Acupuncture & Chinese Medicine
New Patient Form

Patient Name: ____________________________________Date of Birth:___/___/___Age:______Gender:___

Address:____

City:_______________________________________State:_________________Zip:__________

Primary Phone _____-________________ Email:_____________________________________

Marital Status:_____________________________

Emergency Contact:____
Name *Phone* *Relationship*

Are you currently receiving healthcare? yes ☐ no ☐

____
Physician & Office Name *Phone*

Context of Care:

Please list your most important health problems (in order of importance)

1.________________________ 2.________________________ 3.________________________

Have you received treatment for these concerning problems? yes ☐ no ☐

If yes, what modalities? ____

What *three* specific expectations do you have for your visit today?

1.____

2.____

3.____

Please describe your goals for treatment.____

____

Please describe your current state of health.____

What is your level of commitment to address the underlying causes of any of your symptoms that relate to your lifestyle. *Rate from 0-10, 10 being most fully committed.* 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

General

Height:________ Weight: ________ One year ago? ________ Ideal Weight? ________

Do you have an exercise routine? yes ☐ no ☐

What type of exercise do you do? ____________________ How often? ___________

History of trauma? yes ☐ no ☐ History of abuse? yes ☐ no ☐

Occupation:____________________ City:_____________________

Do you enjoy your work? yes ☐ no ☐ why/why not? _______________________

Hrs of sleep per night:________ Bed time:________ Do you wake refreshed? yes ☐ no ☐

Diet, Lifestyle, Habits

What is the current level of stress in your life? *Rate from 0-10, 10 being severe stress.*

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

What things have you found to help in the relieving of your stress?__________________________________

Spiritual Practice? yes ☐ no ☐ what?________________________________

Do you eat three meals per day? yes ☐ no ☐ If no, how many? ________

Please describe your typical daily meals.

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Do you use any of the following? (*please check)*

Alcohol ☐ Tobacco ☐ Coffee ☐ Caffeine ☐ Recreational drugs ☐ Soda ☐

Do you have any cravings? Please specify and describe frequency.____________________________________

____

Do you have any allergies to the following? *(please check)*

Medications ☐ Foods ☐ Seasonal ☐ Animals ☐ Environmental/Chemical ☐

If you checked any, please explain.____

____

Current Medications:

Please list all current prescription medications, over-the-counter medications, vitamins, herbs and nutritional supplements. Include frequency and dosages. Attach a separate sheet if necessary.

Prescription & Over-the-counter medications:____

____

____

Vitamins & Nutritional Supplements:____

____

____

Patient Medical History:

Please check all that apply:

Broken or Fractured Bones ☐ Major Illnesses ☐ Operations & Hospitalizations ☐

If checked, please provide the date, diagnosis, location of injury and/or surgery.__________________________

____

____

Personal & Family History

Check any conditions listed below that you currently have or have had in the past. If there is a family history of any of the conditions listed, please underline and specify.

☐ Appendicitis	☐ Cancer *(type)*__________	☐ Hepatitis *type)*_____
☐ Asthma	☐ Autoimmune Disorder	☐ Blood Clots
☐ Bronchitis	☐ Diabetes	☐ Migraines
☐ Emphysema	☐ Digestive problems	☐ HIV/AIDS
☐ Pneumonia	☐ Addiction	☐ Paralysis
☐ Tuberculosis	☐ Epilepsy	☐ Colitis/Enteritis
☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ High Cholesterol	☐ Mumps	☐ Blood Clots
☐ Hypertension	☐ Scarlet Fever	☐ Syphilis
☐ Stroke	☐ High Fever	☐ Polio
☐ Pace Maker	☐ Bleeding Disorder	☐ Mental Illness
☐ Arteriosclerosis	☐ Intestinal Parasites	☐ Allergies

Immunizations: yes ☐ no ☐ which?____

____

Other relevant history. ____

____

____

____

____

____

Pain & Scars

If you are currently experiencing pain or if you have discomfort anywhere in your body, please indicate by marking the illustration below using the letters that best describe the pain and/or sensations that you are experiencing. If your are experiencing pain that radiates or disperses, please indicate using arrows the direction of sensations. Please draw in areas of scarring.

Sensations Experienced:

