CENTERPATH WELLNESS

New Patient Intake

Name _____ Age _____ Date _____

Birth Date ____/_____/ _____ Phone (cell)_____ Phone (other) _____

Address _____ City _____ State _____ Zip _____

Email _____ Referred By _____

Emergency Contact _____ Relation _____ Phone # _____

Physician _____ Phone # _____ May we contact? Y N

Occupation_____ Employer _____

Main Concerns for your visit

1. _____ How Long _____

2. _____ How Long _____

3. _____ How Long _____

Have you been given a diagnosis? If so, what?

_____

What kinds of treatments have you tried?

_____

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

General Questions

Have you ever had acupuncture before?	Y	N
Are you now or could you be pregnant?	Y	N
Do you have a pacemaker, heart arrhythmia or other heart condition?	Y	N
Have you ever had blood-clotting problems or problems with bleeding?	Y	N
Are you taking blood-thinning medications?	Y	N
Do you take aspirin regularly?	Y	N

Past Medical History

Significant Illness: ○ Cancer ○ Diabetes ○ Hepatitis ○ Thyroid Disease ○ Breathing trouble
○ Fibromyalgia ○ Stroke ○ TB ○ Arthritis ○ Hypertension ○ Heart Disease
○ Depression/Anxiety ○ Anemia ○ STDs ○ HIV/AIDS ○ Seizures ○ Digestive disorder
○ Other:

Family Medical History (indicate family member)

○ Diabetes_____ ○ Cancer_____ ○ Heart Disease_____
○ Hypertension_____ ○ Stroke_____ ○ Hepatitis_____
○ Mental Illness_____ ○ Alcoholism_____ ○ Other_____

Hospitalizations/Surgeries (and approximate dates)

_____

_____

Significant trauma (accidents, injuries, etc.)

_____

_____

Allergies (drugs, food, chemicals, etc.)

_____

_____

Medications

List all **medications and supplements** you have taken in the past 6 months

RX: _____ Dose: _____ Date Started:_____
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Personal

Height: _____ Weight: _____

Habits

How many hours do you sleep per night?_____ What time do you go to bed?_____ Do you wake rested? Y N

Rate your energy level on a scale of 1-10: _____ What time of day is your energy: Highest? _____ Lowest? _____

Do you exercise regularly? Y N Please describe: _____

Do you smoke? Y N What? _____ How much/day?_____ Since _____

Do you take any recreational drugs? Y N What?_____

Diet

How much caffeine do you drink per day? (include coffee, tea, sodas) _____

Type of alcohol you usually drink, if any? _____ Number of drinks/week?_____

How much water do you drink per day? _____

Any dietary restrictions? _____

Please describe your typical daily diet

Breakfast _____

Lunch_____

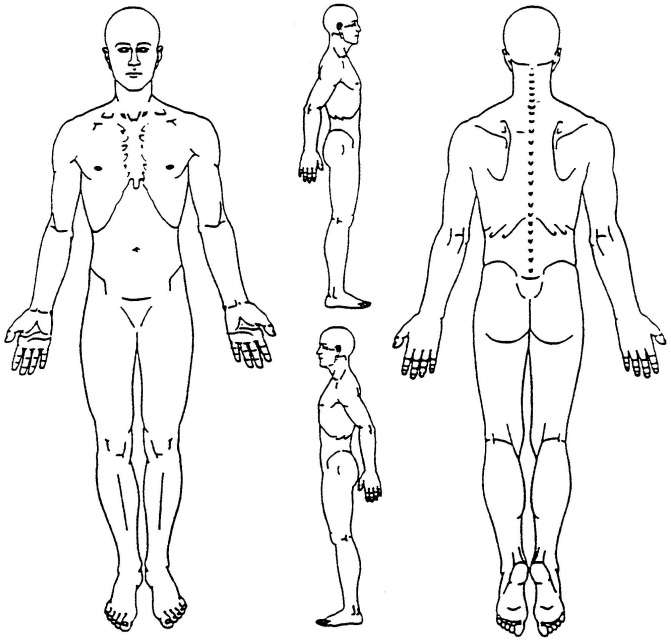
Dinner _____

Snacks_____

Favorite foods _____

Pain (complete if relevant)

