PATIENT INTAKE FORM

CHRISTA P. SALTZMAN, REGISTERED ACUPUNCTURIST

PATIENT DEMOGRAPHICS

PATIENT NAME: _____ **DATE OF BIRTH:** _____
LAST NAME, FIRST NAME, MI

ADDRESS: _____

CITY, STATE, ZIP _____

HOME PHONE: _____ **WORK PHONE:** _____ **EMAIL:** _____

YOUR OCCUPATION: _____ **EMERGENCY CONTACT:** _____
NAME & PHONE NUMBER

GENDER: ❒ FEMALE ❒ MALE **HEIGHT:** _____ **WEIGHT:** _____

REFERRED BY: _____

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ SEPARATED ❒ WIDOWED ❒ CHILD ❒ OTHER

TREATMENT INFORMATION

HAVE YOU EVER HAD AN ACUPUNCTURE TREATMENT? ❒ YES ❒ NO IF YES, WHEN? _____

IF YES, FOR WHAT CONDITION? _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ____ IF YES, NAME OF PHYSICIAN _____

IF YES, FOR WHAT CONDITIONS? _____

_____

PRIMARY REASON(S) FOR SEEKING ACUPUNCTURE? _____

_____

HOW LONG HAVE YOU EXPERIENCED SYMPTOMS? _____ WHEN DID THE PROBLEM BEGIN (BE SPECIFIC): _____

_____

TO WHAT EXTENT DOES THE PROBLEM INTERFERE WITH YOUR DAILY ACTIVITY (SLEEP, WORK EXERCISE, SEX, ETC.)? ____

_____

HAVE YOU BEEN GIVEN A DIAGNOSIS FOR THE PROBLEM? IF SO, WHAT? _____

WHAT KIND OF TREATMENTS HAVE YOU TRIED? _____

OTHER CONCURRENT THERAPIES? _____

YOUR CONDITION IS AGGRAVATED BY: _____

YOUR CONDITION IS IMPROVED BY: _____

SYMPTOMS (CHECK ☑ ALL THAT APPLY)

GENERAL

- ❒ CHILLS
- ❒ DEPRESSION
- ❒ DIZZINESS
- ❒ FAINTING
- ❒ FEVER
- ❒ FORGETFULNESS
- ❒ HEADACHE
- ❒ LOSS OF SLEEP
- ❒ LOSS OF WEIGHT
- ❒ NERVOUSNESS
- ❒ NUMBNESS
- ❒ SWEATS

MUSCLE / JOINT / BONE

PAIN, WEAKNESS, NUMBNESS IN:

- ❒ ARMS
- ❒ BACK
- ❒ FEET
- ❒ HANDS
- ❒ HIPS
- ❒ LEGS
- ❒ NECK
- ❒ SHOULDERS
- ❒ OTHER _____

GENITO-URINARY

- ❒ BLOOD IN URINE
- ❒ FREQUENT URINATION
- ❒ LACK OF BLADDER CONTROL
- ❒ PAINFUL URINATION

GASTROINTESTINAL

- ❒ APPETITE POOR
- ❒ BLOATING
- ❒ BOWEL CHANGES
- ❒ CONSTIPATION
- ❒ DIARRHEA
- ❒ EXCESSIVE HUNGER
- ❒ EXCESSIVE THIRST
- ❒ GAS
- ❒ HEMORRHOIDS
- ❒ INDIGESTION
- ❒ NAUSEA
- ❒ RECTAL BLEEDING
- ❒ STOMACH PAIN
- ❒ VOMITING
- ❒ VOMITING BLOOD

SKIN

- ❒ BRUISE EASILY
- ❒ HIVES
- ❒ ITCHING
- ❒ CHANGE IN MOLES
- ❒ RASH
- ❒ SCARS
- ❒ SORE THAT WON'T HEAL

EYE, EAR, NOSE, THROAT

- ❒ HIGH CHOLESTEROL
- ❒ HIV POSITIVE
- ❒ KIDNEY DISEASE
- ❒ LIVER DISEASE
- ❒ MEASLES
- ❒ MIGRAINE HEADACHES
- ❒ MISCARRIAGE
- ❒ MONONUCLEOSIS
- ❒ MULTIPLE SCLEROSIS
- ❒ MUMPS
- ❒ PACEMAKER
- ❒ PNEUMONIA
- ❒ POLIO

CARDIOVASCULAR

- ❒ CHEST PAIN
- ❒ HIGH BLOOD PRESSURE
- ❒ IRREGULAR HEART BEAT
- ❒ LOW BLOOD PRESSURE
- ❒ POOR CIRCULATION
- ❒ RAPID HEART BEAT
- ❒ SWELLING OF ANKLES
- ❒ VERICOSE VEINS

MEN ONLY

- ❒ BREAST LUMP
- ❒ ERECTION DIFFICULTIES
- ❒ LUMP IN TESTICLES
- ❒ PENIS DISCHARGE
- ❒ SORE ON PENIS
- ❒ OTHER _____

WOMEN ONLY

- ❒ ABORTION
- ❒ ABNORMAL PAP SMEAR
- ❒ BLEEDING BETWEEN PERIODS
- ❒ BREAST LUMP
- ❒ CANDIDA / YEAST
- ❒ EXTREME MENSTRUAL PAIN
- ❒ FIBROIDS
- ❒ HER
- ❒ HOT FLASHES
- ❒ IRREGULAR CYCLE
- ❒ MISCARRIAGE
- ❒ NIPPLE DISCHARGE
- ❒ PAINFUL INTERCOURSE
- ❒ STD HISTORY (CHLAMYDIA, PID, ETC)
- ❒ VAGINAL DISCHARGE
- ❒ VAGINAL ODOR
- ❒ OTHER _____

