New One on One Client Intake Form

Name: _____ Date: _____

Pronoun: ☐ He/Him ☐ She/Her ☐ They/Their ☐ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary Phone: _____ Date of Birth: _____

Emergency Contact & Phone: _____

Occupation: _____ Have you received acupuncture before? ☐ Yes ☐ No

Who are your current physicians? _____

Are you being treated for a ☐ Work-related Accident? ☐ Auto Accident?

How will you be covering treatment? ☐ Health Insurance: _____
☐ Paying Out-of-Pocket ☐ Workers Comp ☐ Auto Accident Coverage ☐ Personal Injury Coverage

IF YOU HAVE NOT ALREADY SUBMITTED YOUR INSURANCE INFORMATION, PLEASE PRESENT YOUR INSURANCE CARD TO FRONT DESK. Thank you!

How did you hear about us?

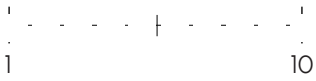
☐ Friend, Family or Colleague
☐ Health Practitioner
☐ Picked up Postcard, Coupon or Misc Print Material
☐ Walked-by or Live in the Neighborhood
☐ Google or Internet search
☐ Yelp
☐ Facebook/Instagram
☐ Other: _____

If a client or health practitioner referred us, we want to thank them!

Client (friend, family, colleague): _____

Health Practitioner or Practice: _____

For office use only:
☐ MB ☐ SC ☐ UP ☐ PC ☐ IN ☐ CC ☐ HF ☐ DL (REV. 3/20)

Please list your top three concerns/ goals in order of importance to you:	Mark an X on the scale to indicate severity of condition	When did this start?	What makes it better?	What makes it worse?
1.				
2.				
3.				

Health History - Check the *Self box* if you have or had the condition and the *Family* box if there is a family history.

Condition	*Self*	*Family*	*Condition*	*Self*	*Family*
Cancer (specify: .....)	☐	☐	**Osteoporosis**	☐	☐
Diabetes	☐	☐	**STD** (specify: .....)	☐	☐
Hepatitis	☐	☐	**Rheumatic fever**	☐	☐
High blood pressure	☐	☐	**Substance dependency**	☐	☐
Heart disease	☐	☐	**Allergies** (specify: .....)	☐	☐
Stroke	☐	☐	**Psychological** (specify: .....)	☐	☐
Seizure disorder	☐	☐			
Thyroid disease	☐	☐	**Kidney disease**	☐	☐

Other Important Health History

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Medications - Please list any medications, herbs, or supplements that you take regularly.

What taken	*For what condition*
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Temperature - How warm or cold you feel relative to other people (e.g. do you usually need to wear more layers or fewer?)

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Numbness
- ☐ Hot flashes
- ☐ Hot at night
- ☐ Night sweats
- ☐ Unusual sweats - specify when & where on body: .....

Digestion

- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea

BM: How often?

..... *x every* ..... *days*

Stools keep shape?

☐ Yes ☐ No

- ☐ Alternating diarrhea & constipation/IBS
- ☐ Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Hernia
- ☐ Hemmorrhoids
- ☐ Excessive hunger
- ☐ Dry stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Pain after BM
- ☐ Foul-smelling stools

Sleep

..... # hours per night

- ☐ Difficulty falling asleep
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking
- ☐ Wake ..... x per night at ..... am
- ☐ Wake to urinate how often: x

Emotions - What emotions are troubling to you or dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Not rested upon waking
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timidness / Shyness
- ☐ Indecisiveness

Energy

- ☐ Sudden energy drop *time of day* .....
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine/stimulants
- ☐ Wired or ungrounded feeling
- ☐ Body or limbs feel heavy
- ☐ Body or limbs feel weak
- ☐ Shortness of breath
- ☐ Heart palpitations
- ☐ Blood pressure high / low
- ☐ Bleed / bruise easily
- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Dizziness/lightheadedness
- ☐ Headaches: ..... *x per week*

Menstruation & Fertility

Age at first menses: .....

Average length of full cycle: ..... *days (i.e. 28)*

Average length of menses: ..... *days (i.e. 3-4)*

Last menses date: .....

# of pregnancies: ..... # of births: ..... # premature: .....

# of abortions: ..... # of miscarriages: .....

Do you take hormonal birth control pills? ☐ Yes ☐ No

Have you seen any specialists to assist in getting pregnant?

☐ Yes ☐ No

If so, what assisted interventions have you tried?

(e.g. IUI, IVF, etc.) .....

Periods

- ☐ Heavy
- ☐ Light
- ☐ Painful
- ☐ Irregular
- ☐ Clots

Cramps

- ☐ Before bleeding
- ☐ First day
- ☐ During Period

During cycle

- ☐ Changes in body/psyche prior to menstruation
- ☐ Fatigue
- ☐ Breast tenderness
- ☐ Mood changes
- ☐ Digestive changes
- ☐ Mid-cycle spotting

Menopause

Age at last menses: .....

Year changes began: .....

- ☐ Vaginal dryness
- ☐ Loss of sex drive
- ☐ Hot flashes: ..... *x per day*
- ☐ Night sweats: ..... *x per week*

PATIENT INFORMED CONSENT

Please read and initial:

I agree to receive acupuncture treatment by the licensed acupuncturists of Mend Acupuncture. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and in very rare cases dizziness or fainting. On occasion current symptoms may worsen before they find relief. I also understand that no guarantee can be made concerning the results of the treatment. _____

If I am pregnant or become pregnant, I will notify my practitioners ***immediately*** (if applicable). _____

I understand that the acupuncturists of Mend Acupuncture use only sterile, disposable, single-use needles, practice safe needling techniques, and maintain a clean and safe environment. _____

I understand that the Mend practice may reach out to medical providers to introduce our services. No confidential information will be released. I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law. _____

I understand that I may be charged the full session fee when an appointment is missed. I understand that I waive my session if I am more than 15 minutes late. _____

I have read this form and have had an opportunity to ask questions about its content. I 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. _____

I agree:

Print Name

Signature

Date

For patients under 18 years of age:

Parent/Guardian Name

Parent/Guardian Signature

Date

CREDIT CARD AUTHORIZATION FORM

We require that an authorized Credit Card be kept on file in the case of late cancellations and no-shows.

I, _____ authorize the use of my credit card for charges

incurred at Mend Acupuncture, including:

- **Treatment fees** not covered by insurance
- **Missed appointment fees:** late cancellations (less than 24 hours notice), no-shows and late arrivals (more than 15 minutes late) may incur a fee of $50.
- **Insurance Billing,** such as**:**
  - co-pays
  - deductibles

Print Name: _____

Signature: _____ Date: _____