Please indicate where you have pain, using the figures below



How would you characterize your pain? (mark all that apply)

○ sharp/stabbing ○ dull/achy ○ burning ○ numb ○ shooting ○ tingling ○ superficial ○ deep

The pain is: (mark all that apply)

○ better / worse with heat ○ better / worse with cold ○ better / worse with movement

○ better / worse with pressure ○ better / worse with rest ○ worse in AM or PM

Please check conditions you have currently or have had in the past 6 months

General ○ Poor sleep ○ Difficulty falling asleep ○ Difficulty staying asleep ○ Localized weakness

○ Fevers ○ Chills ○ Nightsweats ○ Sweats easily ○ Fatigue ○ Change in appetite ○ Poor appetite

○ Craving _____ ○ Desire hot food ○ Desire cold food ○ Weight loss ○ Weight gain

○ Peculiar taste: _____ ○ Strong thirst (hot or cold) ○ Poor balance ○ Poor coordination

Skin & Hair ○ Rashes ○ Hives ○ Itching ○ Eczema ○ Pimples

○ Dryness ○ Dandruff ○ Loss of hair ○ Lumps ○ Other:_____

Head, Eyes, Ears, Nose, Throat ○ Dizziness ○ Headaches ○ Migraines ○ Concussions

○ Ear ache ○ Ear ringing ○ Decreased hearing ○ Blurry vision ○ Visual changes ○ Facial pain

○ Poor night vision ○ Spots in vision ○ Cataracts ○ Glasses/contacts ○ Hay fever/allergies

○ Nose bleeds ○ Sinus problems ○ Difficulty swallowing ○ Dry mouth ○ Other:_____

Cardiovascular ○ High blood pressure ○ Low blood pressure ○ Palpitations ○ Blood clots

○ Chest pain ○ Irregular heart beat ○ Rapid heart beat ○ Fainting ○ Cold hands/feet

○ Swelling of hands/feet ○ Phlebitis ○ Varicose veins ○ Other: _____

Respiratory ○ Asthma ○ Bronchitis ○ Frequent colds ○ Wheezing ○ Pneumonia

○ Cough ○ Coughing blood ○ Production of phlegm – what color_____ ○ Other:_____

Gastrointestinal ○ Nausea ○ Vomiting ○ Diarrhea ○ Constipation ○ Gas ○ Belching

○ Blood in stools ○ Black stools ○ Bad breath ○ Rectal pain ○ Hemorrhoids ○ Pain or Cramps

○ Indigestion ○ Gall bladder disorder ○ Chronic laxative use ○ Other:_____

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/form_____

Genito-Urinary ○ Kidney stones ○ Pain on urination ○ Frequent urination ○ Blood in urine

○ Urgency to urinate ○ Unable to hold urine ○ Frequent urinary tract infections ○ Pause in flow

○ Dribbling ○ Genital pain ○ Genital itching ○ Other:_____

Neurological & Musculoskeletal ○ Seizures ○ Tremors ○ Numbness or tingling of limbs

○ Paralysis ○ Pain/Soreness in muscles ○ Weakness in muscles ○ Other_____

Psychological/Emotional ○ Depression ○ Anxiety ○ Stress ○ Irritability ○ Easily angered

○ Sadness ○ Over-worry ○ Treated for psych condition:_____ ○ Other:_____

Female Health

Age at first menstrual cycle_____ Date of first day of last menstrual cycle_____ Age at menopause_____

Cycle length (interval from start of one cycle to start of next) _____ Number of days of blood flow? _____

Have you ever taken birth control pills? Y N Number of years taken: _____ If stopped, when? _____

