Brielle Acupuncture Center, LLC

732-547-8281

Patient Information:

Date: _____/_____/______
Name (Last, First, Middle): ____
Age: ________________ Birthdate: ______/______/______ Sex: Female Male
Address: ____
City/State/Zip Code: ____
Home Phone No.: (_____)__________________________________ Work Phone No.: (_____)___________________________________
Cell Phone No.: (_____)__________________________________ **E-Mail**: ____
Please specify which phone number we can leave voicemail messages on: __________________________________
Occupation: ____ Employer: ____
Employment Status: □ Full-Time □ Part-Time □ Student □ Retired □Unemployed □Other:______________________
Living Situation: □ Alone □ Friend(s) □ Partner □ Spouse □ Parents
Status: □ Single □ Married □ Divorced □ Widowed
In Case of Emergency Notify: _______________________ Phone No.: (_____)_____________________________________
How did you hear about Brielle Acupuncture Center? □ Phone Book □ Ad □ Web □ Referred By:
Another Patient:_________________________________ Physician/Professional: ____
Other: ____

Insurance Information:

Primary Insurance Name: ____Phone No. __________________________________
Address: ____ City/State:____________________________ Zip: ______________
Subscriber Name: ____ Employer: ____
SSN: __________________________________ Date of Birth: ___________________ Relationship to Patient: _______________________
ID#: _______________________________ Group #: _____________________________________

Secondary Insurance Name: ____ Phone No. __________________________________
Address: ____ City/State:______________________________ Zip: ______________
Subscriber Name: _______________________________________ Employer: ____
SSN: _______________________________ Date of Birth: ____________________ Relationship to Patient: _________________________
ID#: _______________________________ Group #: _____________________________________

Privacy Information:

□ **I have reviewed/received the HIPAA Notice of Privacy Practice for Brielle Acupuncture Center**

____ ____
Signature-Patient or Parent of Minor Relationship to Patient

Financial Agreement:

I claim full financial responsibility for services rendered at Brielle Acupuncture Center and understand that payment is required in full at the time of service. If insurance coverage is available, I, the undersigned, give my authorization to treat and assign directly to Brielle Acupuncture Center, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize Brielle Acupuncture Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ____
Signature-Patient or Parent of Minor Relationship to Patient

Welcome to Brielle Acupuncture Center! Please take a moment to provide us with some information about yourself and your health condition so we may do our best to treat you. Brielle Acupuncture Center abides by all HIPAA laws and regulations and considers this information confidential physician/patient communication.

Major Complaint(s) in order of significance to you:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Medical Status:

General Health: □ Excellent □ Good □ Fair □ Poor

Medications (vitamins, prescriptions, herbal supplements):______________________________

____

____

Recent Tests: (please indicate test results and date below)

	□ Physical	□ Cholesterol	□ Blood	□Pap Smear	□ Mammogram	□ Other : ______
Date:	______	______	______	______	______	______
Results:	______	______	______	______	______	______

Hospitalizations/Operations:

Dates	Hospital	Diagnosis/Operation	Doctor

Current/Recent Health Care Providers:

Name	Dates	Care Provided

Other medical conditions:

- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood transfusions
- ❑ Bleeding tendency
- ❑ Bone disease
- ❑ Bronchitis
- ❑ Bursitis
- ❑ Cancer or tumor
- ❑ Chicken Pox
- ❑ Colon/bowel disease
- ❑ Diabetes
- ❑ Diptheria
- ❑ Drug habit
- ❑ Drug sensitivity or reaction
- ❑ Emotional or mental problems
- ❑ Emphysema
- ❑ Gall stones
- ❑ Gall Bladder problems
- ❑ Heart trouble
- ❑ Hemorrhoids
- ❑ Hepatitis/jaundice
- ❑ Herpes
- ❑ High Blood pressure
- ❑ HIV
- ❑ Hives
- ❑ Kidney stones
- ❑ Kidney or bladder infection
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Lupus
- ❑ Malaria
- ❑ Measles
- ❑ Migraines
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Pancreatitis
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Spinal meningitis
- ❑ Stomach or duodenal ulcer
- ❑ Stroke
- ❑ Tendonitis
- ❑ Tuberculosis
- ❑ Thyroid or goiter trouble
- ❑ Typhoid
- ❑ Venereal disease
- ❑ Varicose veins
- ❑ Other:
  ____
  ____
  ____
  ____

Review of Systems:

General:

- ❑ Cold hands
- ❑ Cold feet
- ❑ Sweaty hands
- ❑ Sweaty feet
- ❑ Aversion to Heat
- ❑ Aversion to Cold
- ❑ Night sweats
- ❑ Hot flashes
- ❑ Perspire easily
- ❑ Lack of perspiration
- ❑ Thirsty
- ❑ Take water to bed

Energy:

- ❑ Shortness of breath
- ❑ Difficulty keeping eyes open throughout the day
- ❑ General weakness
- ❑ Catch colds easily
- ❑ Low energy
- ❑ Feel weak after exercise
- ❑ Wake unrefreshed

Head:

- ❑ Headache (Location:______)
- ❑ Low-pitched ringing in the ears
- ❑ High-pitched ringing in the ears
- ❑ Hearing loss
- ❑ Lump in the throat
- ❑ Grind teeth
- ❑ Frequent cavities
- ❑ Excessive hair loss
- ❑ Sores on tip of the tongue

