Delaware Acupuncture & Nutrition
Intake & Consent Forms

Today's Date ____/____/____

Name _____ Birthdate ____/____/____ Age _____
First Middle Last

Sex Male □ Female □ Height _____ Weight _____ Any significant weight change in last year?_____

Occupation _____ Occupational Hazards _____ Marital Status _____ Children (#) _____

Address _____
Street or P.O. Box City State Zip Code

Home Phone (___)_____-_____ Work Phone (___)_____-_____ Cell Phone (___)_____-_____

Emergency Contact _____ (___)_____-_____ _____
Name Phone Relationship to Patient

How did you hear about us? _____

Would you like to be added to our newsletter? Yes_____ Email:_____ No_____

Have you had acupuncture before? Yes □ No □

Reason for visit today: _____

Any other concerns you'd like to address?_____

How long have you had this condition?_____ Is it getting worse? _____

Does it bother your: Sleep □ Work □ Other □? Describe _____

What seemed to be the initial cause? _____

What seems to make it better? _____
What seems to make it worse? _____

Do you have a pacemaker? _____

WOMEN: are you or might you be pregnant? _____

Are you under the care of a physician now? Yes □ No □ If yes, for what?_____

Who is your physician? _____ Physician's Phone _____

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Family Medical History (List who on line below):

☐ Alcoholism _____	☐ Diabetes _____	☐ Kidney Disease _____	☐ Mental illness _____	☐ Strokes _____
☐ Arteriosclerosis _____	☐ Heart Disease _____	☐ Liver Disease _____	☐ Seizures _____	☐ Substance abuse _____
☐ Cancer _____	☐ High Blood Pressure _____	☐ Lung Disorder _____	☐ Stomach Disorder _____	☐ Other _____

Is your mother still alive? _____ If not, how old was she when she died, and what was the cause of her death?_____

Is your father still alive? _____ If not, how old was he when he died, and what was the cause of his death?

_____

Your Past Medical History (Check any of the following conditions you currently have, or have had in the past.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Aneurysm
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Cancer (What Type)
- ☐ _____
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disorder
- ☐ Mental Illness
- ☐ Major Trauma
- ☐ _____
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Rashes
- ☐ Seizures
- ☐ Stomach Disorder
- ☐ Strokes
- ☐ Substance Abuse
- ☐ Surgery
- ☐ _____
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other (specify)
- ☐ (accident, injury,
- ☐ _____

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Pharmaceuticals taken presently: _____

_____

_____

Supplements: _____

_____

_____

List any known **allergies** to either food or drugs: _____

_____

Do you use/consume any of the following?

	Amount/Frequency		Amount/Frequency		Amount/Frequency
☐ Coffee		☐ Sugar		☐ Alcohol	
☐ Tea		☐ Salty Food		☐ Tobacco	
☐ Soda		☐ Artificial sweetener		☐ Marijuana	
☐ Dairy		☐ Laxatives		☐ Other illegal drugs	

List any foods you crave: _____

How often do you do exercise or do physical work?

☐ Never ☐ Once in a while ☐ Several time per month ☐ Several times per week ☐ Daily

Describe type of activity: _____

Have you had to cut down on exercise or recreation because of your health? _____

Describe your hobbies and interests: _____

What is your overall level of satisfaction with life? _____

Would you say that you are under a lot of stress? _____ **Describe?** _____

What methods do you use to alleviate or cope with stress? _____

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Do you suffer from exhaustion or fatigue? _____ If yes, describe how you feel? _____

_____

How often do you feel fatigue? _____ What time of day do you feel most tired? _____

Do you experience undue worry, difficulty concentrating, or forgetfulness?_____ Describe? _____

_____

General Symptoms

☐ Poor appetite	☐ Prefer cold drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps
☐ Heavy appetite	☐ Prefer hot drinks	☐ Lack of strength	☐ Fever or heat sensation	☐ Vertigo or dizziness
☐ Lack of taste	☐ Poor sleep	☐ Bodily heaviness	☐ Chills or cold sensation	☐ Bleed or bruise easily
☐ Peculiar taste in mouth	☐ Heavy sleep	☐ Cold hands/feet	☐ Night sweats	
Describe_____	☐ Dream-disturbed sleep	☐ Poor circulation	☐ Sweat easily	
_____				

Head, Eyes, Ears, Nose, Throat

☐ Glasses	☐ Blurred vision	☐ Gum problem	☐ Swollen glands	☐ Concussions
☐ Eye strain	☐ Night blindness	☐ Sores on lips or tongue	☐ Lumps in throat	Other head or neck problems:
☐ Eye pain	☐ Glaucoma	☐ Dry mouth	☐ Enlarged thyroid	_____
☐ Red eyes	☐ Cataracts	☐ Excessive salivation	☐ Nose bleeds	_____
☐ Itchy eyes	☐ Teeth problems	☐ Sinus problems	☐ Ringing in ears	_____
☐ Dry eyes	☐ Grinding teeth	☐ Excessive phlegm	☐ Earaches	
☐ Spots in eyes	☐ TMJ	Color of phlegm_____	☐ Headaches	
☐ Poor vision	☐ Facial pain	☐ Recurrent sore throat	☐ Migraines	

