Touchpoint Acupuncture

CONFIDENTIAL INTAKE FORM

DATE: _____

PATIENT INFORMATION

Name: _____ Gender: _____

Age: _____ Date of Birth: _____

Home Address: _____

_____

Home Phone: _____ Cell: _____ Work Phone: _____

Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Date of last medical examination: _____

Occupation: _____

WHAT WOULD YOU LIKE TO ADDRESS TODAY IN THIS TREATMENT?

Primary condition:

Onset: SUDDEN GRADUAL

Was there a significant event that lead to your condition?

Have you seen a physician for this condition? YES NO

If yes, Diagnosis: _____

What other therapies have you tried for your condition?

Secondary condition:

Onset: SUDDEN or GRADUAL

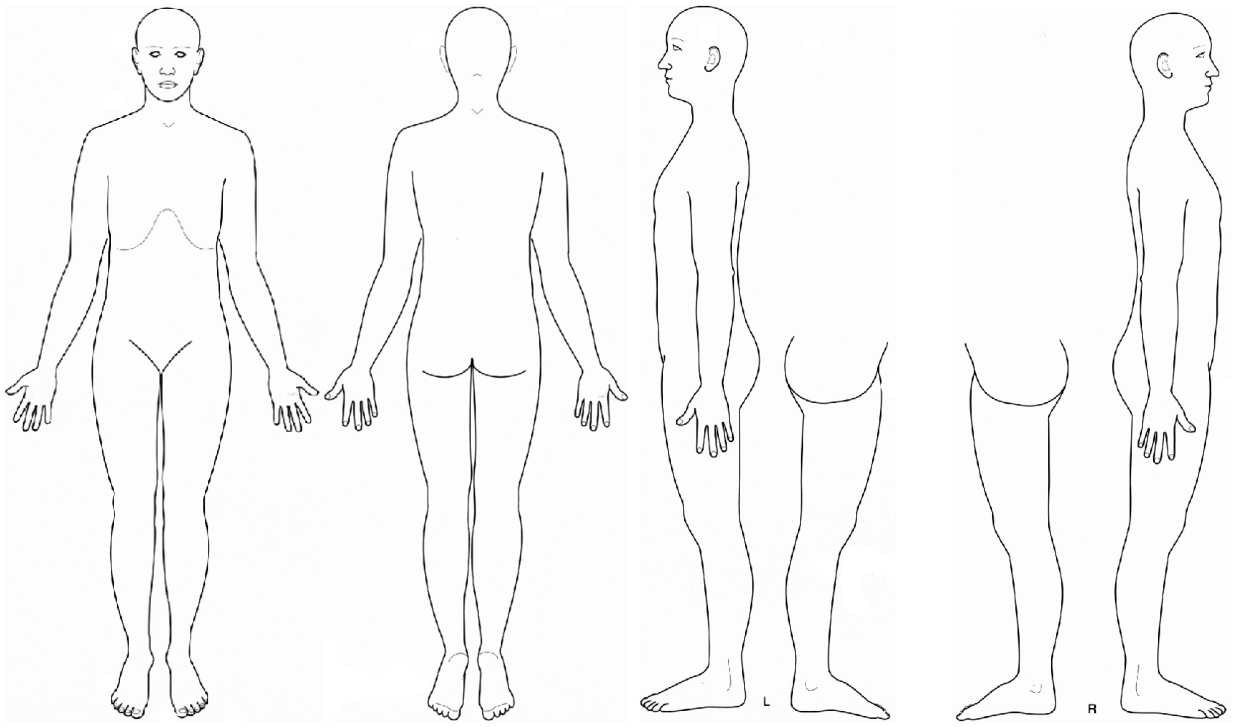
Was there a significant event that lead to your condition?

Have you seen a physician for this condition? YES NO

If yes, Diagnosis: _____

What other therapies have you tried for your condition?

On the diagram, please shade in the areas where you feel symptoms associated with your complaints. PLEASE NUMBER THE conditions (Primary = #1; Secondary = #2):



MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

PERSONAL MEDICAL HISTORY

PLEASE INCLUDE ANY TRAUMA, SURGERIES, OR MAJOR ILLNESSES FROM BIRTH TO PRESENT

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

MUSCULOSKELETAL

- ☐ A C F Joint clicking
- ☐ A C F Limitation of movement
- ☐ A C F Stiffness
- ☐ A C F Spasms or cramps
- ☐ A C F Swelling
- ☐ A C F Weakness
- ☐ A C F Pain (Please indicate where)

_____

_____

EYES, EARS, NOSE & THROAT

- ☐ A C F Loss of vision
- ☐ A C F Eye pain
- ☐ A C F Tearing or eye dryness
- ☐ A C F Eye redness
- ☐ A C F Ear pain &/or infections
- ☐ A C F Loss of hearing
- ☐ A C F Ringing or buzzing in ears
- ☐ A C F Problems with balance (vertigo)
- ☐ A C F Nose bleeds
- ☐ A C F Sinus pain, pressure &/or infections
- ☐ A C F OTHER (Please list)

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RESPIRATORY

- ☐ A C F Chest pain &/or tightness
- ☐ A C F Bluish discoloration of skin
- ☐ A C F Cough
- ☐ A C F Coughing up blood
- ☐ A C F Shortness of breath
- ☐ A C F Sore throat
- ☐ A C F Voice changes
- ☐ A C F Wheezing
- ☐ A C F OTHER (Please list)

