Robin Harris Acupuncture

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Patient Intake Form

Please complete this forma s thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name ______________________________ Gender ❑ M ❑ F Date ____________

Address ____________________ City ______________ State ________ Zip ____________

Email ______________________________

Phone: ❑ Home ______________ ❑ Work ______________ ❑ Cell ______________
(please indicate preferred contact number)

Occupation ______________ Employer ______________________

Date of Birth ______________ Age __________ Height __________ Weight __________

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

Emergency contact ______________________ Relation ______________

Emergency contact number: Home ______________________ Cell ______________

Name of physician ______________________ Phone number ______________
(No contact will be made without your permission)

Your signature ______________________________

GOALS — What health concerns would you like to address through treatment

____

____

____

____

LIFESTYLE HABITS

Alcohol (drinks per week) __________ Coffee/Tea (cups per day) __________ Soda (regular or diet) __________

Cigarettes (packs per day) __________ Drug use (recreational) ______________________

Exercise ❑ Yes ❑ No How often? ______________________

What kind of exercise? ______________________________

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
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						
Musculo-skeletal disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage	For what condition?

Vitamins & Supplements	Dosage	For what condition?

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

Temperature (Kidney)

past	current	
❏	❏	Cold hands
❏	❏	Cold fingers
❏	❏	Cold feet
❏	❏	Cold toes
❏	❏	Sweaty hands
❏	❏	Sweaty feet
❏	❏	Hot overall
❏	❏	Cold overall
❏	❏	Afternoon flushes
❏	❏	Night sweats
❏	❏	Heat in the hands, feet, and chest
❏	❏	Hot flashes
❏	❏	Thirsty
❏	❏	Perspire easily
❏	❏	Lack of perspiration
❏	❏	Take water to bed

Energy (Lung/Kidney)

past	current	
❏	❏	Shortness of breath
❏	❏	Difficulty keeping eyes open during day
❏	❏	General weakness
❏	❏	Easily catch colds
❏	❏	Low energy
❏	❏	Feel worse after exercise

Blood (Liver/Spleen/Heart)

past	current	
❏	❏	Dizziness
❏	❏	See floating black spots

Heart Function

past	current	
❏	❏	Palpitations
❏	❏	Anxiety
❏	❏	Sores on the tip of the tongue
❏	❏	Restlessness
❏	❏	Mental confusion
❏	❏	Chest pain traveling to shoulder
❏	❏	Pacemaker
❏	❏	Frequent dreams
❏	❏	Wake unrefreshed

Lung Function

past	current	
❏	❏	Nasal discharge, color: ________________
❏	❏	Cough
❏	❏	Nose bleeds
❏	❏	Sinus Congestion
❏	❏	Dry mouth
❏	❏	Dry throat
❏	❏	Dry nose
❏	❏	Dry skin
❏	❏	Respiratory allergies, to what? ________________
❏	❏	Alternating chills & fever
❏	❏	Sneezing
❏	❏	Headache, location: ________________
❏	❏	Overall achy feeling
❏	❏	Stiff neck
❏	❏	Stiff shoulders
❏	❏	Sore throat
❏	❏	Difficulty breathing
❏	❏	Sadness
❏	❏	Melancholy

Spleen Function

past	current	
❏	❏	Low appetite
❏	❏	Abrupt weight gain
❏	❏	Abrupt weight loss
❏	❏	Abdominal bloating
❏	❏	Abdominal gas
❏	❏	Gurgling In stomach
❏	❏	Fatigue after eating
❏	❏	Prolapsed organs (diagnosed): ________________
❏	❏	Easily bruised
❏	❏	Hemorrhoids
❏	❏	Pensive
❏	❏	Over-thinking
❏	❏	Worry

Spleen, Stomach, Large Intestine Function

past	current	
❏	❏	Loose stool
❏	❏	Constipated
❏	❏	Incomplete evacuation
❏	❏	Diarrhea
❏	❏	Blood In stools
❏	❏	Mucous In stools
❏	❏	Undigested food in stools

Dampness

past	current	
❏	❏	General sensation of heaviness
❏	❏	Mental heaviness
❏	❏	Mental sluggishness
❏	❏	Mental fogginess
❏	❏	Swollen hands
❏	❏	Swollen feet
❏	❏	Swollen joints
❏	❏	Chest congestion
❏	❏	Nausea
❏	❏	Snoring

