EAST WEST NATURAL MEDICINE

INTEGRATING ANCIENT TRADITIONS WITH MODERN SCIENCE

New Client Intake Form

Name_____ DOB_____ Age_____ Gender_____
Address_____ City _____ State _____
Zip_____ Preferred phone # _____ Alternate phone # _____
Email address_____ Occupation_____
Referred by_____ Have you had acupuncture before: _____When_____
Emergency, contact: _____ Phone # _____

Insurance Information
Health Insurance (Y/N)? _____ Plan Name_____ Member ID:_____
Subscriber Name _____ Subscriber Date of Birth _____
Provider Phone # _____
Are you currently using these benefits for chiropractic care? _____
Personal injury, car accident or work comp patients please provide date of injury
_____

Reason for Visit
Chief Complaint(s)/ what would you most like help with?
1._____
2._____
3._____

Do you have a medical diagnosis for this condition? ☐Yes ☐No

How long have you had this condition?_____

Please list any medications, herbs or supplements you are currently taking:

Are you pregnant? ☐Yes ☐No Are you trying to get pregnant? ☐Yes ☐No

List of past traumas, major injuries or surgeries:

Lifestyle
Diet: Please briefly explain your diet:

Habits: ☐ Coffee __ x day/week ☐ Alcohol ___x day/week ☐ Marijuana ___x day/week
☐ Other recreational drugs ___ x day/week ☐ Sugar ___ x day/week
☐ Tobacco ___x day/week

Exercise: ☐ Yes ☐ No If so, what do you do and how many times a week _____

Condition	Self	Year	Family	Condition	Self	Year	Family
HIV or AIDS				STDs			
Diabetes				Hepatitis			
Asthma				Heart Disease			
Allergies				Dizziness/Vertigo			
Thyroid Disorder				Stroke or TSA			
Chronic Fatigue				Headaches/Migraine			
Addiction				Emphysema			
Frequent Colds				COPD			
Kidney Stones				Gout			
Arthritis				Sinus Infections			
Gall Stones				Lyme Disease			
Scoliosis				Prone to Fainting			
Osteoporosis				High Blood Pressure			
Pneumonia				Rheumatic Fever			
Epilepsy/Seizure				Fibromyalgia			
Frequent UTIs				High Cholesterol			

Cancer (Please describe):

Allergies (Please describe):

Autoimmune Conditions (Please describe):

Chinese Medicine Pattern Differentiation
Please check boxes that apply to you.

Temperature
□ Normal □ Tend to feel hot □ Tend to feel cold □ Hands and feet always cold □ Alternating hot/cold

Sweating
□ When hot outside or exercising □ Sweat easily □ Night Sweats □ Sweaty palms, feet or chest

Eyes, Ears, Nose, Throat
□ Dry eyes □ Itchy eyes □ See floaters □ Night blindness □ Other eye problems □ Frequent runny nose
□ Problems with smell □ Nosebleeds □ Other sinus problems □ Ringing in Ears □ Earaches/ infections
□ Recent hearing loss □ Other ear problems □ TMJ pain □ Recurring sore throat □ Problems with taste

Skin/ Hair
□ Itchy skin □ Dry skin □ Bruise easily □ Hives □ Rashes □ Strong skin allergies □ Overly dry hair
□ Premature greying □ Recent hair loss

General energy levels
□ Low □ Average □ High Energy drops: □ Morning □ Afternoon □ Early evening

Sleep Quality
□ Poor □ Average □ Excellent, Number of hours_____□ Toss and turn □ Overactive mind □ Wake for no reason □ Frequent nightmares □ Vivid dreams □ Wake to urinate: How many times? _____

Stress Level
□ Low □ Moderate □ High
How does your stress affect your life? □ It's overwhelming □ I manage □ I thrive on it
How does stress affect your body? e.g. Heart palpitations, digestive issues, emotional/ depression/ panic attacks

