

# New Patient Intake Form

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name	SS#	Marital Status	Birthdate	/	/
Address		<input type="checkbox"/> M <input type="checkbox"/> F	Age	Ht	Wt
City, State, Zip	Home Phone	Work Phone	Occupation		
Emergency Contact Name & Phone					
Referred by					
Reason for visit today	Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How long have you had this condition?					
Is it getting worse? Does it bother your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Other (what?)					
What seemed to be the initial cause?					
What seems to make it better?					
What seems to make it worse?					
Are you under the care of a physician now? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, for what?		
Who is your physician?			Physician's Phone		
Other concurrent therapies					

**Health Insurance Info:**

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

**Medicare Info:**

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

**Family Medical History**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Alcoholism		<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
			<input type="checkbox"/> High Blood Pressure	

**Your Past Medical History**

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps		<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy		<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major Trauma	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Birth Trauma (your own birth)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	(Car, fall, etc--list)	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever		
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures		
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke		

**Your Diet**

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty Food	Thirst for water: # glasses per day: _____
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**Average Daily Menu**

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in last 2 months: \_\_\_\_\_  
 Vitamins/supplements taken in last 2 months: \_\_\_\_\_

## Your Lifestyle

- Alcohol  
 Tobacco

- Marijuana  
 Drugs

- Stress  
 Occupational Hazards

### Regular Exercise

Type \_\_\_\_\_  
Type \_\_\_\_\_

Frequency \_\_\_\_\_  
Frequency \_\_\_\_\_

## General Symptoms

- Poor appetite  
 Heavy appetite  
 Strongly like cold drinks  
 Strongly like hot drinks  
 Recent weight loss/gain

- Poor sleep  
 Heavy sleep  
 Dream-disturbed sleep  
 Fatigue  
 Lack of strength

- Bodily heaviness  
 Cold hands or feet  
 Poor circulation  
 Shortness of breath  
 Fever

- Chills  
 Night sweats  
 Sweat easily  
 Muscle cramps  
 Vertigo or dizziness

- Bleed or bruise easily  
 Peculiar taste (describe)  
\_\_\_\_\_  
\_\_\_\_\_

## Head, Eyes, Ears, Nose, Throat

- Glasses  
 Eye strain  
 Eye pain  
 Red eyes  
 Itchy eyes  
 Spots in eyes  
 Poor vision  
 Blurred vision

- Night blindness  
 Glaucoma  
 Cataracts  
 Teeth problems  
 Grinding teeth  
 TMJ  
 Facial pain  
 Gum problems

- Sores on lips or tongue  
 Dry mouth  
 Excessive saliva  
 Sinus problems  
 Excessive phlegm  
Color of phlegm \_\_\_\_\_

- Recurrent sore throat  
 Swollen glands  
 Lumps in throat  
 Enlarged thyroid  
 Nose bleeds  
 Ringing in ears  
 Poor hearing  
 Earaches

- Headaches  
 Migraines  
 Concussions  
Other head or neck problems  
\_\_\_\_\_  
\_\_\_\_\_

## Respiratory

- Difficulty breathing when lying down  
 Shortness of breath

- Tight chest  
 Asthma/whooping

- Cough  
Wet or Dry? \_\_\_\_\_  
Thick or thin? \_\_\_\_\_

Color of phlegm \_\_\_\_\_

- Coughing blood  
 Pneumonia

## Cardiovascular

- High blood pressure  
 Blood clots

- Low blood pressure  
 Fainting

- Chest pain  
 Difficulty breathing

- Tachycardia  
 Heart palpitations

- Phlebitis  
 Irregular heartbeat

## Gastrointestinal

- Nausea  
 Vomiting  
 Acid regurgitation  
 Gas  
 Hiccup  
 Bloating  
 Bad breath

- Diarrhea  
 Constipation  
 Laxative use  
 Black stools  
 Bloody stools  
 Mucous in stools

- Intestinal pain or cramping  
 Itchy anus  
 Burning anus  
 Rectal pain  
 Hemorrhoid  
 Anal fissures

