Acupuncture & Wellness Specialists
acupuncture • massage • cupping • herbs • diet • lifestyle

PATIENT INFORMATION

DATE _____

NAME_____

ADDRESS_____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE_____ **CELL PHONE** _____

DATE OF BIRTH_____ **AGE** _____ **MARITAL STATUS** _____

MALE ___ **FEMALE** ___ **OCCUPATION** _____

PLACE OF EMPLOYMENT _____

E-MAIL ADDRESS _____

EMERGENCY CONTACT _____ **PHONE** _____

RELATIONSHIP _____

PHONE # WHERE YOU WANT TO RECEIVE CALLS _____

(CHECK ONE):
_____ **O.K. TO LEAVE MESSAGE WITH DETAILED INFO.**
_____ **LEAVE MESSAGE WITH CALLBACK NUMBER ONLY.**
_____ **DO NOT CALL!**

HOW DID YOU FIND OUT ABOUT US?

(CHECK ONE)

( ) FRIEND or RELATIVE	**( ) AD IN PAPPER**	**( ) GROUPON**
( ) MEDICAL DOCTOR	**( ) WALK IN**	**( ) LIVING SOCIAL**
( ) HEALTH CARE/EXPO	**( ) WEBSITE**	**( ) OTHER**

IT IS RESPOSIBILITY OF THE PATIENT TO NOTIFY OF ANY CHANGES IN THIS INFO!

PATIENT NAME_____ (GUARDIAN IF UNDER 18)
(PRINT)

PATIENT/GUARDIAN _____ DATE _____
(SIGNATURE)

PATIENT INTAKE FORM

Name _____ Date _____

NOW: ☐ PREGNANT ☐ PACEMAKER ☐ AIDS ☐ HEPATITIS ☐ BLOOD TRANSFUSION

FAMILY HISTORY:

☐ Abuse ☐ AIDS ☐ Alcoholism ☐ Allergies ☐ Asthma ☐ Cancer ☐ Diabetes
☐ Drugs ☐ Heart Disease ☐ High Blood Pressure ☐ Respiratory Diseases ☐ Seizures
☐ Stroke ☐ Other _____

YOUR PAST MEDICAL HISTORY/ILLNESSES:

☐ Aids ☐ Alcoholism ☐ Arthritis ☐ Asthma ☐ Auto Immune Disease ☐ Bronchitis ☐ Cancer
☐ Chronic Fatigue Syndrome ☐ Chronic Lung Disease ☐ Diabetes ☐ Drugs ☐ Heart Disease
☐ Hepatitis ☐ Hernia ☐ High Blood Pressure ☐ Kidney Disease ☐ Organ Transplant ☐ Pneumonia
☐ Rheumatic Fever ☐ Seizures/Epilepsy ☐ Sexually Transmitted Diseases (STD)_____
☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers ☐ Vaccine Reaction ☐ Whooping Cough

SURGERIES: (Please include dates)

1. _____
2. _____
3. _____

TRAUMATIC INJURY: (Please include dates)

Car accident _____
Falls _____
Other _____

ALLERGIES:

Drugs _____
Chemicals _____
Food _____
Others _____

CURRENT MEDICATIONS:

OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:

Chemical: _____ Acid/Alkalines: _____
Heavy Metals: _____ Physical Labor: _____
Electrical: _____ Psychological: _____

HABITS/EXCESSIVE USAGE:

☐ alcohol ☐ chocolate ☐ cigarettes ☐ coffee ☐ cola ☐ drugs ☐ exercise ☐ food ☐ salt
☐ sex ☐ sugar ☐ tea ☐ other _____

CHIEF COMPLAINT / REASON FOR COMING IN: _____

_____

GENERAL

- ☐ poor appetite
- ☐ change in appetite
- ☐ large appetite
- ☐ cravings
- ☐ weight gain
- ☐ weight loss
- ☐ fevers
- ☐ chills
- ☐ sweating
- ☐ night sweats
- ☐ sweats easily
- ☐ headache
- ☐ insomnia
- ☐ hours of sleep _____
- ☐ easy to fall asleep
- ☐ heavy sleeper
- ☐ light sleeper
- ☐ dream disturbance
- ☐ hard to fall back asleep
- ☐ tremors/shaking
- ☐ dizziness
- ☐ poor coordination
- ☐ vertigo
- ☐ edema
- ☐ bleeds easily
- ☐ bruises easily
- ☐ fatigue/tired
- ☐ sudden drop in energy

Are you taking:

