

Brielle Acupuncture Center

Manasquan, NJ 08736

732-547-3395

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: _____
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 understand that in order to ensure continuation of care, the staff and/or practitioner at Brielle Acupuncture Center may need to leave messages on the answering machine at my home or with any individual who may answer my home phone. These messages may include: appointment confirmations, follow up calls, etc.

I DO wish to have messages left I DO NOT wish to have messages left

Please specify which phone #: _____

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 for _____ and understand that payment is required in full at the time of service. **Patient**

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)

	<input type="checkbox"/> Physical	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Blood	<input type="checkbox"/> Pap Smear	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Other : _____
Date:	_____	_____	_____	_____	_____	_____
Results:	_____	_____	_____	_____	_____	_____

Hospitalizations/Operations:

<u>Dates</u>	<u>Hospital</u>	<u>Diagnosis/Operation</u>	<u>Doctor</u>
_____	_____	_____	_____
_____	_____	_____	_____

Current/Recent Health Care Providers:

<u>Name</u>	<u>Dates</u>	<u>Care Provided</u>
_____	_____	_____
_____	_____	_____

Other medical conditions:

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Bone disease <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bursitis <input type="checkbox"/> Cancer or tumor <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Colon/bowel disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Diphtheria <input type="checkbox"/> Drug habit <input type="checkbox"/> Drug sensitivity or reaction <input type="checkbox"/> Emotional or mental problems <input type="checkbox"/> Emphysema <input type="checkbox"/> Gall stones | <ul style="list-style-type: none"> <input type="checkbox"/> Gall Bladder problems <input type="checkbox"/> Heart trouble <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis/jaundice <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood pressure <input type="checkbox"/> HIV <input type="checkbox"/> Hives <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney or bladder infection <input type="checkbox"/> Liver disease <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Lupus <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Migraines <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps | <ul style="list-style-type: none"> <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Spinal meningitis <input type="checkbox"/> Stomach or duodenal ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Tendonitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Thyroid or goiter trouble <input type="checkbox"/> Typhoid <input type="checkbox"/> Venereal disease <input type="checkbox"/> Varicose veins <input type="checkbox"/> Other: _____ _____ _____ _____ |
|---|--|---|

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: _____

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

Women's Health History:

Date last period began: _____

Date prior period began: _____

Age of first period: _____

Are you sexually active? _____ Do you practice safe sex? _____

Are you pregnant? _____ (if you are currently pregnant, please answer Pregnancy Questions below)

Are you trying to get pregnant? _____ How long? _____ (see Fertility Form)

Current birth control method: _____ How long? _____

Normally (not on pills), the number of days from the start of one period to the start of the next: _____ Average number of days in flow: _____

Color (normal, bright red, pale, brown, rust, dark, purple, other): _____

Amount of flow: Heavy Moderate Light Pain/cramps (location, dull, sharp, other): _____

Cramps during ovulation: _____ Clots (large, small, black, purple, red, other): _____

Do you experience any of the following pre-menstrual symptoms?

Nausea Vomiting Water Retention Breast Swelling Food Cravings Headaches Migraines

Breast Tenderness Depression Irritability Anxiety Other Emotions: _____

Do you have any sexual concerns to discuss?

How would you describe your sexual energy?

Do you douche regularly? With what? _____

Do you use vaginal lubricants? _____

Do you have any unusual vaginal discharge or vaginal dryness/itching? _____

Do you have excessive facial hair? _____

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Difficult

- Urgent
- Frequent
- Incontinence

Gynecological:

- <25 day cycle
- >35 day cycle
- Irregular Periods
- Spotting Between Periods
- Loose bowel movements at onset of menses
- Regular yeast infections
- UTI or Bladder Infections

- Abnormal Pap Smears
- Endometriosis
- Uterine Fibroids
- PCOS (Polycystic ovarian syndrome)
- POF (Premature ovarian failure)
- PID (Pelvic inflammatory disease)
- Any pelvic abnormalities
- Other: _____

Pregnancies (including miscarriages and abortions):

<u>Dates</u>	<u>Sex</u>	<u>Weight</u>	<u>Problems</u>	<u>Fertility Treatment</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

