New Patient Intake Form

Have you or your spouse been in the US Armed service? _____

Patient Name: _____ Today's Date: _____

Address:_____

Phone: _____H _____W or C

M/F Height:_____ Weight: _____ Birth Date: _____ Emergency Contact:_____

_____

Present Health Concerns:

1. _____
2. _____
3. _____

Please list all medications you are currently taking (if needed, continue on the back or attach your list):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any vitamins, minerals, or herbs you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any allergies you have: _____

Do you follow any diet regimen or restrictions? _____

Personal Habits:

- ☐ Tobacco: packs per day ____
- ☐ Alcohol: drinks per day ____ (or per week_____)
- ☐ Exercise regularly, how often? _____
- ☐ Caffeine, coffee, tea, and cola: cups per day ____
- ☐ Recreational drugs: times per week ___
- ☐ High stress, due to _____

Please indicate the locations of any **pain** you currently have on the drawing.

Major illnesses and approximate dates:

_____

_____

_____

Major Injuries:

_____

_____

_____

Operations:

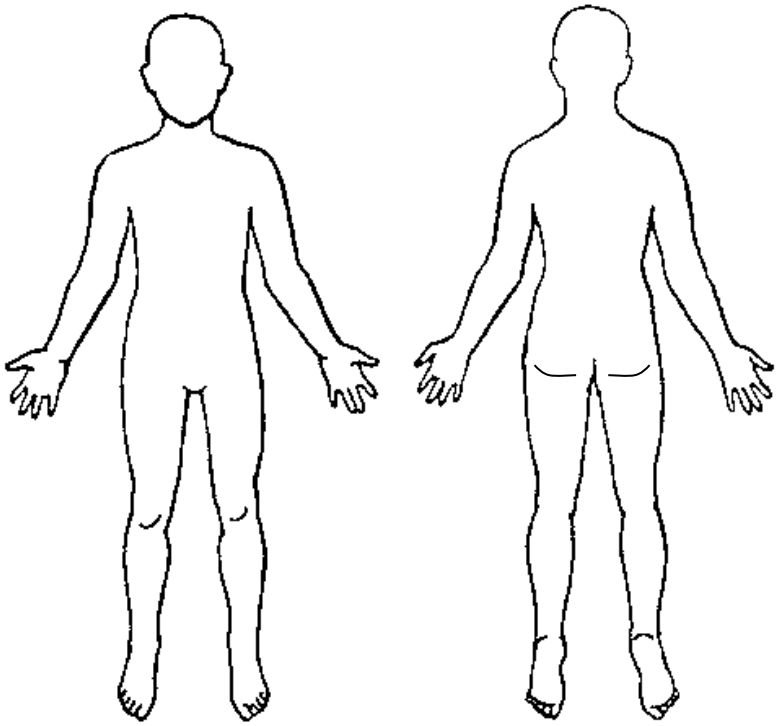
_____

_____

_____

Primary Care Physician:

_____



Front Back

Please mark a C next to any conditions you currently experience and mark a P next to any conditions you have had in the past. **Patient Name:_____**

SKIN
__Hives
__Rashes
__Eczema
__Acne
__Dry Skin
__Bruise easily
__Moles or Lumps
__Sores
__Other _____

HEAD AND NECK
__Dizziness
__Fainting
__Neck pain or stiffness
__Headaches
__Blurry Vision
__Spots or floaters in vision
__Itchy eyes
__Ringing in ears
__Poor hearing
__Sinus infection
__Hay fever or allergies
__Sore throat
__Difficulty swallowing
__Mouth sores
__Other _____

RESPIRATORY
__Chronic cough
__Coughing up blood
__Coughing up phlegm
__Asthma or wheezing
__Emphysema
__Frequent colds
__Shortness of breath

CARDIOVASCULAR
__Palpitations
__Chest pain or tightness
__Rapid heart beat
__Poor circulation
__Swelling of ankles
__Blood clots
__High blood pressure, hypertension
__Low blood pressure, hypotension

MUSCLES AND JOINTS
__Joint pain
__Sore muscles
__Weak muscles
__Back Pain
__Other _____

