



Patient Name:	Date:
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PATIENT INTAKE FORM

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	DOB: / /
Address:			City:
State:	Zip:	E-mail:	
Best Phone # to reach you = Home / Work / Cell : ()			
Marital Status: M S W D	Occupation:	How many hours per week do you work?	
Emergency Contact Name:		Contact Phone #: ()	
If we are unable to reach you, is it okay for us to leave a message on your Voicemail /person who answers the phone? <input type="checkbox"/> yes <input type="checkbox"/> no			
How did you hear about us? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Community Impact <input type="checkbox"/> Drive-by <input type="checkbox"/> Community Newsletter <input type="checkbox"/> internet search <input type="checkbox"/> Referral/Other: _____			
Have you had Acupuncture treatments before? <input type="checkbox"/> YES <input type="checkbox"/> NO		Do you Bruise easily? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you have any of the following? <input type="checkbox"/> Pacemaker <input type="checkbox"/> Insulin Pump		<input type="checkbox"/> Seizure Disorders <input type="checkbox"/> Bleeding disorder	
<input type="checkbox"/> pain analgesic pump <input type="checkbox"/> No electronic devices implanted in my body		<input type="checkbox"/> Nerve Stimulator <input type="checkbox"/> Pregnant	

Conditions	Severity	Frequency
Please list your reasons for coming (health conditions) in the order of importance	Rate pain or symptoms from "0" none to "10" severe None.....Severe	Please check the box that best represents the amount of time you feel your pain or symptoms
1.	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
2.	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
3.	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
4.	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
5.	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%

For each condition listed above, please mark how it happened:		
1	Date began?:	How did it begin?:
2	Date began?:	How did it begin?:
3	Date began?:	How did it begin?:
4	Date began?:	How did it begin?:
5	Date began?:	How did it begin?:

For each condition listed above, please check if it is better or worse with any of the following:													
	Heat		Cold		Rest		Activity		Massage		Other		Please Describe
	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

How do the conditions above impair or limit your daily activities?

Please list the medical doctors or health care providers (chiropractors, naturopaths) currently treating you:
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Patient Name: _____	Date: _____
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Diet & Exercise	
Do you have a regular exercise program? <input type="checkbox"/> yes <input type="checkbox"/> no	Describe: _____
Have you ever been on a restricted diet? <input type="checkbox"/> yes <input type="checkbox"/> no	Describe: _____
Do you consume: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee (caffeine) <input type="checkbox"/> Soda	
If so, how much: _____	

Patient Medical History
1. List ALL disorders your are <u>CURRENTLY</u> being treated for (include the dates of when you were diagnosed): _____
2. List ALL Chronic Illnesses you have had in the past (Examples: STDs, Heart Attack, Stroke, Infections, Diabetes, high blood pressure, etc.) (Include Dates): _____
3. List ALL Hospitalizations, Accidents or Surgeries you have had in the past (Includes Dates): _____
4. List ALL Medications (prescription & over-the-counter) you are <u>CURRENTLY</u> taking (include duration of use & Dosage): _____
5. List ALL Allergies (Food, Medications, Pollen, etc): _____
6. List ALL Nutritional Supplements, Herbs, or vitamins you are currently taking: _____
7. List ALL Medical Conditions of your immediate family (mother, father, siblings): _____

Quadruple Visual Analogue Scale (VAS)

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example: **No Pain** _____ *Headache* _____ *Neck* _____ *Low Back* _____ **worst possible pain**
 0 1 ② 3 4 ⑤ 6 7 8 ⑨ 10

1. What is your TYPICAL or AVERAGE pain?

 (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

2. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

 (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

3. What is your pain level AT ITS WORST (how close to "10" does your pain get at its worst)?

 (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)



Patient Name: _____	Date: _____
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<u>Test</u>	<u>Date</u>	<u>Results</u>	
X-ray (s)			<p>Indicate where you have pain or other symptoms:</p> <p>++ = Sharp aa = Dull Ache tt = tingling // = numb bb = burning ss = stiffness</p>
MRI (s)			
CT (CAT) Scan (s)			
Ultrasound (s)			
Cholesterol			
Blood Sugar			
Mammogram			
PAP Smear			
Breast Exam			

<p>Your Treatment Goals</p> <p>What goals do you want to achieve with Acupuncture treatments?</p> <p>_____</p>

<p style="text-align: center;"><u>YOUR Commitment to Treatments</u></p> <p>On a scale of (0-10), 10 being 100% commitment, how would you rate your commitment to getting rid of your problem /disorder/symptoms? _____</p>	<p style="text-align: center;"><u>Rate YOUR Health</u></p> <p>On a scale of (0-10), 10 being your body's Optimal Health how would you rate your present health condition? _____</p>
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Have you been to a Physician within the past year for your health condition?

I (**patient's name**) _____, am notifying the acupuncturist (**Jimmy Yen**), of the following:

Yes No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (**initials of patient/guardian**) **Date:** _____

Yes No I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. **It is my responsibility and choice whether to follow this advice.**

If you have checked NO for both boxes above, I, Jimmy Yen, L. Ac., am requesting that you be evaluated by a physician. It is YOUR responsibility and YOUR choice whether to follow this advice.