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Respiratory

☐ Difficulty breathing when lying down	☐ Tight chest	☐ Cough	Color of phlegm	☐ Coughing blood
	☐ Asthma / wheezing	Wet or dry?_____	_____	☐ Pneumonia
☐ Shortness of breath		Thick or thin?_____		

Cardiovascular

☐ High blood pressure	☐ Fainting	☐ Tachycardia	☐ Mitral valve prolapse	Other (describe):
☐ Blood clots	☐ Chest pain	☐ Heart palpitations	☐ Phlebitis	_____
☐ Low blood pressure	☐ Difficulty breathing	☐ Heart murmur	☐ Irregular heartbeat	_____

Gastrointestinal

☐ Nausea	☐ Diarrhea	☐ Intestinal pain or cramping
☐ Vomiting	☐ Constipation	☐ Itchy anus
☐ Acid regurgitation	☐ Laxative use	☐ Buring anus
☐ Gas	☐ Black stools	☐ Rectal pain
☐ Hiccup	☐ Bloody stools	☐ Hemorrhoid
☐ Bloating	☐ Mucous in stools	
☐ Bad breath	☐ Incontinence	

Muskuloskeletal

Describe quality of pain (stabbing, throbbing, burning, cramping, pulling, achey, etc.) to right.

☐ Neck/shoulder pain	☐ Low back pain	☐ Limited range of motion	Other (describe):
☐ Muscle pain	☐ Joint pain	☐ Limited use	_____
☐ Upper back pain	☐ Rib pain		_____

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Skin and Hair

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/skin texture	Other (describe):
☐ Hives	☐ Psoriasis	☐ Itching	☐ Premature graying of hair (if not familial)	_____
☐ Ulcerations	☐ Acne	☐ Hair loss	☐ Fungal infections	

Neuropsychological

☐ Seizures	☐ Poor memory	☐ Anxiety	☐ Abuse survivor	☐ ADD/ADHD
☐ Numbness	☐ Depression	☐ Irritabililty	☐ Considered/attempted suicide	Other (describe): _____
☐ Tics	☐ Mania	☐ Easily stressed	☐ Seeing a therapist	_____

Genito-urinary

☐ Painful urination	☐ Blood in urine	☐ Dribbling urine/erratic flow	☐ Increased libido	☐ Testicular pain
☐ Burning urination	☐ Milky/cloudy urine	☐ Bedwetting	☐ Decreased libido	
☐ Frequent urination	☐ Dark urine	☐ Wake to urinate	☐ Impotence	
☐ Urgent urination	☐ Unable to hold urine	☐ Kidney stones	☐ Premature ejaculation	
☐ Foul smelling urine	☐ Incomplete urination	☐ Venereal disease		

Gynecology

Age menses began _____	☐ Irregular periods	☐ Endometriosis	# Pregnancies _____	Date last period began:
Age at menopause _____	☐ Painful periods	☐ Fibroids	# Live births _____	_____
Cycle length _____	☐ PMS	☐ Ovarian cysts	# Abortions _____	Other (describe): _____
Duration of flow _____	☐ Vaginal discharge	☐ Breast lumps	# Miscarriages _____	
Color (brown, purple, pale red)	(color)_____	☐ Breast tenderness	# Premature births _____	
☐ Blood clots	(texture) _____	☐ Painful intercourse		
_____	☐ Vaginal odor	Date of last PAP:		

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OVERALL STATE OF HEALTH

Do you experience symptoms affecting your emotions, mental focus, and all or part of your body?

Never In the past Yearly Monthly Weekly Daily

Patient Signature _____ Date _____

_____ Date _____

(If under 18 years old, parent or guardian must also sign here.)

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By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at Delaware Acupuncture & Nutrition.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to terminate acupuncture treatment at any time.

Chinese Herbs, Homeopathic Remedies, Dietary Supplements: I understand that substances from the Oriental Materia Medica, homeopathy, and/or dietary supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Delaware Acupuncture & Nutrition as soon as possible.*

Cupping: I understand that if I receive cupping as part of therapy, there is a risk of local bruising, minor bleeding, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Other Modalities: I understand that I may receive treatment using other modalities (within the scope of practice of licensed acupuncturist as permissible by Delaware Law), including *but not limited to*: laser, auricular (ear) acupuncture or acupressure, dietary counseling and food therapy, Qigong, etc. I am aware that certain adverse side effects may result. These may include but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse these other modalities.

PRESCRIPTION MEDICATIONS FROM YOUR M.D.: I understand that it is not uncommon for patients to experience beneficial changes in their health that may affect their need for existing prescription medications and dosages. I am aware that in the course of my treatment, it may be necessary to more frequently consult with my prescribing physician(s) regarding medications and dosages. I understand that it is ***absolutely necessary*** to disclose any and all prescription medications and dosages I am taking to my acupuncturist, as these may affect my treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:**_____
(Patient or Legal Guardian)

Printed Name: _____

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my identifiable health information by Delaware Acupuncture & Nutrition for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Delaware Acupuncture & Nutrition is not required to agree to the restrictions that I may request. However, if Delaware Acupuncture & Nutrition agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time except to the extent that Delaware Acupuncture & Nutrition has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Delaware Acupuncture & Nutrition Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Printed Name Relationship of Representative (if applicable)

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