is no more joy in life whatsoever. Comparable to throat cancer.
	10 Unimaginable Unspeakable	Pain so intense you will go unconscious shortly. Most people have never experienced this level of pain. Those who have suffered a severe accident, such as a crushed hand, and lost consciousness as a result of the pain and not blood loss, have experienced level 10.

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

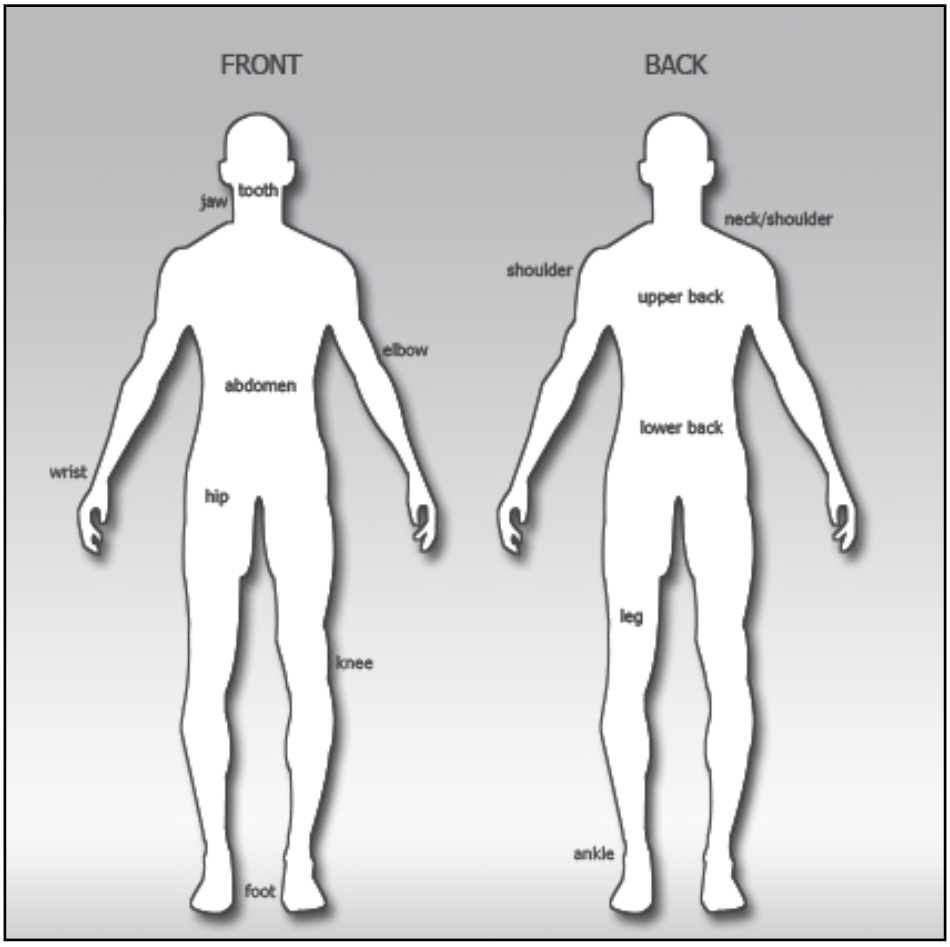
0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION


FRONT
BACK
jaw
tooth
neck/shoulder
shoulder
upper back
elbow
abdomen
lower back
wrist
hip
leg
knee
ankle
foot

ACUPUNCTURE CENTER INFORMED CONSENT TO TREAT AND PAYMENT AGREEMENT

I hereby request and consent to the performance of acupuncture treatments and the 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 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 above or any other office or clinic.

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 have an unpleasant smell or taste. I will immediately notify a member of 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 bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamp. 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 the clinic uses sterile disposable needles and maintains a clean and 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 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_____

PAYMENTS

We request payment at the time of services rendered. Prepayment will be required for future visits that have previous unpaid balances. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Our office only accepts cash and all major credit cards.

Initial _____

I understand that any billing of my insurance company is a courtesy provided by my doctor and that I am ultimately responsible for 100% of my bill. Should I fail to pay in full, I will be responsible for collection costs. Cancellation Made With Less Than 24 hour notice will be charged $25.00 for the first occurrence, and the full cost of the visit for additional occurrences.

Initial _____

MAJOR MEDICAL INSURANCE

Although we cannot guarantee any reimbursement from your health insurance company, we are glad to answer any questions concerning the billing process. As a courtesy to you, we will bill your insurance company. Please provide a copy of your insurance card whenever your plan renews or changes. If your plan requires precertification it is your responsibility to inform us in writing when It is required. It is not our responsibility for missing insurance company precertification requirements. If your plan changes due to COBRA or other policy changes it is your responsibility to inform us in writing of these changes. Your reimbursement may be affected because of these items ultimately it is your responsibility.

Initial _____

In signing below, I understand all these policies and agree to pay for treatments accordingly, and also agree that I am responsible for any unpaid balances. Additionally, I understand that this letter supersedes any previous telephone or other verbal communication about office policies and fees. I understand that AIMC may report me to a credit-reporting agency or take legal action as necessary to be paid for services rendered.

PATIENT SIGNATURE _____ **DATE**_____