Patient/Guardian signature _____ **Date** _____

Acupuncturist's signature _____ **Date** _____



Patient Name:

Date:

Request & Consent of Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Jimmy I. Yen, L. Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Jimmy I. Yen, L. Ac., including those working at Yen acupuncture & herbal clinic, Inc. or any other office or clinic, whether signatories to this form or not.

I understand methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Acupressure (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a 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 then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services in this office.

I understand that I am financially responsible for all charges and for all services rendered on my behalf or my dependents. I agree to pay in full for all charges when services are rendered.

I agree to give 24 hours notice if I am going to be unable to make my scheduled appointment. I fully understand I will be charged the regular fee if I miss an appointment without giving 24 hours notice.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an 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 at Yen Acupuncture & Herbal Clinic.

Insurance Filing Process (please read)

I understand and agree that health/accident insurance policies are an agreement between an insurance carrier and myself. I understand that my insurance will be billed for services rendered in this office and that I am responsible for any services not paid and/or not covered by my insurance. Furthermore, **I understand that verification of insurance benefits is NOT a guarantee of payment. In the event your insurance company refuses to pay this office for treatment, you are responsible for all fees and further insurance appeal becomes your responsibility.** I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and any fees for collection of past due accounts. I also understand that if I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable.

Patient/Guardian Signature:

Date:



Patient Name:

Date:

Health History Questionnaire
(Please check all that apply to you currently)

Habits:

- Cigarettes / Dip
How often?
Coffee
How often?
Recreational Drugs
How often?
alcohol
How often?

Emotional / Mental / Stress:

- Irritable Anxiety
Depression Mood Swings
Post Traumatic Stress
Low stress, unaffected
Mild stress, manageable
Moderate stress, life affected
High stress, not manageable

Eyes:

- red / irritated / burning dry
light-sensitive Itchy
decreased vision / floaters / blurred
Excessive tearing Twitching
Poor Night Vision Swelling

Ears:

- Ringing (high pitch)
Ringing (low pitch)
Ear aches / pressure
Frequent Ear Infections
Diminished hearing

Nose:

- Congested
Sneezing / Itchy
Runny w/ clear discharge
Red / Irritated
Decrease in Smell
Nosebleeds
Sinus Infections

Mouth & Throat:

- Dry Mouth or Throat
Grind Teeth / TMJ
Canker Sores / Tongue Ulcers
Gum Disease
Sore Throat
Scratchy Throat
feel lump in throat
increase in thirst
decrease in thirst or not thirsty

Sleep:

- Difficulty Falling Asleep
Difficulty Staying Asleep
Poor Sleep Quality / Restless
Nightmares

Immune System:

- Allergies to Pollen/food/Medications
Auto-immune disorder (s)
Frequent colds

Respiration:

- Shortness of Breath
Cough w/ blood
Cough w/ thick yellow sputum
Cough w/ thick white sputum
Dry Hacking Cough
Asthma / Wheezing
Frequent Bronchitis
Pneumonia
Tightness in Chest

Cardiovascular & Blood:

- Heart Disease
Palpitations / Fluttering
Chest Pain
High Blood Pressure
Low Blood Pressure
Irregular Heart Beat
Varicose Veins
Swelling in arms and legs (edema)
High Cholesterol
Bleed Easily
Anemia
Stroke

Digestion & Metabolism:

- Indigestion
Ab Bloating / Gas
Ab Pain / Cramps
Heartburn
Nausea
Vomiting
Frequent Belching / Burping
Recent excessive Weight Gain
Recent excessive Weight Loss
Poor Appetite
Excessive Hunger
chronic fatigue
low energy
Diabetes

Bowel Movement:

- Hemorrhoids
Diarrhea
Loose Stools
Constipation
Difficult Defecation
Blood in Stool
Mucous in Stool

Liver & Gall Bladder Function:

- Jaundice
Brittle Nails
Liver Inflammation
Fatty Liver
Gall Bladder Inflammation
Gall Bladder Stones / Sludge

Urination, Kidney & Bladder:

- Urination w/ Burning / Pain / Pressure
Urinary Incontinence
Increase in urine Frequency (day / night)
Decrease in Urine Frequency
Retention of urine
Urgency
Excessive
Scanty / Retention of Urine
Blood in urine
Frequent Bladder Infections
Frequent Kidney Infections
Kidney Stones
Enlarged Prostate

Skin:

- Dry, Scaly
Itchy
Red
Oily
white heads
Painful / burning
Excessive Facial/Body hair
Jaundice

Neurological:

- Vertigo
Dizziness, light headed
Paralysis / Partial Paralysis
Seizures / Convulsions
Tremors / Twitching
Numbness / Tingling

Reproductive Organs:

- Female / Male genitals
Enlarged / Shriveled
Itchy / Tender / Dry / Inflamed
Erectile Dysfunction

Vaginal Discharge:

- no vaginal discharge
egg white discharge during ovulation
sporadic vaginal discharge

Hormones:

- decrease in sex drive (libido)
Hot flashes / hot flushes
Cold Hands & feet
Night Sweats
Spontaneous Sweating
Vaginal Dryness
Irregular Menstruation

Females Only:

- Irregular menstrual cycles
PMS Symptoms:
Age of Menopause:
Age of Hysterectomy: