# PROTEA ACUPUNCTURE • NEW PATIENT INTAKE FORM

| | | | |
|---|---|---|---|
| **Name:** | | **Gender:** | **Today's Date:** |
| **Legal Name** if different from above [optional]**:** | | | **Date of Birth:** |
| **Address:** | | | |
| **Phone:** | | **Email:** | |
| **Height:** | **Weight:** | **Usual Blood Pressure:** | |
| **Employer:** | | **Occupation:** | |
| **Physician** Name & Phone**:** | | | |
| **Emergency Contact** Name & Phone**:** | | | |
| **Current Relationship Status** [single, married, partnered, etc]**:** | | | |
| **Is this your first time having acupuncture?** | | **How did you hear about Protea Acupuncture?** | |

## MAIN COMPLAINTS

| Please list your **top three complaints/concerns in order of importance to you.** | Mark an X on the scale to indicate the **severity of the condition.** | **When did this start?** | Indicate by circling whether each of the following makes it Better, Worse, or No Change | | | |
|---|---|---|---|---|---|---|
| | | | **Heat** | **Cold** | **Damp** | **Exercise** |
| **#1:** | 1 — 10 | | Better Worse No Change | Better Worse No Change | Better Worse No Change | Better Worse No Change |
| **#2:** | 1 — 10 | | Better Worse No Change | Better Worse No Change | Better Worse No Change | Better Worse No Change |
| **#3:** | 1 — 10 | | Better Worse No Change | Better Worse No Change | Better Worse No Change | Better Worse No Change |

## HEALTH HISTORY

Check the YOU box if you have or had the condition and note the year it began. Check the FAMILY box if there is a family history.

| CONDITION | YOU | YEAR | FAMILY |
|---|---|---|---|
| Cancer (specify) | ○ | | ○ |
| Diabetes | ○ | | ○ |
| Hepatitis | ○ | | ○ |
| High blood pressure | ○ | | ○ |
| Heart Disease | ○ | | ○ |
| Stroke | ○ | | ○ |
| Seizure disorder | ○ | | ○ |
| Thyroid disease | ○ | | ○ |
| Asthma | ○ | | ○ |
| Pacemaker | ○ | | ○ |
| Eating disorder | ○ | | ○ |
| Osteoporosis | ○ | | ○ |
| STD (specify) | ○ | | ○ |
| Rheumatic fever | ○ | | ○ |
| Substance dependency | ○ | | ○ |
| Allergies (specify) | ○ | | ○ |
| Psychological (specify) | ○ | | ○ |
| Kidney disease | ○ | | ○ |
| Anemia | ○ | | ○ |
| History of trauma | ○ | | ○ |

## INJURIES & SURGERIES **(including dental)**

Please list what happened to what body area and when it occurred.

_____

_____

_____

## MEDICATIONS

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

_____

_____

## DIET & EXERCISE

Do you have a special diet now or have you had one in the past?

_____

Do you exercise regularly? If so, what and how often?

_____

Do you use or have you used any of the following? How often?

| | Amount per week | If quit, how long ago? |
|---|---|---|
| Coffee / Tea | _____ | _____ |
| Soda | _____ | _____ |
| Tobacco | _____ | _____ |
| Alcohol | _____ | _____ |
| Other drugs | _____ | _____ |

# PROTEA ACUPUNCTURE • NEW PATIENT INTAKE FORM

## HEALTH QUESTIONNAIRE

Mark an X on the scales and check any boxes of symptoms or conditions you have had **in the past month**, in any applicable sections.

### TEMPERATURE

How warm or cold you feel relative to other people.
Do you usually need to wear more layers or fewer?

COLD ——— HOT

- ○ Cold hands or feet
- ○ Chills
- ○ Cold "in the bones"
- ○ Numbness
- ○ Thirst, no desire to drink
- ○ Absence of thirst
- ○ Excessive thirst
- ○ Night sweats
- ○ Unusual sweats (specify when, where on body)
  _____
  _____
- ○ Hot hands, feet, or chest
- ○ Hot flashes
- ○ Hot in afternoon
- ○ Hot at night

### MOISTURE

Overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ○ Dry skin
- ○ Dry hair
- ○ Dry eyes
- ○ Dry, brittle nails
- ○ Dry mouth
- ○ Dry lips
- ○ Dry throat
- ○ Dry nose
- ○ Nosebleeds
- ○ Edema / swelling (where? _____ )
- ○ Rashes (where? _____ )
- ○ Itching (where? _____ )
- ○ Dandruff
- ○ Oily skin
- ○ Oily hair
- ○ Pimples
- ○ Weight gain or loss

### DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____ x every _____ days
Stools keep shape? ○ Yes ○ No

- ○ Alternating diarrhea & constipation / IBS
- ○ Indigestion
- ○ Gas
- ○ Bloating
- ○ Belching
- ○ Poor appetite
- ○ Nausea
- ○ Vomiting
- ○ Bad breath
- ○ Heartburn
- ○ Hernia
- ○ Hemorrhoids
- ○ Excessive hunger
- ○ Dry stools
- ○ Difficult to pass
- ○ Tired after BM
- ○ Pain with BM
- ○ Foul-smelling stools

### ENERGY

LOW ——— HIGH

- ○ 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

### EMOTIONS

What emotions dominate your experience?