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CARDIOVASCULAR

- ☐ A C F Changes in skin temperature & color
- ☐ A C F Chest pain &/or pressure
- ☐ A C F Edema
- ☐ A C F Fainting
- ☐ A C F Fatigue
- ☐ A C F Palpitations
- ☐ A C F Skin ulceration
- ☐ A C F Swelling of the ankles &/or legs
- ☐ A C F OTHER (Please list)

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DIGESTIVE

- ☐ A C F Abdominal distention/bloating
- ☐ A C F Abdominal mass
- ☐ A C F Abdominal pain
- ☐ A C F Acid regurgitation &/or Heartburn
- ☐ A C F Rectal bleeding
- ☐ A C F Constipation
- ☐ A C F Diarrhea
- ☐ A C F Gas
- ☐ A C F Eating disorder
- ☐ A C F Indigestion
- ☐ A C F Nausea
- ☐ A C F Vomiting
- ☐ A C F OTHER (Please list))

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UROGENITAL

- ☐ A C F Difficulty with urine flow
- ☐ A C F Incontinence
- ☐ A C F Painful urination
- ☐ A C F Red urine
- ☐ A C F Urinary tract infection (UTI)
- ☐ A C F OTHER (Please list)

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NEUROLOGICAL

- ☐ A C F Changes in consciousness
- ☐ A C F Confusion
- ☐ A C F Difficulty concentrating
- ☐ A C F Dizziness
- ☐ A C F Dysphasia (impaired ability to speak)
- ☐ A C F Gait disturbance
- ☐ A C F Headache
- ☐ A C F Numbness and/or tingling
- ☐ A C F Loss of consciousness
- ☐ A C F Paralysis
- ☐ A C F Post shingles pain
- ☐ A C F Problems coordinating movements
- ☐ A C F Severe forgetfulness
- ☐ A C F Tremor
- ☐ A C F Weakness
- ☐ A C F OTHER (Please list)

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INTEGUMENTARY (SKIN)

- ☐ A C F Changes in hair
- ☐ A C F Changes in nails
- ☐ A C F Changes in skin color
- ☐ A C F Itching
- ☐ A C F Never sweat
- ☐ A C F Rash and/or skin lesion
- ☐ A C F Unusual sweating
- ☐ A C F Wounds that will NOT heal
- ☐ A C F OTHER (Please list)

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PSYCHOLOGICAL

- ☐ A C F Feelings of grief
- ☐ A C F Feeling of sadness
- ☐ A C F Feeling fearful/anxious/nervous
- ☐ A C F Difficulty managing anger
- ☐ A C F Feeling worried or overly pensive
- ☐ A C F Feelings of panic
- ☐ A C F Extreme mood swings
- ☐ A C F Extreme lack of emotion
- ☐ A C F OTHER (Please list)

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SLEEP

- ☐ A C F Difficulty falling asleep
- ☐ A C F Dream disturbed sleep
- ☐ A C F Wake up & cannot fall back asleep
- ☐ A C F OTHER (Please list)

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_____

MISCELLANEOUS

- ☐ A C F Extremely low energy/fatigue
- ☐ A C F OTHER (Please list)

_____

_____

FOR MEN ONLY

- ☐ A C F Fertility concerns
- ☐ A C F Prostate problems
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

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FOR WOMEN ONLY

- ☐ A C F Abnormal vaginal bleeding
- ☐ A C F Fertility concerns
- ☐ A C F Irregular menstruation
- ☐ A C F Menopausal symptoms
- ☐ A C F No menses
- ☐ A C F Pain with menses
- ☐ A C F Pain during or after intercourse
- ☐ A C F Pelvic pain
- ☐ A C F Premenstrual symptoms
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

_____

_____

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: _____

Births _____
Miscarriages _____
Abortions _____

FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER _____
FATHER _____
SIBLINGS _____
MATERNAL GRANDPARENTS _____
PATERNAL GRANDPARENTS _____

Touchpoint Acupuncture

Informed Consent

Thank you for choosing Touchpoint Acupuncture. I look forward to working with you on your path toward your true health potential.

Everyone responds to treatment differently therefore, I cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let me know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly.

Under New York State law, all acupuncture patients are advised to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

During treatment, if you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let me know immediately. This is known as needle shock, and while this occurrence is extremely rare, it helps to let me know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include, but are not limited to, local bruising, mild pain in the area treated; brief generalized fatigue, tingling or numbness.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Please wear comfortable, loose clothing.
- Please avoid treatment when excessively fatigued, hungry, full, or emotionally upset.
- I am unable to treat patients who are intoxicated and/or are abusing substances.

I have been informed that I have a right to refuse any form of treatment. I have also had an opportunity to ask questions about the above statement's content, and by signing below I agree to be treated at Touchpoint Acupuncture. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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 have read and understand the above statement Date

Signature of Client or client representative

_____

Print name of Client or client representative

I understand that there is a 24-hour cancellation policy. I agree to pay the full price of a session if I cancel less than 24 hours within the scheduled appointment time.

_____ _____

Signature of Client or client representative Date

_____

Print name of Client or client representative

Touchpoint Acupuncture

Notice of HIPAA Privacy Practice

I am aware that the HIPAA privacy notice of Touchpoint Acupuncture is posted on the Touchpoint Acupuncture website: www.touchpointacupunctur.com, which can be accessed at any time. I am also aware that I can request a printed copy of the HIPAA Privacy Practice at any time.

_____ _____

Signature of Client or client representative Date