P - Sharp pins & needles

A - Aching

B - Burning

N - Numbness

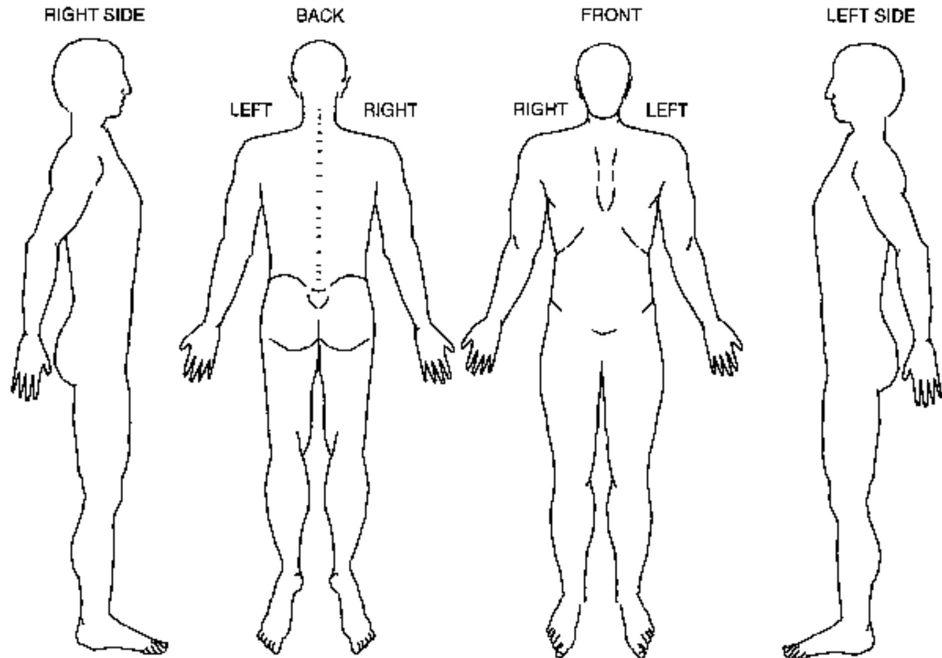
F - Fixed

S - Sharp/Stabbing

D - Dull

C - Cramping

** Draw in scars



Please indicate your level of pain: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What makes the pain better?

- ☐ Warmth/Heat
- ☐ Cold
- ☐ Rest
- ☐ Movement
- ☐ Soft Pressure
- ☐ Hard Pressure

What makes pain worse?

- ☐ Warmth/Heat
- ☐ Cold
- ☐ Rest
- ☐ Movement
- ☐ Soft Pressure
- ☐ Hard Pressure

Review of Systems

Kidney Function
Overall Temperature

- ☐ Cold Hands
- ☐ Cold Fingers
- ☐ Cold Toes
- ☐ Cold Feet
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Hot Bodily Temp.
- ☐ Cold Bodily Temp.
- ☐ Afternoon Flushes
- ☐ Night Sweats
- ☐ Heat in the hand, feet & chest
- ☐ Hot flashes at any time of day
- ☐ Thirst
- ☐ Easily Perspire
- ☐ Lack of perspiration

Lung, Kidney Function (Overall Energy)

- ☐ Shortness of Breath
- ☐ Difficulty Inhalation
- ☐ Difficulty Exhalation
- ☐ Difficulty keeping eyes open (daytime)
- ☐ General Weakness
- ☐ Easily Catch Colds
- ☐ Low Energy
- ☐ Feel worse after exercise
- ☐ Chronic (daily) fatigue & malaise

Lung Function

- ☐ Nasal Discharge (color ___________)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies
- ☐ Alt. Fever & Chills
- ☐ Sneezing
- ☐ Headache
- ☐ Overall achy bodily feeling
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Sore Throat
- ☐ Difficulty Breathing
- ☐ Grief
- ☐ Sadness
- ☐ Melancholy

Spleen, Stomach, SI, LI Function

- ☐ Loose stools
- ☐ Strong odorous Stools
- ☐ Constipated
- ☐ Incomplete Stools
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Mucous in Stools
- ☐ Undigested food in Stools

Heart Function

- ☐ Anxiety
- ☐ Restlessness
- ☐ Sores on the tip of tongue
- ☐ Chest pain (traveling to shoulder)
- ☐ Frequent dreams
- ☐ Wake feeling fatigued

Spleen Function

- ☐ Low appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas
- ☐ Gurgling noise in Stomach
- ☐ Fatigue after eating
- ☐ Bruise Easily
- ☐ Prolapsed Organs which? ____________
- ☐ Muscle weakness/fatigue
- ☐ Sedentary work
- ☐ Worry
- ☐ Over-thinking

Liver, Spleen, Heart Function

- ☐ Dizziness
- ☐ See floating black spots

Stomach Function

- ☐ Burning sensation after eating
- ☐ Hunger shortly after eating
- ☐ Large appetite
- ☐ Bad Breath
- ☐ Canker Sores (mouth)
- ☐ Bleeding, swollen or painful gums
- ☐ Acid Reflux
- ☐ Heartburn
- ☐ Ulcers
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach Pain
- ☐ Vomiting

Liver, Gallbladder Function

- ☐ Chest Pain
- ☐ Chest Tightness
- ☐ Alt Diarrhea & Constipation
- ☐ Bitter taste in mouth
- ☐ Irritability
- ☐ Anger easily
- ☐ Depression
- ☐ Frustration
- ☐ Skin Rashes
- ☐ Pain at top of head
- ☐ Temporal Headaches
- ☐ Numbness
- ☐ Muscle Twitching
- ☐ Muscle Cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck & Shoulder Tension
- ☐ High-pitched Ring (Ears)
- ☐ Hernias

