Welcome!

Thank you for your interest in acupuncture and Chinese herbal medicine. Enclosed you will find several forms to fill out and bring with you to the first appointment. If you have any questions, you can reach me at 718.626.4263 and I will be happy to help you.

In preparing for your treatment,

- Wear comfortable, loose fitting pants and shirt.
- Make sure that you have eaten atleast 30 minutes before your treatment. Please do not come on an empty stomach or after having eaten a large meal or after consuming alcohol.
- Try to avoid strenuous exercise or activity after the treatment, as well as overeating or overdrinking.
- The initial treatment usually lasts about 1.5 hours and follow-up visits typically last one hour.
- Treatments are payable by credit card, cash or check.
- If you are unable to keep an appointment, contact me as soon as possible so that we can reschedule your appointment. Please note that there is a $25 fee for missed appointments.

Regards,

Katherine Scofield, L.Ac.

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Acupuncture and
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718.626.4263

# Patient Intake Form

Please complete as thoroughly as possible. All answers are considered confidential.

**GENERAL INFORMATION**

Name _____ Gender ❑ M ❑ F Date _____

Address_____ City _____State ____ Zip _____

Phone: ❑ Home _____ ❑ Work_____ ❑ Cell_____
*(Please indicate preferred contact number)*

Email_____

Date of Birth _____ Age _____ Height _____ Weight _____

❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated/Divorced

Occupation_____ Employer_____

Emergency Contact Name _____ Relation_____

Emergency Contact Number: Home_____ Cell _____

Primary physician_____ Phone number _____
*(No contact will be made without your permission)*

Refererd by: _____

**REASON FOR TODAY'S VISIT** _____

How long have you had this condition? _____

How did it happen? _____

What makes it better? _____ What makes it worse? _____

Medical diagnosis of condition _____

Current or previous treatment received _____

Is or was it helpful and why? _____

Have you received acupuncture before? Y ❑ N ❑

If so, for what condition? _____ Was it helpful? _____

**FAMILY HISTORY** — Please complete the below indicating any illnesses that apply to you or close family members. Place an "X" or the date in the appropriate box.

| | self (date) | mother | father | sibling | spouse/partner | children |
|---|---|---|---|---|---|---|
| Good health | | | | | | |
| Alcohol or other drug use | | | | | | |
| Depression or mental illness | | | | | | |
| Allergies | | | | | | |
| High blood pressure/heart disease/stroke | | | | | | |
| Cancer or tumors | | | | | | |
| Diabetes | | | | | | |
| Seizures | | | | | | |
| Hepatitis/other liver disorder | | | | | | |
| Muscular-skeletal disorder | | | | | | |
| HIV/AIDS | | | | | | |
| Blood or bleeding disorders/anemia | | | | | | |
| Thyroid disorders | | | | | | |
| Kidney disorders | | | | | | |
| Deceased (age) | N/A | | | | | |

**MEDICAL** — Please list emergency room visits or hospitalizations for any serious medical illness or operation, other than normal child delivery.

| Year | Operation/Illness | Hospital or Treatment Location |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**MEDICINES/SUPPLEMENTS** — Please list all medications, vitamins and/or food supplements you are currently taking.

| Medication/Supplement | Dosage | For what condition? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**CONDITIONS/SYMPTOMS** — Please mark any condition you have experienced in the past or currently.

**General**
*past current*

❑❑ Insomnia
❑❑ Frequent colds
❑❑ Fatigue
❑❑ Poor memory
❑❑ Tendency to be cold
❑❑ Tendency to be hot
❑❑ Recent weight loss/gain
❑❑ Cold hands & feet
❑❑ Chills
❑❑ Fever
❑❑ Other

_____

**Head & Neck**
*past current*

❑❑ Headaches
❑❑ Migraines
❑❑ Stiff neck
❑❑ Dizziness
❑❑ Fainting
❑❑ Enlarged Thyroid
❑❑ Other

_____

**Ears**
*past current*

❑❑ High-pitch ringing
❑❑ Low-pitch ringing
❑❑ Hearing loss
❑❑ Infections/pain
❑❑ Discharge
❑❑ Vertigo
❑❑ Other (describe)

_____

**Nose, Throat & Mouth**
*past current*

❑❑ Sinus problems
❑❑ Hay fever / allergies
❑❑ Frequent sore throat
❑❑ Difficulty swallowing
❑❑ Mouth or tongue ulcers
❑❑ Nose bleeds
❑❑ Dry Nose
❑❑ Swollen glands
❑❑ Loss of voice
❑❑ TMJ
❑❑ Facial pain
❑❑ Gum problems
❑❑ Dry mouth
❑❑ Teeth problems / pain
❑❑ Teeth grinding
❑❑ Other