Stomach Function

past	current	
❏	❏	Burning sensation after eating
❏	❏	Large appetite
❏	❏	Bad breath
❏	❏	Mouth (canker) sores
❏	❏	Bleeding, swollen or painful gums
❏	❏	Heartburn
❏	❏	Acid regurgitation
❏	❏	Ulcer (diagnosed)
❏	❏	Belching
❏	❏	Hiccups
❏	❏	Stomach pain
❏	❏	Vomiting

Eyes (Liver Function)

past	current	
❏	❏	Itchy
❏	❏	Bloodshot
❏	❏	Hot
❏	❏	Dry
❏	❏	Watery
❏	❏	Gritty
❏	❏	Blurry vision
❏	❏	Decreased night vision
❏	❏	Near-sighted
❏	❏	Far-sighted

Liver/Gall Bladder Function

past	current	
❏	❏	Alternation diarrhea & constipation
❏	❏	Chest pain
❏	❏	Tight sensation in chest
❏	❏	Bitter taste In mouth
❏	❏	Anger easily
❏	❏	Frustration
❏	❏	Depression
❏	❏	Irritability
❏	❏	Frequently unable to adapt to stress; cause of stress: ______________
❏	❏	Skin rashes
❏	❏	Headache: at top of head
❏	❏	Tingling sensation
❏	❏	Numbness
❏	❏	Muscle spasms
❏	❏	Muscle twitching
❏	❏	Muscle cramping
❏	❏	Seizures
❏	❏	Convulsions
❏	❏	Lump in throat
❏	❏	Neck tension
❏	❏	Neck: limited range-of-motion
❏	❏	Depression
❏	❏	Shoulder tension
❏	❏	Shoulder: limited range-of-motion
❏	❏	High-pitched ringing in ears
❏	❏	Gall stones
❏	❏	Sexually transmitted disease(s); spcify: ______________

Kidney/Urinary Bladder Function

past	current	
❏	❏	Frequent cavities
❏	❏	Easily broken bones
❏	❏	Sore knees
❏	❏	Weak knees
❏	❏	Cold sensation in knees
❏	❏	Low back pain
❏	❏	Memory problems
❏	❏	Wake frequently to urinate
❏	❏	Low-pitched ringing in ears
❏	❏	Kidney stones
❏	❏	Bladder infections
❏	❏	Lack of bladder control
❏	❏	Fear
❏	❏	Easily startled
❏	❏	Excessive hair loss

Urination

past	current	
❏	❏	Normal color
❏	❏	Dark yellow
❏	❏	Clear
❏	❏	Reddish
❏	❏	Cloudy
❏	❏	Scanty
❏	❏	Profuse
❏	❏	Strong odor
❏	❏	Blood
❏	❏	Painful
❏	❏	Discharge
❏	❏	Difficult
❏	❏	Urgent
❏	❏	Frequent

Male — Genital

past	current	
❏	❏	Impotence
❏	❏	Premature ejaculation
❏	❏	Nocturnal emission
❏	❏	Pain/itching of genitalia
❏	❏	Lumps in testicles
❏	❏	Increased libido
❏	❏	Decreased libido
❏	❏	Other (describe) ______________

Women — Gynecology

past	current	
❏	❏	Menopause
❏	❏	Irregular periods
❏	❏	Menstrual cramps
❏	❏	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
❏	❏	Other (describe) ______________

Currently pregnant: trimester ________

Past pregnancies:

# of live births: ______________

# of miscarriages ______________

# of abortions ______________

Other Information

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____

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Patient Signature ______________________________ Date ______________

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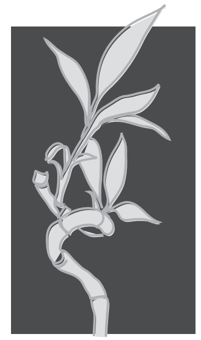

Consent to Services

Services to be Provided
Treatments may include the insertion of sterile needles, bodywork, gua sha (rubbing of the skin with a smooth object), cupping (the application of glass cups with vacuum to the skin) and/or the application of heat to the skin. I understand that I may refuse any of these techniques at any time.

Risks/Possible Side Effects
Treatment may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

No Guarantees
Acupuncture 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 or guardian if client is a minor) Date

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