



san marcos community
acupuncture clinic

Patient Intake Form

Today's Date: ____ / ____ / ____

Patient's Name: _____
Last Name First Name M.I.

Sex: Male Female Date of Birth: ____ / ____ / ____ Marital Status: _____

Address: _____
Street City State Zip Code

Email: _____ Occupation: _____

Phone # (H) _____ (W): _____ Ext. _____ (C): _____

Emergency contact: Name & relationship: _____ Phone #: _____

Physician Name: _____ Physician's phone #: _____

Do you have any electronic device? (Such as, cardiac pacemaker, hearing aid, etc.) Yes No

Have you had acupuncture treatment or taken Chinese herbs before? Yes No

Reason for visit today _____

How long have you had this condition? _____

List all concurrent therapies _____

What are your health goals? _____

Family Medical History

- Allergies Asthma Cancer Diabetes Heart disease High blood pressure
- Other _____

Past Medical History

(Check any of the following conditions you currently have, or had in the past.)

- | | |
|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High/low Blood Pressure |
| <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgery (list) _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Trauma (car, fall, etc.) _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Other _____ |

Please indicate the use and frequency of the following:

- Alcohol _____ Tobacco _____ Exercise _____
- Recreational drugs _____ Coffee/Tea _____ Water _____

Please list all medications and supplements you are currently taking (include contraceptives, vitamins, etc.)

Check all conditions you currently have or had and are a significant part of your medical history:

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> Prefer cold drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweat |
| <input type="checkbox"/> Prefer hot drinks | <input type="checkbox"/> Stress | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Chills | <input type="checkbox"/> Irrational fears (list): _____ |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Fever | _____ |

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Productive cough | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> color of phlegm _____ | <input type="checkbox"/> Itchy/burning anus |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Hemorrhoid |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anal fissure |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Other intestinal problem |

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Burping | <input type="checkbox"/> Diarrhea/loose stool | <input type="checkbox"/> Rectal prolapse |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Low Appetite | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Gum problems | <input type="checkbox"/> High Appetite | <input type="checkbox"/> Peculiar taste: _____ |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Bloating | <input type="checkbox"/> Cravings | <input type="checkbox"/> Muscle pain/cramps |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Edema |

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Tongue ulcers |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty brathing | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Irritability | <input type="checkbox"/> Mental disturbance | |

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Infertility | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Increased sex drive | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Other ear disorder |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Impotence | <input type="checkbox"/> Hair loss | |

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> poor vision | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Migraines | <input type="checkbox"/> Gall stone |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Brittle or soft nails | |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Hypochondriac pain | |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Other eye disorders | <input type="checkbox"/> Emotional disturbances | |

For female patients only

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Length of cycle ___ days | <input type="checkbox"/> Length of flow ___ days | <input type="checkbox"/> PMS | <input type="checkbox"/> Currently breastfeeding |
| <input type="checkbox"/> Strength of flow _____ | <input type="checkbox"/> clots | <input type="checkbox"/> # Pregnancies _____ | <input type="checkbox"/> Age at menopause _____ |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Breasts lumps | <input type="checkbox"/> # Live births _____ | <input type="checkbox"/> Date of last period: _____ |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Currently pregnant | _____ |

Pain

Location _____

Frequency _____

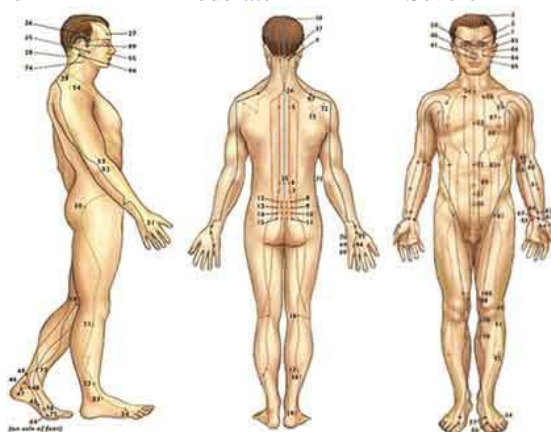
Time of Day _____

Characteristics _____

Others _____

Please rate severity of pain:

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Possible Pain
 None Mild Moderate Severe



Please mark the painful areas

Pursuant to the requirements ‘183.6(e) of this title (relating to Denial of License; Discipline of Licensee) and TEX.OCC.CODE ANN., ‘205.351 governing the practice of acupuncture.

I _____, am notifying the acupuncturist of the following:

___ Yes ___ No I have been evaluated by a physician or dentist for the condition being treated within the last 12 months before acupuncture was performed.

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after 120 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Signature of patient or Parent/Guardian if minor

Date

Informed Consent

I hereby request that the Acupuncturist treat me. I also authorize him/her to perform on me whatever therapeutic methods in his/her scope of practice that he/she sees fit. The therapeutic methods that are under a Licensed Acupuncturist are: acupuncture, electrical stimulation, moxibustion, recommendation of energy flow exercises, dietary suggestions, and referral suggestions. The acupuncturist had fully explained to me the nature and purpose of the treatment and the risks involved. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include but are not limited to: bruising, bleeding, aggravation of current injuries, nerve pain, pneumothorax, and puncture of organs. I understand that I have been given no guarantee as to the results that may be obtained.

Signature of patient or Parent/Guardian if minor

Date

Authorization and release

I certify that the above information is correct to the best of my knowledge. I will not hold any providers or any staff members of *San Marcos Community Acupuncture Clinic* responsible for any error or omissions that I may have made in the completion of this form. I hereby authorize *San Marcos Community Acupuncture Clinic* to furnish information to my insurance carriers and treating physicians concerning my (or my child's) illness, condition, and treatments.

Signature of patient or Parent/Guardian if minor

Date

Please choose a payment plan and initial:

Initial	Income	Acupuncture Treatments	Additional Treatments Within a week
	Under \$20,000	\$20	\$20
	\$20,000 - \$30,000	\$25	\$20
	\$30,000 - \$40,000	\$30	\$25
	Over \$40,000	\$35	\$30

*There is an additional \$10 consultation fee at the first appointment.

Payment and Cancellation Policies

Daniella Sadeh and Haicam Yan, Licensed Acupuncturists of San Marcos Community Acupuncture Clinic

Payment is by cash, Mastercard, or Visa. Full payment is expected at the time services are rendered.

If you must cancel your appointment, call as soon as possible to allow time to rebook your time slot. You must call 24 hours before your appointment or else you will be charged in full for your cancelled appointment. Exceptions can be made for family and medical emergencies or natural disasters, and we allow one late cancellation for each patient that has made several other appointments on time.

If you are more than ten minutes late for your appointment we will do what we can to fit you in. This may require you to wait so that we can keep other patients on schedule. We will do everything we can to treat you in a timely manner, but you will be charged for the appointment whether or not we have time available to treat you. Patients are scheduled every fifteen minutes, and we ask that you arrive a few minutes early to help everyone stay on schedule.

If you have an appointment and you don't call and you don't show up, you will be charged for your appointment regardless of the reason. Payment is expected either at the next appointment or by mail.

If the acupuncturist must cancel your session for any reason, she will call you by 5:00 pm the day before. If she cannot reach you or leave a message with a family member or your voice mail, your rescheduled appointment will be no charge.

I, (Print Name) _____, certify that I have read and understood the statements above and agree to abide by them.

Signature: _____ Date: _____