_____

**Skin and Hair**
*past current*

❑❑ Hives
❑❑ Rashes
❑❑ Eczema / psoriasis
❑❑ Dry skin
❑❑ Easily bruised
❑❑ Changes in moles / lumps
❑❑ Change in skin color
❑❑ Itching
❑❑ Dandruff
❑❑ Hair Loss
❑❑ Premature gray hair
❑❑ Change in nails
❑❑ Other (describe)

_____

**Perspiration**
*past current*

❑❑ Sweat easily/often
❑❑ Night sweats
❑❑ Rarely sweat

**Cardiovascular**
*past current*

❑❑ High blood pressure
❑❑ Low blood pressure
❑❑ Chest pain or tightness
❑❑ Palpitations
❑❑ Rapid heart beat
❑❑ Irregular heart beat
❑❑ Poor circulation
❑❑ Swollen ankles
❑❑ Phlebitis
❑❑ Anemia
❑❑ History of heart disease
❑❑ Heart murmur
❑❑ Varicose veins
❑❑ Other (describe)

_____

**Gastrointestinal**
*past current*

❑❑ Indigestion
❑❑ Hiccups
❑❑ Acid regurgitation
❑❑ Stomach Ulcer
❑❑ Nausea / Vomit
❑❑ Bloating
❑❑ Gas
❑❑ Belching
❑❑ Intestinal pain
❑❑ Diarrhea
❑❑ Constipation
❑❑ Laxative use
❑❑ Bloody stool
❑❑ Mucus in stool
❑❑ Undigested food in stool
❑❑ Unformed stool
❑❑ Hemorrhoids
❑❑ Other (describe)

_____

**How often do you move your bowels?** _____

**Eyes**
*past current*

❑❑ Glasses/contact lenses
❑❑ Blurred vision
❑❑ Poor night vision
❑❑ Spots or floaters
❑❑ Eye pain
❑❑ Glaucoma
❑❑ Double vision
❑❑ Cataracts
❑❑ "Lazy" eye
❑❑ Red eyes
❑❑ Itchy eyes
❑❑ Teary/watery
❑❑ Other (describe)
_____

**Respiratory**
*past current*

❑❑ Difficulty breathing when lying down
❑❑ Shortness of breath with rest
❑❑ Shortness of breath upon exertion
❑❑ Asthma / wheezing
❑❑ Chronic cough
Type: Wet or Dry
❑❑ Excessive phlegm: Thick or Thin
Color _____
❑❑ Coughing up blood
❑❑ COPD
❑❑ Tight chest
❑❑ Pneumonia
❑❑ Other (describe)
_____

**Musculoskeletal**
*past current*

❑❑ Joint pain/swelling
❑❑ Sore muscles
❑❑ Weak muscles
❑❑ Difficulty walking
❑❑ Limited range of motion
❑❑ Pain (describe)
Nature: _____
Frequency: _____
Duration: _____
❑❑ Other (describe)
_____

**Neurological**
*past current*

❑❑ Seizures
❑❑ Tremors
❑❑ Numbness or tingling
❑❑ Paralysis
❑❑ Poor coordination
❑❑ Poor concentration
❑❑ Gait disturbance
❑❑ Speech difficulty
❑❑ Other (describe)
_____

**Mental/Emotional**
*past current*

❑❑ Depression
❑❑ Mood swings
❑❑ Irritability
❑❑ Difficulty relaxing
❑❑ Loneliness
❑❑ Sensitive
❑❑ Shyness
❑❑ Frequent crying
❑❑ Frequent worry

**Urinary**
*past current*

❑❑ Pain on urination
❑❑ Frequent urination: ___ x per day
❑❑ Urgent urination
❑❑ Blood in urine
❑❑ Incontinence
❑❑ Incomplete urination
❑❑ Burning with urination
❑❑ Wake to urinate: ___ x per night
❑❑ History of UTI
❑❑ Kidney stone
❑❑ Urine color: red, yellow, dark
❑❑ Other (describe)
_____

**Male — Genital**
*past current*

❑❑ Impotence
❑❑ Premature ejaculation
❑❑ Nocturnal emission
❑❑ Pain/itching of genitalia
❑❑ Lumps in testicles
❑❑ Increased libido
❑❑ Decreased libido
❑❑ Sexually transmitted disease
(specify) _____
❑❑ Other (describe)
_____

**Women — Gynecology**
*past current*

❑❑ Menopause
❑❑ Irregular periods: Early or Late
❑❑ Menstrual pain: Before During After
❑❑ Excessive blood flow
❑❑ Menstrual blood clots
❑❑ Abnormal pap smear
❑❑ Vaginal infections
❑❑ Vaginal pain/itching
❑❑ Uterine fibroids
❑❑ Endometriosis
❑❑ Breast tenderness
❑❑ Breast lumps, cysts
❑❑ Increased libido
❑❑ Decreased libido
❑❑ Sexually transmitted disease
(specify) _____
❑❑ Other (describe)
_____