GASTROINTESTINAL
__Nausea
__Acid reflux
__Indigestion
__Bloating
__Abdominal pain
__Diarrhea
__Constipation
__Poor appetite
__Excessive hunger
__Vomiting blood
__Bloody or black tarry stools
__Hemorrhoids
__Bad breath
__Gall bladder problems
__Recent weight change

URINARY
__Frequent urination
__Painful urination
__Frequent urinary infections
__Kidney stones
__Increased thirst
__Lack of thirst

Other Concerns:

NEUROLOGICAL
__Seizures
__Tremors
__Loss of balance
__Numbness or tingling of limbs
__Paralysis
__Nerve pain (sciatica, trigeminal)

MOOD AND EMOTIONS
__Insomnia
__Frequent dreams/nightmares
__Fatigue
__Agitation
__Anxiety
__Panic attacks
__Depression
__Anger
__Confusion
__Forgetfulness
__History of psychiatric treatment
__Other _____

INFECTIONS (self or partner)
__HIV
__TB
__Hepatitis
__Sexually transmitted disease (gonorrhea, chlamydia, syphilis, genital warts, herpes)

TEMPERATURE
__Hot flashes
__Night sweats
__Frequent low fever
__Cold hands or feet
__Feeling too warm
__Desire for cold beverages
__Feeling too cold

Patient Name:_____

MALE REPRODUCTIVE

__Pain/itching of genitalia
__Genital discharge
__Low libido
__Excessive libido
__Impotence
__Weak urinary stream
__Enlarged prostate
__Other_____

OR

FEMALE REPRODUCTIVE

Age at 1st menses_____
Date of last menses_____
Length of cycle _____(days between periods)
Length of flow_____days
Color of flow: __pale red __red __dark red
__purple __brownish. Other:_____
Number of pregnancies_____
Number of births_____
Number of miscarriages _____
Number of abortions_____
__Irregular cycle length
__Heavy menstrual flow
__Little menstrual flow
__Clots
__Menstrual cramps

__Premenstrual beast tenderness
__Breast lumps
__Breast fibroids
__Premenstrual mood swings
__Spotting between periods
__Menopausal symptoms
__Low libido
__Chronic yeast infections
__Other vaginal infections
__Cervical cancer
__Abnormal PAP smear
__Pelvic inflammatory disease
__Polycystic ovaries
__Uterine fibroids
__Endometriosis
__Use oral contraceptives for_____ years
Type of contraceptive used_____
__Other concerns:

China Rose Acupuncture PLLC
Candace Quinn, Licensed Acupuncturist 10692 Flint Plaza, Flint TX

Patient Advisory and Consent Form

Acupuncture is an ancient Chinese medical system using very fine, single use, sterile needles and other techniques to stimulate nerves and improve circulation of blood and qi in order to alleviate pain or improve health.

Acupuncture and other traditional techniques used in this clinic are generally very safe. Serious side effects occur in less than 0.01% of treatments overall and have never occurred with this acupuncturist. More common side effects include:

- Minor bleeding or bruising occurs in about 3% of treatments
- Bruising is more common after gua sha (rubbing) or cupping techniques
- Moxibustion uses a smoldering herb to warm acupuncture points and burns or scaring are a potential risk of this technique
- Drowsiness, light headedness, or fainting may occur in certain patients after treatment. Always get up slowly from your treatment.

Chinese herbal formulas are traditionally considered safe, although some herbs may be toxic at large doses and some herbs are inappropriate during pregnancy or in combination with certain prescription drugs. It is therefore important that I know what medications you are taking. If you have any unpleasant reactions, including nausea, diarrhea, or rashes, discontinue taking the herbs and contact me.

You should let me know if you:

- have a pace maker – electrical stimulation of acupuncture points should not be done
- have a bleeding disorder or are taking anticoagulant medications
- are, or become, pregnant

An acupuncturist is not a primary care physician; therefore it is recommended that you consult a physician regarding the condition or conditions for which you seek acupuncture.

You signature below indicates you have read and understood the information above, that any questions you had where answered, and that you consent to having treatment.

_____
Print patient's full name

X _____ Date _____
Signature of patient (or guardian if a minor)

_____ Date _____
Signature of acupuncturist

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physicians assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, PO Box 2018, MC-263, Austin, TX 78768-201 1-800-201-9353 www.tmb.state.tx.us