Were menses regular before the pills? Y N Were menses regular after stopping the pills? Y N

Are you currently trying to conceive? Y N

○ Endometriosis ○ Fibroids ○ Frequent vaginal infections ○ Pelvic infections ○ Vaginal discharge

○ Ovarian cysts ○ Irregular periods ○ Clots (small or large) ○ Cramps/pain prior to/during periods

○ Moodiness related to cycle ○ Breast tenderness ○ Low libido ○ Breast lumps ○ Fertility problems

○ Hot flashes ○ Vaginal dryness ○ Painful intercourse ○ Other:_____

Menstrual blood color: __Light pink __Light red __Bright red __Dark red __Black red __Brown

_____ # pregnancies _____ # of births _____ # miscarriages _____ # terminated _____ # premature births

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Male Health

○ Prostate problem ○ Impotence ○ Ejaculation problems ○ Discharge ○ Fertility problems

○ Painful/swollen testicles ○ Genital lesions ○ Other:_____

INFORMED CONSENT

I, _____, hereby request and consent to receive acupuncture and other procedures within the scope of the practice of acupuncture from Centerpath Wellness PLLC, and any Licensed Acupuncturist working with them. I understand Oriental Medical treatments include various modalities including but not limited to the following:

- Insertion of disposable, stainless steel acupuncture needles of various sizes into my body at different depths and locations
- Heated moxibustion treatment using the herb Artemisia vulgaris, or a heat lamp may be placed on or near any part of my body. The heat might cause slight discomfort or leave a small scar or blister on the skin. With any type of heat, there is risk of burn
- A vigorous massage technique called "gua sha" may produce redness, tenderness or slight bruising of the skin that typically lasts 1-5 days
- Cupping may be used to promote circulation. Suction from the cups may produce red or purple marks that typically last 3-5 days.
- Electrical stimulation may be used to enhance the treatment at various acupuncture points

I have been informed that I have the right to refuse any form of treatment. I understand and am informed that, as in allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that though these risks are unlikely to occur, they are possible. These risks include but are not limited to: bleeding, bruising, nerve pain, punctured organ, aggravated symptoms, appearance of new symptoms, fainting and fatigue. Some possible side effects of taking herbs include nausea, gas, stomachache, vomiting, headache, diarrhea, and rashes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment to be in my best interest based on the known facts at the time. I also understand there is always the possibility of unexpected complications and I understand no guarantee of cure or improvement of my condition is given or implied.

POLICIES AND PROCEDURES

1. Appointment reminders and follow-up communication
We may use or disclose your health information to provide you with appointment reminders and follow-up communication via phone, voicemail, email or letter.

2. Privacy Practices
I have reviewed Centerpath Wellness PLLC's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

3. Payment
Payment is due in full at the time of service. We accept cash, checks, and most major credit cards.
Your appointment time is reserved specifically for you. In the event of a missed appointment or cancellation with less than 24 hours notice, you will be charged a late-cancellation fee of $30.
A $30.00 fee will be charged for returned checks.
We reserve the right to change our fee scale without notice.

NOTIFICATION REGARDING EVALUATION BY A PHYSICIAN
In the State of Texas, acupuncture and Oriental medicine is not considered "primary care." As a result, Centerpath Wellness PLLC is required to have you respond to the following statements before you may be treated.

I, _____, am notifying Centerpath Wellness PLLC of the following:
I have been evaluated by a physician, dentist, or nurse practitioner for the condition being treated within 12 months before the acupuncture was performed: _____ Yes _____ No
_____ (initials) I recognize that I should be evaluated by a physician or dentist for the condition being treated.

I have completed this form to the best of my knowledge. I have read and understand the informed consent, privacy and procedures information, have been told about the risks and benefits of acupuncture and other procedures. By signing below I agree to a course of treatment in Oriental medicine, and 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.

Patient's Name (please print) _____

Patient's Signature _____ Date _____