**Menstruation:**
Age of first menses: _____ years old
Length of menstrual flow: _____ days
Length of cycle:_____ days
Menstrual flow: Heavy Med Light
Color of menses: Dark Bright Pale
Date of last period: ___/____/_____
Current use of birth control: Y ❑ N ❑
If yes, type: _____

**Mental/Emotional, cont**

*past current*

❑❑ Compulsive behaviors
❑❑ Difficulty focusing
❑❑ Hopeless outlook
❑❑ Suicidal thoughts
❑❑ Loss of temper
❑❑ Frustration
❑❑ Other (describe)

_____

**Sleep**

*past current*

❑❑ Difficulty falling asleep
❑❑ Difficulty staying asleep
❑❑ Vivid dreams
❑❑ Restless sleep
❑❑ Dream-disturbed sleep
❑❑ Tired upon waking

Time to bed: _____ pm / am
Time to wake: _____ am / pm

**Women – Gynecology, cont**

Currently pregnant? Y ❑ N ❑
If yes, trimester: _____
Trying to get pregnant? Y ❑ N ❑

Number of births: _____
Number of abortions: _____
Number of miscarriages: _____

**ALLERGIES** – Please list any allergies to food, medicines, chemicals, or environment below.

| Allergen | Reaction | For how long? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**LIFESTYLE HABITS –** Please complete all questions below

How is your appetite? ❑ None ❑ Low ❑ Good ❑ Excessive Do you eat 3 meals a day? Y ❑ N ❑

Taste preferences? ❑ Salty ❑ Sour ❑ Bitter ❑ Sweet ❑ Spicy

Describe your diet _____

Are you often thirsty? Y ❑ N ❑ Drink preference: ❑ Hot ❑ Cold ❑ Room Temperature

Fluid intake (oz. per day) _____ Alcohol (drinks per week) _____ Coffee/Tea (cups per day) _____

Soda (drinks per week) _____ Cigarettes (packs per day) _____ Drug use (recreational) _____

Exercise ❑ Yes ❑ No If yes, how often and what type? _____

Energy level on a 1-10 scale (10 being the highest) _____ When is it the highest? _____ Lowest? _____

Patient Signature_____ Date _____

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# Consent to Services

**Services to be Provided**
Treatment may include acupuncture, moxibustion, cupping, electrical stimulation, gua sha, heat applied to the skin, and/or Chinese herbs. I understand that I may refuse any of these techniques at any time. I understand that I am not required to take Chinese herbs but must follow the directions for administration and dosage if I do take them.

**Risks/Possible Side Effects**
Treatment may result in certain side effects, including local bruising, minor bleeding, fainting, pain or discomfort, electric shock (from electrical stimulation), changes in bowl movement, and the possible aggravation of symptoms existing prior to treatment. *Should I experience any problems which I associate with the intake of herbal substances, I should suspend taking them and call my practioner as soon as possible.*

**No Guarantees**
Acupuncture and Chinese Medicine serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I acknowledge that I have not received any guarantees or promises as to the results from the services provided.

**Client Responsibilities**
It is my responsibility as a client to inform my acupuncturist of all aspects of my health and that, as service progresses, to inform my acupuncturist of changes that occur. I will inform my acupuncturist if I am pregnant and/or suspect pregnancy at any time. If I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my acupuncturist.

**Medical Treatment**
An acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

**Fees and Charges**
I have been informed of the fees for service, and I understand that payment is due when the services are provided. If I do not cancel an appointment by phone at least 24 hours in advance, then I am liable for the full amount of the missed appointment.

I have read and understand the information in this form and I understand the possible risks and complications involved. I have had the opportunity to ask questions regarding the proposed services, this form, and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results. I hereby voluntarily consent to acupuncture treatment.

Patient Name**:** _____

_____ _____
Patient Signature (or parent/guardian if patient is a minor) Date

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**Notice of Privacy Practices**
*Health Insurance Portability and Accountability Act (HIPPA) requires that healthcare professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice.*

During your course of treatment, I will use and disclose your Protected Health Information only for treatment, payment and when required by law. Furthermore, you will be contacted when necessary using the phone number and address you have provided unless you specifically request otherwise.
Upon written request:
• You have the right to review or obtain copy of your health record from me. You have the right to request that we amend your Protected Health Information.
• Your Protected Health Information is kept confidential and not shared with anyone else unless you sign a separate consent form for the release of information.
• You have the right to request additional restrictions on the use and disclosure of your Protected Health Information.

If you have any questions about your rights or believe your privacy rights have been violated, please let me know. You also have the right to file a complaint with the U.S. Secretary of Health and Human Services (Office of Civil Rights: 1-800-368-1019) with no fear of retaliation.

I acknowledge I have received and understand this Notice of Privacy Practices.

_____
Signature