

Coast Family Acupuncture - New Patient Intake Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone #: _____ Text? Y N

Date of Birth: _____ Blood Pressure: _____ / _____ Height: _____ Weight: _____

Relationship Status: Single Married Separated Divorced Widowed Living with partner Other _____

Other Health Care Providers: _____

Are you or may you be currently pregnant? Y N How did you hear of our clinic: _____

Have you been treated by Acupuncture or Oriental Medicine Before? Y N If yes, when? _____

Employer: _____ Occupation: _____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=unbearable)

1. _____ ago
 Heat makes it: better no change worse
 Cold makes it: better no change worse
 Damp weather: better no change worse
 Exercise/Activity: better no change worse

1 2 3 4 5 6 7 8 9 10

2. _____ ago
 Heat makes it: better no change worse
 Cold makes it: better no change worse
 Damp weather: better no change worse
 Exercise/Activity: better no change worse

1 2 3 4 5 6 7 8 9 10

3. _____ ago
 Heat makes it: better no change worse
 Cold makes it: better no change worse
 Damp weather: better no change worse
 Exercise/Activity: better no change worse

1 2 3 4 5 6 7 8 9 10

EXERCISE

Do you exercise regularly? If so, what types? What frequency/duration?

HEALTH HISTORY

Check D if you have / had the condition and note the year it started.
 Check O if there is a family history of the condition

	You	Year	Family		You	Year	Family
Cancer type(s):	D _____		O _____	Osteoporosis	D _____		O _____
Diabetes	D _____		O _____	Seizure Disorder	D _____		O _____
Hepatitis	D _____		O _____	Thyroid Disease	D _____		O _____
Anemia	D _____		O _____	Rheumatic Fever	D _____		O _____
Stroke	D _____		O _____	Venereal Disease	D _____		O _____
Aids/HIV	D _____		O _____	Allergies type(s):	D _____		O _____
Gastritis / Pancreatitis	D _____		O _____	Mental Illness	D _____		O _____
Asthma	D _____		O _____	Kidney Disease	D _____		O _____
Pacemaker	D _____		O _____	Chronic Fatigue	D _____		O _____
Arthritis	D _____		O _____	Chronic Pain	D _____		O _____
Herpes	D _____		O _____	Diverticulitis/IBS	D _____		O _____
Raynaud's Disease	D _____		O _____	Emphysema	D _____		O _____
Alcoholism	D _____		O _____	Hypo/Hyperglycemia	D _____		O _____
Lyme Disease	D _____		O _____	Heart Disease	D _____		O _____
Elevated Cholesterol	D _____		O _____	Addiction	D _____		O _____
Infertility	D _____		O _____	High Blood Pressure	D _____		O _____
				Other:	D _____		O _____

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American
 Current or past eating disorder? Y N

Typical Breakfast:

Typical Lunch:

Typical Dinner:

Typical Snacks:

HABITS

	Amt/Wk	If quit, yr?		Amt/Wk	If quit, yr?
Coffee/Tea			Alcohol		
Soda			Drugs		
Tobacco			Other:		

Coast Family Acupuncture: Health History Form

MEDICATIONS

Please list all Medications, Herbs, and Supplements that you take regularly.

INJURIES & TRAUMAS (PHYSICAL / EMOTIONAL)

SURGERIES

When?	What happened?	When?	What surgery?

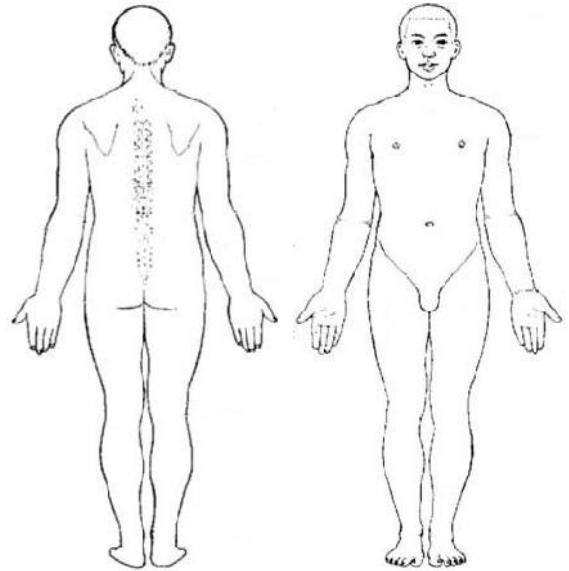
CHILDHOOD HEALTH HISTORY

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent Earaches | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Forceps Delivery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Other Birth Trauma: _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent Cold/Flu | <input type="checkbox"/> Prolonged Labor | <input type="checkbox"/> Other: _____ |

MUSCULOSKELETAL/EXTREMITIES

Pain, Weakness, Numbness in:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Wrists | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Hands | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Fingers | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Back: U/M/L | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Hips | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Edema | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Bone Deformities | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Whole Body Pain | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Restricted Movement |
| <input type="checkbox"/> Other _____ | | |



Please mark all places on the body where you have any concern →

HEAD, EYES, EARS, NOSE, THROAT

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Dry Lips/Mouth |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Dry Throat |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Lip/Mouth Sores | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excess Ear Wax | <input type="checkbox"/> Tongue Sores | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Red/Itchy Eyes | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Heavy-headed |
| <input type="checkbox"/> Spots in Eyes | <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Poor Smell | <input type="checkbox"/> Jaw Locks/Clicks | <input type="checkbox"/> Light-headed |

CARDIOVASCULAR

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bleed/Bruise Easily | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Spontaneous Sweating | <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fast Heart Rate | <input type="checkbox"/> Varicose/Spider Veins | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hands/Feet Swelling | <input type="checkbox"/> Low Blood Pressure |

RESPIRATORY

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficult Inhale/Exhale | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain on Deep Inhalation | <input type="checkbox"/> Phlegm (color: _____) |
| <input type="checkbox"/> Frequent Fevers | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Difficulty Breathing when lying down |

Coast Family Acupuncture: Health History Form

GASTROINTESTINAL

- BM: How Often? x/ day(s) Black Stools Dry Stools Hiatal Hernia Poor Appetite Excessive Hunger
 Stools keep shape? Y/N Bloating Difficult to Pass Hemorrhoids Indigestion Heartburn/Reflux
 Bowel Incontinence Belching Tired after BM Gas Rectal Pain Nausea/Vomiting
 Feel a "lump in throat" Bad Breath Cramps w/ BM Blood in Stool Abdominal Pain
 Peculiar Tastes/Smells Excess Saliva Unsatisfying BM Stomachaches IBS/Crohn'Disease
 Chronic Diarrhea Chronic Constipation

GENITO-URINARY

- Clear Urine Burning Urine Urgent Urine Fluid in = Fluid out Erectile Dysfunction Testicular Pain Jock Itch
 Cloudy Urine Painful Urine Frequent Urine Incontinence Decreased Libido Excess Libido Vasectomy
 Dark Urine Scanty Urine Kidney Stones Difficult Start / Stop Premature Ejaculation Prostate Disease Herpes
 Blood in Urine Profuse Urine Frequent UTI Genital Pain Nocturnal Emission Genital Sores Hernia

GYNECOLOGICAL

- Vaginal Dryness Fibroids Cramps Age of First Menses _____ Time Between Cycles: _____ days
 Vaginal Sores PMS Clots Date of Last Menses _____ Length of Menses: _____ days
 Vaginal Discharge Infertility Breasts Tender Digestive Change w/ Period Menopause: Age _____
 Irregular Periods Ovarian Cysts Mood Changes Fibrocystic Breast Tissue Number of Pregnancies: _____
 Painful Periods Heavy Periods Fatigue w/ Period Polycystic Ovarian Disease Number of Births: _____
 Endometriosis Light Periods Spotting Difficult / Painful Intercourse Lost or Terminated Pregnancy

NEURO-PSYCHO-EMOTIONAL

- Seizures Nervousness Bi-Polar Angry Concussion Seasonal Affective Disorder
 Loss of Balance Anxiety Poor Memory Sad Poor Concentration Difficulty Expressing Emotion
 Vertigo/Dizziness Panic Attacks Forgetful Grief Overthinking Frequently Sigh/Yawn
 Areas of Numbness Irritable ADD/ADHD Joy Tremors Other: _____
 Lack of Coordination Depression Indecision Fearful Easily Stressed

ENERGY

- Wired Fatigue
 Dependence on Caffeine Body Feels Heavy
 Energy Drop after Eating Body Feels Weak
 Sudden Energy Drop: Time of Day: _____

Low 1 2 3 4 5 6 7 8 9 10 High

SLEEP

- Difficulty Falling Asleep Sleep Walk/Talk Not Rested on Waking
 Difficulty Staying Asleep Disturbing Dreams Wake ___x/night
 Excessive Sleep Wake to Urinate Sleep ___hours/night
 Not Enough Sleep Restless Sleep

Too Little (Insomnia) 1 2 3 4 5 6 7 8 9 10 Too Much (Hypersomnia)

SKIN, HAIR AND NAILS

- Rashes Eczema Thick Skin Dry Nails Hair Loss Ulcerations
 Acne Psoriasis Scaly Skin Discolored Skin Dry/Brittle Hair Weak Nails
 Dandruff Dermatitis Thin Skin Dark Under Eyes Premature Greying Ridged Nail
 Itching Face Flushing Thin Nails Nail Fungus Recent Moles Change in Skin/Hair Texture
 Warts Hives Dry Skin Abscesses/Infections Lumps Other _____

Low

High

TEMPERATURE & THIRST

- Cold Hands/Feet Thirst for Cold Drinks Excessive Thirst Hot Flashes Unusual Sweats:
 Cold "In the Bones" Thirst for Hot Drinks Hot Hands Hot in Afternoon Where on Body: _____
 Areas of Numbness Thirst, No Desire to Drink Hot Feet Hot at Night What Time: _____ am/pm
 Chills Absence of Thirst Hot Chest Night Sweats Cold all the time
 Hot all the time

Coast Family Acupuncture: Jason Moore, L.Ac.

510 Cypress St., Suite C200

Fort Bragg, CA 95437

Phone: (707) 964-1111

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist practicing at Coast Family Acupuncture or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Coast Family Acupuncture, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. *(Patient Initials_____)*

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. *(Patient Initials_____)*

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is also a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant or if my medical condition changes in any way. *(Patient Initials_____)*

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. *(Patient Initials_____)*

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. 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.

PATIENT SIGNATURE	X	(Date)
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HIPAA CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Y Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Y Obtain payment from third-party payers.
- Y Conduct normal healthcare operations such as quality assessments and Physician certifications.

I have been informed by you; of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (please print): _____

Signature: _____

Relationship to Patient: _____ Date: _____ / _____ / _____

Coast Family Acupuncture – Jason Moore, L.Ac.
510 Cypress St., Suite C200
Fort Bragg, CA 95437
(707) 964-1111

COASTFAMILYACUPUNCTURE.COM

Coast Family Acupuncture Financial Policy

We accept cash, check, and credit / debit cards as payment methods.

We ask for your cooperation in providing 24-hour notice in advance if it is necessary to cancel or reschedule an appointment. All appointments that are rescheduled or cancelled with less than 24-hour advance notice, and appointments missed without notice, will be charged for the cost of that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package .

Late policy

We will do our best to accommodate you if you arrive late for your appointment. However, if you arrive more than 10 minutes late and we are unable to accommodate you, we will consider it a missed appointment and enforce our financial policy.

Returned checks

There will be a \$20 charge for any returned checks.

Thank you for your understanding,

Jason Moore, L.Ac.

I have read and understood the above policies. My signature below constitutes my agreement with the foregoing:

Signature: _____ Date: _____

Printed Name: _____