Neurological/ Emotional
□ Panic attacks □ Depression □ Other

Appetite
□ Normal □ Low □ High □ Strong cravings

Digestion
□ Normal □ Heartburn □ Acid reflux □ Gas/ Bloating □ Abdominal pain □ Nausea
□ Bad breath □ Loose stool □ Diarrhea □ Blood in stool □ Mucous in stool

Bowel movements
□ 1x/day □ 2-3x/ day □ More than three □ Every other day □ 2-3x/week □ One a week or fewer

Urination
□ Normal □ Frequent □ Urgent □ Burning □ Difficult □ Unable to stop flow
Wake up at night to urinate Y/N:_____ How many times a night?_____

Chest
□ Chest pain/ tightness □ Palpitations □ Rapid Heartbeat □ Heavy chest sensation □ Shortness of Breath □ Difficulty breathing when lying down

Menstruation
□ Regular □ Irregular □ No cycle 1st day of last menstrual period_____Total Length of Cycle_____
Total days of bleeding_____Painful periods: □ No □ Before □ During □ After □ Clots
History of: □ Fibroids □ PCOS □ Endometriosis □ Other:
# of pregnancies _____ # of births _____ # of abortions/miscarriages _____
Please indicate any other symptoms that arise with menstruation (headaches/ fatigue/ bloating/ digestive issues):

Anything else you'd like to add?

Menopausal
□ Peri- □ Post ___# of Hot Flashes a day ___# of sweats a week □ Vaginal dryness □ Loss of sex drive

Emotions: What emotion(s) dominate your experience?
□ Anger □ Irritability □ Anxiety □ Worry □ Obsessive thinking □ Sadness □ Grief □ Depression
□ Joy □ Fear □ Timid/shy □ Indecision

Height: _____ Weight: _____ Blood Pressure: _____

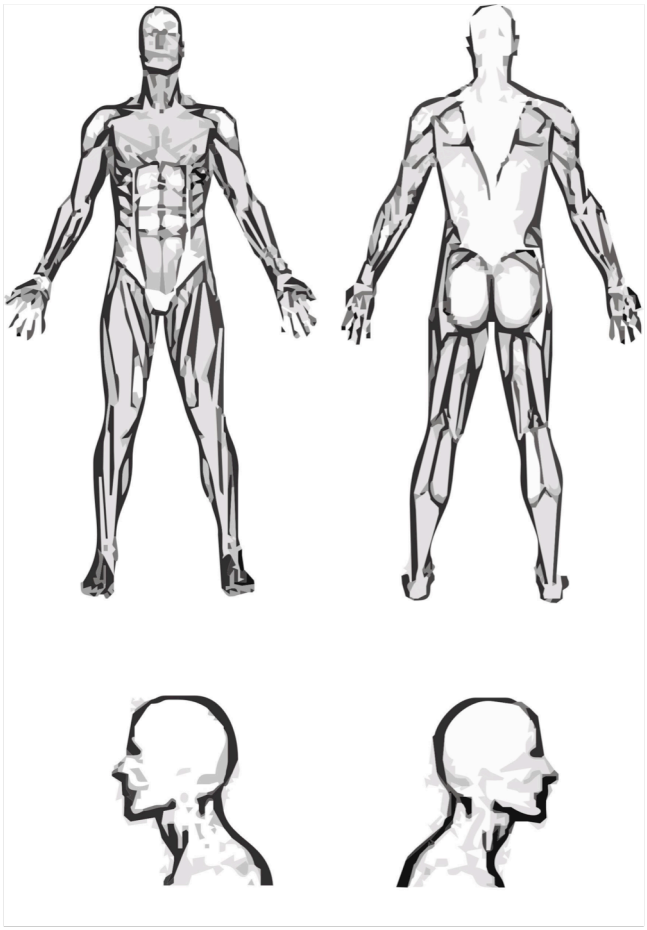
Pain

On a scale of one to ten, one would be barely noticeable, three would be bothersome, five would be painful, seven would impact your activities, nine would make you immobile, ten would incapacitate you.