- where_____________
- ☐ Gallstones
- ☐ STD's which________________
- ☐ Alcohol Consumption # drinks per day_______
- ☐ Recreational Drugs how often?____________

Liver Function (eyes)

- ☐ Painful
- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry Vision
- ☐ Decreased Night Vision
- ☐ Far-sighted
- ☐ Near-sighted

Internal Dampness

- ☐ Night Sweats
- ☐ Bodily sensation of heaviness
- ☐ Mental Heaviness
- ☐ Mental Sluggishness
- ☐ Swollen Hands
- ☐ Swollen Feet
- ☐ Swollen Joints
- ☐ Chest Oppression/ Congestion
- ☐ Hunger with inability to eat
- ☐ Nausea
- ☐ Snoring

Kidney, Bladder Function

- ☐ Low Back Pain
- ☐ Sore Knees
- ☐ Weak Knees
- ☐ Cold Sensation in Knees
- ☐ Easily Broken Bones
- ☐ Frequent cavities, teeth problems
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in ears
- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Lack of Bladder Control
- ☐ Wake during the night to urinate
- ☐ # of times per night __________
- ☐ Fear
- ☐ Easily Startled

Libido

- ☐ Normal

Bladder Function (Urination)

- ☐ Urine Color
- ☐ Pale ___ Dk Yellow ___ Clear ____
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong Odor
- ☐ Painful
- ☐ Urgent
- ☐ Frequent

Men Only

- ☐ Swollen Testes
- ☐ Testicular Pain
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Feeling of cold or numbness in genitals
- ☐ Erectile Difficulties
- ☐ Hernia
- ☐ Other _________________________

Women Only

- ☐ Nausea
- ☐ Vomiting
- ☐ Food Cravings
- ☐ Water Retention
- ☐ Breast Swelling
- ☐ Breast Tenderness
- ☐ Headaches
- ☐ Migraines
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Dull pain where ______________
- ☐ Sharp pain where ______________

_____ Age of first menses

_____ Average # days in flow

_____ Average # days in entire cycle

_____ # of children

_____ # pregnancies

_____ Age of menopause (if applicable)

yes **no** Regular menses cycles?

yes **no** Are you pregnant?

yes **no** Bleeding between periods?

yes **no** Irreg. discharge?

Date of last menses?______

Please fill in menstrual chart

	Color normal, pale, bright red, brown, rust, dark purple, other	**Amount of flow** normal, heavy, light	**Pain** dull, sharp, other
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

Do you have any other health concerns not addressed in this questionnaire?

____

____

____

____

Patient Signature (or Guardian, if minor) ____________________ Date __________

ACUPUNCTURE STATEMENT OF INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Joshua Green LAc. EAMP, Sacred Root Acupuncture & Naturopathic Medicine, on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that there are minor risks associated with acupuncture treatment including, but not limited to, slight bleeding and/or bruising of the skin. I understand that the risk of infection is negligible when using single use, disposable needles.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture and applicable modalities. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts then known, and act in my best interest.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

Following your treatment:

1) Occasionally, a person may feel light headed after an acupuncture treatment. If this happens to you, please sit for a while in the designated area. You'll feel fine in a few minutes.
2) Minor bleeding and bruising may occur.
3) Symptoms can worsen after a treatment (very small % of patients). If this occurs contact your Acupuncturist.
4) Herbs prescribed for the patient are intended for his or her use only, and should not be used by those for whom they are not dispensed.

Please sign and date below to indicate that you have read and understand this form.

____ ____________________

Patient Signature (or Guardian, if under age 18) Date

HIPPA Notice of Privacy Practices

Please review the following information carefully. It discusses how your medical information may be used and disclosed and how you can gain access to this information.

This HIPPA Notice of Privacy Practices explains how we may use and disclose your Protected Health Information (PHI) to carry out treatment, for payment of healthcare operations, and for other purposes that are permitted or required by law.

Uses and Disclosures of Protected Health Information

Treatment:

We may use and disclose your PHI in order to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party to whom has already obtained your permission to have access to your PHI. For example, we would disclose your PHI to another practitioner with whom you have begun treatment, if requested. This would be done in order to ensure that the practitioner has the necessary information to manage your care accordingly.

Payment:

Your PHI will be used as needed to obtain payment for your healthcare related services. This may include certain activities that your health insurance plan may undertake before it approves or pays for healthcare services provided.

Healthcare Operations:

We may use or disclose, as needed, your PHI in order to support the activities of your healthcare providers practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign-in sheet at registration desk where you will be asked to sign in and indicate your healthcare provider. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

Required by Law:

We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. Public health issues such as communicable diseases, legal proceeding, law enforcement, coroners, funeral directors, organ donation, criminal activity, national security, workers compensation, abuse or neglect may require the use of your PHI. You will be notified, as required by the law, of any such uses or disclosures.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. You may revoke this authorization at any time, in writing, except to the extent that your healthcare provider or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

________________________________ __________________________

Patient or Guardian signature Date