Bowel movements:

Frequency \_\_\_\_\_

Texture/form \_\_\_\_\_

Color \_\_\_\_\_

Odor \_\_\_\_\_

## Musculoskeletal

- Neck/shoulder pain  
 Muscle pain

- Upper back pain  
 Low back pain

- Joint pain  
 Rib pain

- Limited range of motion  
 Limited use

Other (describe)  
\_\_\_\_\_

## Skin and Hair

- Rashes  
 Hives  
 Ulcerations

- Eczema  
 Psoriasis  
 Acne

- Dandruff  
 Itching  
 Hair loss

- Change in hair/skin texture  
 Fungal infections

Other hair or skin problems  
\_\_\_\_\_  
\_\_\_\_\_

## Neuropsychological

- Seizures  
 Numbness  
 Tics

- Poor memory  
 Depression  
 Anxiety

- Irritability  
 Easily stressed  
 Abuse survivor

- Considered/attempted suicide  
 Seeing a therapist

Other (specify)  
\_\_\_\_\_  
\_\_\_\_\_

## Genito-urinary

- Pain on urination  
 Frequent urination  
 Urgent urination

- Blood in urine  
 Unable to hold urine  
 Incomplete urination

- Venereal disease  
 Bedwetting  
 Wake to urinate

- Increased libido  
 Decreased libido  
 Kidney stone

- Impotence  
 Premature ejaculation  
 Nocturnal emission

## Gynecology

- Age menses began

Length of cycle (day 1 to day 1)  
\_\_\_\_\_

- Duration of flow  
\_\_\_\_\_

- Irregular periods  
 Painful periods  
 PMS

- Vaginal discharge (color)  
\_\_\_\_\_

- Vaginal sores  
 Vaginal odor  
 Clots

- Breast lumps  
# Pregnancies \_\_\_\_\_  
# Live births \_\_\_\_\_  
Premature births \_\_\_\_\_  
Age at Menopause \_\_\_\_\_

Date of last PAP  
\_\_\_\_\_

Date last period began  
\_\_\_\_\_

## Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Oriental medicine has a great deal to offer as a health care system, however it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

WE, THE UNDERSIGNED, AFFIRM THAT (X) \_\_\_\_\_ (Patient) HAS BEEN ADVISED BY Peter Scolaro (Licensed Acupuncturist) TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

X \_\_\_\_\_ Patient Signature

X \_\_\_\_\_ Date

\_\_\_\_\_  
Licensed Acupuncturist Signature

\_\_\_\_\_  
Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatment and other procedures associated with the practice of traditional Oriental medicine provided by the clinical staff (Licensed Acupuncturists or Massage Therapists). I have discussed the nature and purpose of my treatment with the clinical staff.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as massage.

I have been informed that acupuncture is a safe method of treatment, but that it may have effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. I understand that I must indicate if I have any bleeding or bruising disorders or are taking blood thinners, as this will affect the course of treatment. I understand that I must indicate if I am allergic to silicon, latex, or vinyl products, as this will affect the course of treatment.

Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that I must indicate if I have diabetes, as this will affect the course of treatment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I will notify the clinical staff member who is caring for me if I am or become pregnant.

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 known to them, is in my best interests.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

To be completed by the patient (or patient's representative if a minor or physically or legally incapable).

To be completed by the member of The clinical staff providing care.

X \_\_\_\_\_  
Date consent completed

\_\_\_\_\_  
Peter Scolaro  
Print name of clinical staff

X \_\_\_\_\_  
Print name of patient

\_\_\_\_\_  
Signature of clinical staff

X \_\_\_\_\_  
Signature of patient or representative

X \_\_\_\_\_  
Print name of patient representative (if applicable)

Peter Scolaro, L.Ac.  
New York State Licensed Acupuncturist

**PATIENT CONSENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

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\_\_\_\_\_ hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Practice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any of the changes that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all my questions have been answered to my full satisfaction in a way that I can clearly understand:**

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship

Date Signed \_\_\_\_\_

Witness: \_\_\_\_\_