Complaint	1-10
Headache/Migraine	
Back	
Neck/Shoulder	
Elbow	
Knee	
Hand/Finger	
Wrist	
Ankle	
Foot/Toe	
Hip/Sciatic	
Other:	

Please describe the quality of the pain next to the corresponding body part on the right:
(Sharp, Dull, Achy, Numb, Constant, Intermittent, Throbbing, Hot, Cold).

What makes it better or worse?



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Informed Consent to Treatment

I understand that the methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, massage, applied kinesiology, Chinese and Western Herbal medicine, nutritional and lifestyle counseling.

I have the opportunity to discuss with the acupuncturists, Nicole Anderson L.Ac., Jessica Piazza L.Ac., Jeffrey Callinan L.Ac., Deena Stapleton L.Ac. the nature and purpose of acupuncture treatments and procedures.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain and treating certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there will be some bruising, numbness or tingling near the needling site that may last a few days, and dizziness and fainting can occur on rare occasions. There have been very rare incidences reported in the literature of infection, scarring, spontaneous miscarriage, nerve damage, and/or organ puncture. Such serious problems have not occurred in this clinic. Generally, there will be slight bruising after cupping that may last a few days. This clinic uses only pre sterilized, disposable needles and maintains a clean and safe environment.

The herbs and nutritional supplements recommended here (which are from plant, animal and mineral sources) have a long history of use in Traditional Chinese Medicine. We source only high quality herbs and products, considered safe in normal dosages, a few can be toxic if large doses are ingested. I understand that some herbs may be inappropriate during pregnancy, and if I become pregnant I will inform my acupuncturist. If I experience any gastrointestinal upset or allergic reactions to the herbs or nutritional supplements I will inform my acupuncturist. I understand that to receive the greatest benefit from herbs and supplements I need to comply with the instructions and recommended dosages given to me by my acupuncturist.

I understand that clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I agree to give at least 24 hours to my acupuncturist or administrative staff in the event I need to change, cancel or miss an appointment. I understand that if I do not show up for my appointment, the business is at a loss for my unfilled appointment time and therefore I will be liable for a $50 missed appointment fee. In the event of an emergency this 24 hour cancellation policy will be waived. Please Initial_____

Printed Name: _____ **Date:** _____

Signature: _____

Parent/Guardian Signature: _____ **Date:** _____

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FINANCIAL POLICY

We offer several methods of payment for your acupuncture care and you may choose the plan which best suit your needs. Please read carefully and choose the plan that you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future. If special financial arrangements are necessary, please consult with the business manager during your initial consultation.

OUR MAIN CONCERN IS YOUR HEALTH AND WELL-BEING AND WE WILL DO OUR BEST TO HELP YOU.

PLAN ONE: The **self-pay** plan means that all fees will be paid when rendered. Fees are discounted for payment at the time of service.

PLAN TWO: If you have **insurance**, we will check your benefits and if applicable, we will bill for you as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. We participate in many insurance plans that may allow nominal out of pocket expense. **Your copay is due as services are rendered**. You are also responsible for portions of your bill that exceed your insurance limits.

If a claim is denied, the balance for care received up to that date is due in full in 30 days.

I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account.

PLEASE ADVISE WHICH PLAN YOU WOULD LIKE TO USE: _____

Please sign below to indicate your understanding of our financial policies. If you do not understand, please allow us to review the policies with you until they are clear.

Printed Name: _____ **Date: _____**

Signature: _____

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Financial Agreement Health Insurance

(Please complete only if you intend to use health insurance)

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangements

Your co-payment is due at the time of service.

You also agree that any check sent to you when you have not paid in full to the provider will be brought in to the provider to pay the remaining balance.

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information

By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

Printed Name: _____ **Date: _____**

Signature: _____