DATE OF LAST MENSTRUAL PERIOD: _____

DATE OF LAST PAP SMEAR: _____

HAVE YOU HAD A MAMMOGRAM? _____

ARE YOU PREGNANT? ___

NUMBER OF CHILDREN ___

MEDICATIONS

(PRESCRIPTION AND OVER THE COUNTER)

_____

_____

_____

PHARMACY: _____ **PHONE:** _____

ALLERGIES

_____

_____

_____

_____

CONDITIONS (CHECK ☑ ALL THAT APPLY)

- ❒ AIDS
- ❒ ALCOHOLISM
- ❒ ANEMIA
- ❒ ANOREXIA
- ❒ APPENDICITIS
- ❒ ARTHRITIS
- ❒ ASTHMA
- ❒ BLEEDING DISORDERS
- ❒ BREAST LUMP
- ❒ BRONCHITIS
- ❒ BULIMIA
- ❒ CANCER
- ❒ CATARACTS
- ❒ CHEMICAL DEPENDENCY
- ❒ CHICKEN POX
- ❒ DIABETES
- ❒ EMPHYSEMA
- ❒ EPILEPSY
- ❒ GLAUCOMA
- ❒ GOITER
- ❒ GONORRHEA
- ❒ GOUT
- ❒ HEART DISEASE
- ❒ HEPATITIS
- ❒ HERNIA
- ❒ HERPES
- ❒ HIGH CHOLESTEROL
- ❒ HIV POSITIVE
- ❒ KIDNEY DISEASE
- ❒ LIVER DISEASE
- ❒ MEASLES
- ❒ MIGRAINE HEADACHES
- ❒ MISCARRIAGE
- ❒ MONONUCLEOSIS
- ❒ MULTIPLE SCLEROSIS
- ❒ MUMPS
- ❒ PACEMAKER
- ❒ PNEUMONIA
- ❒ POLIO
- ❒ PROSTATE PROBLEM
- ❒ PSYCHIATRIC CARE
- ❒ RHEUMATIC FEVER
- ❒ SCARLET FEVER
- ❒ STROKE
- ❒ SUICIDE ATTEMPT
- ❒ THYROID PROBLEMS
- ❒ TONSILLITIS
- ❒ TUBERCULOSIS
- ❒ TYPHOID FEVER
- ❒ ULCERS
- ❒ VAGINAL INFECTIONS
- ❒ VENEREAL DISEASE

❒ OTHER (DESCRIBE): _____

PLEASE LIST ANY MAJOR EMOTIONAL OR PHYSICAL TRAUMAS YOU'VE EXPERIENCED: _____

_____

_____

LIFESTYLE (CHECK ☑ ALL THAT APPLY AND DESCRIBE FREQUENCY OF USE)**:**

❒ TOBACCO _____ ❒ ALCOHOL _____

❒ RECREATIONAL DRUGS _____ ❒ CAFFEINATED BEVERAGES _____

DO YOU EXERCISE? _____ **TYPE AND FREQUENCY OF EXERCISE** _____

FAMILY HISTORY

DIAGNOSIS	MOTHER	FATHER	SIBLINGS

ALLERGIES			
ARTHRITIS			
ASTHMA			
CANCER			
DIABETES			
HEART DISEASE			
KIDNEY DISEASE			
LIVER DISEASE			
LUNG DISORDERS			
MENTAL ILLNESS / DEPRESSION			
SUBSTANCE ABUSE			
ALCOHOL ADDICTION			
STOMACH DISORDERS			
GENETIC DISORDERS			
OTHER			

FOR FAMILY NO LONGER LIVING:

AGE OF MOTHER UPON DEATH: _____ CAUSE OF DEATH: _____

AGE OF FATHER UPON DEATH: _____ CAUSE OF DEATH: _____

AGE OF SIBLING(S) UPON DEATH: _____ CAUSE OF DEATH: _____

DIETARY PREFERENCES (CHECK ☑ ALL THAT APPLY)

- ❒ VEGETARIAN
- ❒ RAW FOODS DIET
- ❒ LOW FAT DIET
- ❒ HIGH PROTEIN, LOW CARB. DIET
- ❒ DIARY / MILK / CHEESE
- ❒ EGGS
- ❒ CHICKEN
- ❒ FISH / SEAFOOD
- ❒ RED MEAT
- ❒ ARTIFICIAL SWEETENERS
- ❒ FAST FOOD / BURGERS / FRIES
- ❒ SPICY / HOT
- ❒ SWEET
- ❒ SOUR
- ❒ SALTY
- ❒ CARBONATED DRINKS
- ❒ COFFEE
- ❒ TEA
- ❒ ICE CHEWING
- ❒ EXTREME THIRST
- ❒ THIRST WITH NO DESIRE TO DRINK

PATIENT RELEASE FORM

CHRISTA P. SALTZMAN, REGISTERED ACUPUNCTURIST

I understand that acupuncture is NOT a substitute for conventional medical diagnosis and treatment.

Techniques commonly employed in the application of acupuncture are:

- ❒ Acupuncture needling – treatment will consist of the insertion of sterile, disposable needles at specific sites on the body. Stimulation of said needles may be by manipulation, electrical stimulation, or the application of warming substances (moxa) on the needle itself.

- ❒ Auxiliary / Associated therapies – massage, assisted stretching, topical application of liniments.

There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include, but are not limited to, the use and abuse of alcohol, tobacco, steroids, painkillers, stimulants, antidepressants, psycho-pharmaceutical and illegal drugs.

I, _____, certify that I have read and understand the
(print name)
statements above. I also certify that I have informed my acupuncturist of all my known physical, mental, and medical conditions along with any medications I am taking. I will keep him/her informed of any changes.

Signature: _____ Date: _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____