- ○ Anger
- ○ Irritability
- ○ Anxiety
- ○ Worry
- ○ Obsessive Thinking
- ○ Sadness
- ○ Grief
- ○ Depression
- ○ Joy
- ○ Fear
- ○ Timidness / Shyness
- ○ Indecisiveness

### SLEEP

# of hours per night: _____

- ○ Difficulty falling asleep
- ○ Wake ____ x per night @ _____ am / pm
- ○ Wake to urinate: how often?
  _____
- ○ Disturbing dreams
- ○ Restless sleep
- ○ Not rested upon waking

**HEALTH QUESTIONNAIRE CONTINUES ON NEXT PAGE**

## HEALTH QUESTIONNAIRE (continued)

Mark an X on the scales and check any boxes of symptoms or conditions you have had **in the past month**, in any applicable sections.

### EYES, EARS, NOSE, THROAT

- ○ Poor vision
- ○ Night blindness
- ○ Red eyes
- ○ Itchy eyes
- ○ Spots in vision
- ○ Sinus congestion
- ○ Phlegm (color? _____ )
- ○ Poor hearing
- ○ Ringing in ears
- ○ Excessive earwax
- ○ Sore throat
- ○ Dental problems
- ○ Mouth sores
- ○ Cough

### URINARY

- ○ Decrease in flow
- ○ Dribbling
- ○ Difficulty starting or stopping
- ○ Incontinence
- ○ Urgency to urinate
- ○ Frequent urination
- ○ Pain on urination
- ○ Burning sensation on urination
- ○ Cloudy urine
- ○ Blood in urine

### REPRODUCTIVE

Are you sexually active? ○ Yes ○ No

Any recent changes in sex drive? ○ Yes ○ No

- ○ Sores on genitals
- ○ Genital discharge
- ○ Genital pain
- ○ Pain with orgasm
- ○ Pain on penetration

**Penile & Prostate (**If applicable):

- ○ Erectile dysfunction
- ○ Premature ejaculation
- ○ Jock itch ○ Vasectomy
- ○ Prostate disease

### MENOPAUSE

If applicable

Age at last menses: _____

Year changes began: _____

- ○ Hot flashes: _____ x per day
- ○ Vaginal dryness
- ○ Loss of sex drive
- ○ Night sweats: _____ x per week

### MENSES & PREGNANCY

if applicable

Age at first menses: _____

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

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

Last menses start date: _____

# of pregnancies: ____ # of births: ____ premature: ____

# of abortions or miscarriages: ____

Do you take hormonal birth control pills? _____

**Periods**

- ○ Heavy
- ○ Light
- ○ Painful
- ○ Irregular

**Cramps**

- ○ before bleeding
- ○ first day
- ○ during period

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

## NOTICE OF PRIVACY PRACTICES
## PATIENT ACKNOWLEDGEMENT

**Right to Obtain a Copy of the Notice:**

You have the right to ask for and get a paper copy of the notice of privacy practices, and any revisions we make to the notice at any time.

**As indicated by my signature below I hereby acknowledge receipt and understanding of the Notice of Privacy Practices.**

**Print Patient's Name:** _____

**Signature of Patient or Person Authorized to Consent:** _____

**Date:** _____

# Protea Acupuncture – Whole Body Wellness

Heather Huber, L.Ac, Dipl. O.M., CMT

## Patient Informed Consent Agreement

I agree to receive acupuncture treatments and related therapies by Heather Huber, L.Ac, CMT. Treatment methods may include, but are not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, herbal medication, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Infection is also a possible risk. However, I understand Heather Huber, L.Ac., CMT uses only sterile disposable needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large dosages, and some herbs may be inappropriate to take during pregnancy. I will notify Heather Huber, L.Ac., CMT immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Heather Huber, L.Ac., CMT to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

**I will notify Heather Huber, L.Ac, CMT if I become pregnant.**

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.

**If I am unable to make a pre-scheduled appointment, I agree to cancel at least 24 hours in advance. For Sunday appointments I agree to cancel at least 48 hours in advance.** I understand that failure to do so will result in my being **charged the full amount** of the treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of my slot may be given to another client.

I understand that Heather Huber, L.Ac., CMT has the right to refuse treatment to any patient at any time. Reasons for refusal of treatment include crude behavior or inappropriate conduct.

**By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent for treatment form shall cover the entire course of treatment for my present condition and for any future condition which I seek treatment.**

**I have read this information and consent to treatment by Heather Huber, L.Ac., CMT:**

_____
Print Name of Patient (and Representative)

_____
Print Name of Practitioner

X_____
Patient Signature

X_____
Heather Huber, L.Ac. CMT

_____
Today's Date