Cardiovascular:

- ❑ Palpitations
- ❑ Chest pain
- ❑ Chest pain traveling to shoulder
- ❑ Tight sensation in the chest
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Swelling of ankles
- ❑ Varicose veins

Respiratory:

- ❑ Asthma
- ❑ Hay fever
- ❑ Difficulty breathing
- ❑ Cough
- ❑ Dry mouth
- ❑ Dry throat
- ❑ Dry nose
- ❑ Dry skin
- ❑ Nose Bleeds
- ❑ Sinus congestion
- ❑ Nasal discharge (Color:____)
- ❑ Alternating fever and chills
- ❑ Sneezing
- ❑ Overall achy feeling
- ❑ Sore throat

Gastrointestinal:

- ❑ Stomach pain
- ❑ Abrupt weight gain
- ❑ Abrupt weight loss
- ❑ Abdominal bloating
- ❑ Abdominal gas
- ❑ Gurgling noises in the stomach
- ❑ Fatigue after eating
- ❑ Low appetite
- ❑ Prolapsed organs (Which organ?_____)
- ❑ Easily bruised
- ❑ Hemorrhoids
- ❑ Burning sensation after eating
- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth (canker) sores
- ❑ Bleeding, swollen or painful gums
- ❑ Heartburn
- ❑ Acid regurgitation
- ❑ Ulcer (diagnosed)
- ❑ Belching
- ❑ Hiccoughs
- ❑ Vomiting

Elimination:

- ❑ Alternating diarrhea and constipation
- ❑ Loose stools
- ❑ Constipated
- ❑ Incomplete
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Mucous in stools
- ❑ Undigested food in stools

Phlegm/Damp:

- ❑ General sensation of heaviness in the body
- ❑ Mental heaviness
- ❑ Mental sluggishness
- ❑ Mental fogginess
- ❑ Swollen hands/feet
- ❑ Swollen joints
- ❑ Chest congestion
- ❑ Nausea
- ❑ Snoring

Musculoskeletal:

- ❑ Easily broken bones
- ❑ Sore knees
- ❑ Weak knees
- ❑ Cold sensation in knees
- ❑ Low back pain
- ❑ Skin rashes
- ❑ Headache at the top of the head
- ❑ Tingling sensation
- ❑ Numbness
- ❑ Muscle spasms
- ❑ Muscle twitching
- ❑ Muscle cramping
- ❑ Seizures
- ❑ Convulsions
- ❑ Neck tension
- ❑ Limited range of motion in neck
- ❑ Shoulder tension
- ❑ Limited range of motion in shoulder

Eyes/vision:

- ❑ Itchy
- ❑ Bloodshot
- ❑ Hot
- ❑ Dry
- ❑ Watery
- ❑ Gritty
- ❑ Blurry vision
- ❑ Decreased night vision
- ❑ Near-sighted
- ❑ Far-sighted
- ❑ Dizziness
- ❑ Seeing floating black spots

Emotional

- ❑ Anger easily
- ❑ Frustration
- ❑ Depression
- ❑ Irritability
- ❑ Fear
- ❑ Easily startled
- ❑ Anxiety
- ❑ Restlessness
- ❑ Mental confusion
- ❑ Frequent dreams
- ❑ Insomnia
- ❑ Over-thinking/Worry
- ❑ Sadness
- ❑ Melancholy
- ❑ Memory problems

Genitourinary:

- ❑ Kidney stones
- ❑ Bladder infections
- ❑ Wake during the night to urinate
- ❑ Lack of bladder control

Habits:

Dietary preferences/restrictions: ____

Sample of day's menu:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Food/Drink temperature preference: __________________ Cravings: ____________________________

Allergies (foods, pollens, penicillin, etc.): ____

____

Feeling after you eat (tired, energized, etc.): ____________________________

Energy level throughout the day (1 (low) to 10 (high):____________________________

Best time of day: ______________________ Worst time of day: ____________________________

Routine physical exercise: Type of exercise: ____

How many minutes? __________________________ How often? ____________________________

Tobacco use (how much): __________________________ Previously: ________________ How long? ____________________

Alcohol use (how much): __________________________ How often? ____________________________

Caffeine use (how much): __________________________ How often? ____________________________

Stresses: (family, work, self, etc.)

____

____

____

____

Please indicate any areas of pain in your body: ____

____

Is the pain: Sharp Burning □ Aching □ Cramping □ Dull □ Moving □ Fixed □Other: ____________________________

Do the following lessen the pain? □ Pressure □ Cold □ Heat □ Exercise □ Other: ____________________________

Do the following worsen the pain? □ Pressure □ Cold □ Heat □ Exercise □ Other: ____________________________

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given at Brielle Acupuncture Center is based upon Traditional Chinese medical principles and natural treatment only and does not constitute a western medical diagnosis. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, it is my responsibility to advise my physician of any herbal supplements I am currently taking.

I have read all of the information in this intake form and have informed Brielle Acupuncture Center of all known physical conditions, medical conditions and medications. I also agree to keep them informed of any changes.

Patient Signature: ____ Date:___________________