- ☐ Aspirin
- ☐ Blood Thinners
- ☐ Vitamins
- ☐ Herbs
- ☐ Supplements

Energy level: ☐ high ☐ moderate ☐ low

Thirsty, desires: ☐ hot ☐ cold ☐ room temp. ☐ no desire

Coldness: ☐ hands ☐ feet ☐ back

Heat: ☐ hands ☐ feet ☐ solar plexus ☐ abdomen ☐ whole body

Stiffness: ☐ joints ☐ back ☐ limbs

Intolerance to: ☐ hot ☐ cold ☐ wind ☐ fan ☐ A/C

Pain: ☐ upper back ☐ lower back ☐ upper limbs ☐ lower limbs ☐ whole body

Rate the pain: Scale 1-10 (10 worst) _____

SKIN AND HAIR

- ☐ rashes
- ☐ eczema
- ***skin:*** ☐ dry ☐ moist
- ☐ sores
- ☐ ulcers
- ☐ herpes
- ☐ psoriasis
- ☐ eruptions
- ☐ discharge
- ☐ pimples/acne
- ☐ bruises
- ☐ hives
- ☐ itching
- ☐ sweating
- ☐ change in skin texture
- ☐ dandruff
- ☐ loss of hair
- ☐ balding
- ☐ thinning of hair
- ☐ change in hair
- ☐ other hair problems: _____
- ☐ other skin problems: _____

HEAD, EYES, EARS, NOSE, MOUTH & THROAT

Head

- ☐ dizziness
- ☐ migraine
- ***Headaches:***
  - ☐ frontal
  - ☐ temporal
  - ☐ vertex
  - ☐ occipital
- ☐ head injury
- ☐ facial pain
- ☐ facial paralysis
- ☐ sinus problems

other: _____

Eyes (R/L)

- ☐ cataract/ glaucoma
- ☐ eye pain
- ☐ twitching
- ☐ floaters/spots
- ☐ poor vision
- ☐ blurry vision
- ☐ night blindness
- ☐ itchiness
- ☐ glasses/contacts
- ☐ red eyes

other: _____

Ears (R/L)

- ☐ loss of hearing
- ☐ discharge
- ☐ earaches
- ☐ poor hearing
- ☐ itchiness

Ringing in ears:

- ☐ loud ☐ soft
- ☐ high pitch
- ☐ low pitch
- ☐ inflammation
- ☐ tenderness

other: _____

Nose

- ☐ loss of smell
- ☐ good sense of smell
- ☐ nose bleeds
- ☐ allergies
- ☐ nasal discharge

color: ☐ yellow ☐ white ☐ clear ☐ green

amount: ☐ scanty ☐ mod ☐ heavy ☐ thick ☐ thin

other: _____

Mouth

- ☐ grind teeth
- ☐ drooling
- ☐ excess saliva
- ☐ dry mouth
- ☐ gum disease
- ☐ bad breath
- ☐ gum bleeding
- ☐ gum swelling
- ☐ taste in mouth
- ☐ ulcers
- ☐ sores

other: _____

Throat

- ☐ dry throat
- ☐ hoarseness
- ☐ recurrent sore throat
- ☐ loss of voice
- ☐ difficulty swallowing
- ☐ lump in throat
- ☐ frequent tonsilitis

other: _____

CARDIOVASCULAR

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ dizziness
- ☐ fainting
- ☐ palpitations
- ☐ chest pain
- ☐ cold hands/feet
- ☐ swelling hands/feet
- ☐ irregular heart beat
- ☐ insomnia
- ☐ difficulty in breathing
- ☐ shortness of breath
- ☐ dream disturbance
- ☐ poor memory
- ☐ mania/delirium
- ☐ coma
- ☐ loss of consciousness

other: _____

RESPIRATORY

- ☐ pneumonia
- ☐ bronchitis
- ☐ asthma
- ☐ coughing blood
- ☐ wheezing

cough: how long? _____ ☐ dry ☐ croup ☐ rapid ☐ other

phlegm: ☐ thin ☐ thick ☐ clear ☐ white ☐ yellow ☐ green

- ☐ tightness in chest
- ☐ shortness of breath
- ☐ fullness in chest

difficulty breathing: ☐ sitting ☐ lying down

- ☐ other chest discomfort

GASTROINTESTINAL

- ☐ food allergies
- ☐ vomiting
- ☐ cramping
- ☐ gas
- ☐ abd/stomach pain
- ☐ nausea
- ☐ taste in mouth
- ☐ belching
- ☐ bad breath
- ☐ hiccup
- ☐ constipation
- ☐ diarrhea
- ☐ loose stools
- ☐ bloody/black stools
- ☐ ulcers
- ☐ increased appetite
- ☐ poor appetite
- ☐ hungry-no desire to eat
- ☐ difficult stools
- ☐ mucus in stools
- ☐ hemorrhoids
- ☐ hernia
- ☐ rectal pain
- ☐ rectal bleeding
- ☐ tenderness in abdomen
- ☐ fullness in abdomen
- ☐ burning in abdomen
- ☐ like/dislike pressure
- ☐ like/dislike cold
- ☐ like/dislike warmth

GENITO-URINARY

- ☐ burning /painful urine
- *color*: ☐ cloudy ☐ pale ☐ dk yellow ☐ pink/red
- ☐ unable to hold urine
- ☐ wakes up to urinate
- ☐ poor stream/scanty urine
- ☐ dribbling urine
- ☐ unable to urinate
- ☐ frequent urination
- ☐ urgency to urinate
- ☐ diminished sex drive
- ☐ increased sex drive
- ☐ impotency
- ☐ genital itching
- ☐ genital sores/pain
- ☐ discharge
- ☐ history of kidney stones
- ☐ history of bladder infections
- ☐ history of prostate problems
- ☐ history of STD

MUSCULO-SKELETAL

☐ joint pain	*upper limbs*:	☐ pain	☐ swelling	☐ burning	☐ weakness	☐ numbness ☐ tingling
		☐ tenderness		☐ stiffness		
☐ joint swelling	*lower limbs*:	☐ pain	☐ swelling	☐ burning	☐ weakness	☐ numbness ☐ tingling
		☐ tenderness		☐ stiffness		
☐ joint stiffness	*back*:	☐ pain	☐ swelling	☐ burning	☐ weakness	☐ numbness ☐ tingling
		☐ tenderness		☐ stiffness		
☐ sciatica	*neck*:	☐ pain	☐ swelling	☐ burning	☐ weakness	☐ numbness ☐ tingling
		☐ tenderness		☐ stiffness		

NEUROPHYSIOLOGICAL

- ☐ history of emotional problems
- ☐ depression
- ☐ anxiety
- ☐ easily stressed
- ☐ confusion/foggy
- ☐ lack of clarity
- ☐ moody
- ☐ fear/fright
- ☐ hyper
- ☐ melancholy
- ☐ grieving
- ☐ easy to anger
- ☐ irritability
- ☐ restlessness
- ☐ emotional
- ☐ frequent sighing
- ☐ over-worried
- ☐ bad-tempered
- ☐ joyful
- ☐ giddy
- ☐ over-thinking
- ☐ talkative
- ☐ silent
- ☐ extrovert
- ☐ introvert
- ☐ poor memory
- ☐ seizures
- ☐ tremors/shaking
- ☐ convulsions
- ☐ coma
- ☐ concussion
- ☐ paralysis
- ☐ trauma at birth ☐ vaginal delivery ☐ cesarean
- ☐ considered/attempted suicide
- ☐ unable to focus
- ☐ phobia _____

GYNECOLOGY AND PREGNANCY [Last Menstrual Period _____ Last PAP _____]

- ☐ no. of pregnancies ___
- ☐ no. of live births _____
- ☐ no. of miscarriages ___
- ☐ no. of premature births _____
- ☐ no. of abortions _____
- ☐ infertility
- ☐ pain during intercourse
- ☐ uterine prolapse
- ***birth control pills***: type _____ how long? _____
- ☐ age at first menses _____
- ☐ length of period _____
- ☐ number of days in cycle __
- ☐ early menstrual cycle (less than 21 days)
- ☐ late menstrual cycle (less than 35 days)
- ☐ irregular menstrual cycle
- ☐ ***menopause***: ☐ pre ☐ post
- ☐ age at menopause _____
- ☐ history of ovarian cysts
- ☐ history of uterine problems
- ☐ fibroids
- ☐ abd. Bloating/fullness
- ☐ pain with stools
- ☐ mood change before period
- ☐ body change before period
- ***menstrual pain/cramps***: ☐ before ☐ during ☐ after
- ☐ days of heavy flow _____
- ☐ endometriosis
- ***flow***: ☐ thick ☐ thin
- ***amount***: ☐ scanty ☐ mod ☐ heavy ☐ very heavy
- *color*: ☐ lt. red ☐ red ☐ dk red ☐ dk purple
- ***clots***: ☐ large ☐ small
- ***vaginal discharge***: ☐ odor ☐ no odor ☐ watery ☐ thick ☐ curdy ☐ itchy
- *color*: ☐ clear ☐ white ☐ yellow ☐ bloody
- ☐ vaginal burning/itching
- ☐ vaginal pain
- ☐ vaginal sores

BREAST

- ☐ history of breast disease
- ☐ breast lumps/masses
- ☐ history of breast cancer
- ☐ breast tenderness
- ☐ breast fullness/swelling
- ☐ breast pain

breast discharge: ☐ clear ☐ white ☐ yellow ☐ green ☐ black ☐ blood ☐ watery ☐ thin ☐ thick

other: _____

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INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture and Traditional Chinese Medicine on me (or patient named below, for whom I am legally responsible) by the acupuncture practitioner named below and/or other licensed acupuncture practitioner serving as back-up for practitioner, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to acupuncture, electrical stimulation, moxibustion, cupping, Tui-Na(Chinese Massage), Gua- Sha, point injection therapy, joint manipulation, Qi Gong/Tai Chi, laser on acupuncture points, Oriental herbs, Western herbs and nutritional supplements and homeopathic remedies to promote health and wellbeing, dietary and life style counseling. I understand that herbs may need to be prepared and consumed according to instructions provided orally and in writing. These herbs may have an unpleasant taste and/or smell. I will immediately notify the acupuncturist and/or 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 generally a safe method of treatment, but may have some side effects, including minor bruising, numbness or tingling near the sites of needling that may last a few days, dizziness or fainting, a broken needle, or may produce a temporarily flare-up of symptoms. Bruising is a common side effect of cupping. Fainting can most easily be avoided if patient takes care not to come to treatment when he/she is exhausted, tired or hungry. To avoid needle breakage, patient must limit their movement while on the table. With sterile, disposable needles there is no risk of AIDS or Hepatitis from the needles. Unusual risks of acupuncture are rare but include pneumothorax (lung puncture), nerve damage, organ puncture and spontaneous miscarriage. I understand that while this document describes the major risks of treatment, other side effects 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, rashes, diarrhea, hives and tingling of the tongue.

The acupuncture practitioner must be advised if the patient has a pacemaker, cardiac condition, bleeding disorder, history of seizures, is or may be pregnant. Patients who take blood thinners such as Coumadin (Warfarin) should probably not to get acupuncture do to the increased risk of bleeding and should consider “needless” electrical stimulation of acupuncture points.

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which based on the facts then known is in my best interest. While there are a number of alternatives that exist, the prognosis for treatment depends on the patient’s condition, the duration and frequency of treatment and the responsiveness of the patient to both the treatment and the treatment plan. I understand that results are not guaranteed.

I understand that the practitioner and/or clinical staff may review my patient records and lab. reports for treatment, payment or health care operations, but all my records will be kept confidential and will not be released without my written consent. The patient has the right to restrict the use of their info. may revoke this part of the Consent, but the practitioner does not have to agree to those restrictions. This information is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, Notice of privacy and Patients Rights, 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

□ Patient □ Parent □ Guardian

Office Representative: _____ DATE: _____

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Yusuf Mihaylov, AP

PATIENT NAME: _____

PATIENT ADDRESS: _____

CITY, STATE & ZIP (MUST HAVE)_____

PATIENT PHONE #_____

PATIENT DATE OF BIRTH_____

PATIENT SUBSCRIBER NUMBER/ID#_____

GROUP#_____

INSURED NAME AND ID # IF DIFFERENT FROM ABOVE_____

RELATIONSHIP TO INSURED: _____SELF _____SPOUSE ____CHILD _____ OTHER_____

_____SINGLE _____MARRIED _____OTHER

INSURANCE COMPANY NAME:_____

INSURANCE COMPANY PHONE #_____

CLAIM # IF AN ACCIDENT_____

DATE OF ACIDENT/INJURY_____

OTHER INFORMATION_____

TO BE COMPLETED BY OFFFICE STAFF

NO COVERAGE_____COVERAGE_____

DEDUCTIBLE $_____ AMOUNT MET $_____

VISIT PER YEAR_____ ALLOWABLE_____ OTHER_____

ACUPUNCTURE ___YES___NO VISITS/UNITS_____

OFFICE VISITS ____YES____NO

PHYSICIAL THERAPY___YES___NO VISITS/UNITS_____

WHEN THE PRIMARY INSURED IS NOT THE PATIIENT YOU MUST GET THE INSURED DATE OF BIRTH AND NAME ALSO.

Fax form to 954-441-7872