Red Dragon Acupuncture Initial Intake Form

Today's Date: _____/_____/_____

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information

Name_____ Birthdate_____/_____/_____

Age_____ Gender Identity/Pronoun_____(F, M, other)

Address_____ City_____

State_____ Zip_____

Phone Numbers (please mark * next to best number):

Home_____ Cell_____ Work_____

E-mail Address_____

Marital Status_____ # of Children_____ Their Age(s)_____

Your Education Level_____(HS, College, Grad)

Occupation_____ Hours per Week_____

Employer_____

Emergency Contact

Name_____ Phone_____

Relationship_____

Under 18 - Responsible Party Information

Name_____ Relationship_____

Healthcare Providers

Please list those with whom you work:

GP/Primary Care:_____

OB/GYN:_____

Specialist (describe):_____

Chiropractor:_____

Massage Therapist:_____

Physical Therapist:_____

Psychotherapist:_____

Personal Trainer:_____

Midwife:_____

Other:_____

May I contact these providers to ensure coordination of your care? ▢ Y ▢ N

Previous experience with acupuncture? ▢ Y ▢ N

With whom and results_____

_____

_____

Health History

Please list your major health concerns in order of importance to you:

Check those that apply to your past medical/health history:

- ▢ Adverse reaction to medical treatment
- ▢ Alcoholism
- ▢ Allergies
- ▢ Arthritis or Rheumatism
- ▢ Asthma
- ▢ Attempted Suicide
- ▢ Birth Trauma
- ▢ Bleeding Disorder
- ▢ Blood Disease
- ▢ Cancer or Tumor
- ▢ Diabetes
- ▢ Emphysema
- ▢ Eating Disorder
- ▢ Fibromyalgia
- ▢ Heart Disease
- ▢ Hepatitis/Liver Disease
- ▢ Herpes
- ▢ High Blood Pressure
- ▢ HIV/AIDS
- ▢ Immune Disorder
- ▢ Joint Replacement
- ▢ Kidney Disorder
- ▢ Low Blood Pressure
- ▢ Lyme Disease
- ▢ Lymph Nodes Removed
- ▢ Mental Illness
- ▢ Multiple Sclerosis
- ▢ Pacemaker
- ▢ Polio
- ▢ Rheumatic Fever
- ▢ Sciatica
- ▢ Scarlet Fever
- ▢ Seizures/Epilepsy
- ▢ Sinus Infections
- ▢ Skin Disease
- ▢ Special Diet
- ▢ Stroke
- ▢ Substance Abuse
- ▢ Thyroid Disease
- ▢ Tuberculosis
- ▢ Ulcer
- ▢ Venereal Disease/STD
- ▢ Other_____

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

_____

_____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc.):

Date_____/_____ Event_____

Date_____/_____ Event_____

Date_____/_____ Event_____

Date_____/_____ Event_____

Date_____/_____ Event_____

Date_____/_____ Event_____

Family History (List any family physical or mental illnesses and age of death if applicable):

Mother_____

Father_____

Grandparents_____

Siblings_____

Children_____

Medications/Herbs/Supplements (List those you are currently taking):

Name_____ Reason_____
How Long_____ Dose_____

Name_____ Reason_____
How Long_____ Dose_____

Name_____ Reason_____
How Long_____ Dose_____

Name_____ Reason_____
How Long_____ Dose_____

Name_____ Reason_____
How Long_____ Dose_____

Name_____ Reason_____
How Long_____ Dose_____

Lifestyle Habits

Describe your typical daily diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Special Diet_____

3 worst foods you eat_____

What is the major source of joy in your life?

What is the major source of stress in your life?

Lifestyle Habits, Cont.

Average 6-8 hours of sleep?

Have a supportive relationship?

Have a history of abuse?

Enjoy your work?

Take vacations?

Spend time outside?

Exercise? Describe:_____

Watch TV? How many hours weekly?

Read books? How many hours weekly?

Computer games/browsing? How many hours weekly?

Spiritual/Religious practice? Describe:_____

Smoke cigarettes? Frequency?

Smoke cigarettes in the past? How many years/frequency?

Eat out often? How many meals per week?

Drink coffee? How many cups per day?

Drink tea? How many cups per day?

Drink soft drinks? How many per day?

Use sugar? How much?

Drink alcohol? How many drinks per week?

Use recreational drugs? What and how often?

Have an addiction? To what and for how long?

Lifestyle Habits, Cont.

Been outside the U.S. in the past 12 months? Where?

What are your goals for your health?

_____

_____

_____

_____

Please circle your level of commitment to correcting your health issues (1 = lowest, 10 = highest)

1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent (if applicable):

Chest X-ray_____/_____

GI Series_____/_____

TB Skin Test_____/_____

EKG_____/_____

Pap Smear_____/_____

Pneumonia Shot_____/_____

Mammogram_____/_____

Sigmoidoscopy_____/_____

Flu Shot_____/_____

Stool Blood Test_____/_____

Complete Physical_____/_____

Other_____ _____/_____

Please mark the appropriate squares in the following list of symptoms. If you have had a symptom in the PAST and do not have it now, check the box, if you are having the symptom CURRENTLY, circle the symptom.

Liver / Gallbladder
▢ Depression / Stress
▢ Headaches / Migraines
▢ Red / Dry / Itchy Eyes
▢ Visual Problems / Blurred Vision
▢ Dizziness
▢ GallStones
▢ Feeling of Lump in Throat
▢ Clenching Teeth at Night
▢ Muscle Cramping / Twitching
▢ Neck / Shoulder Pain / Tightness
▢ Seizures / Tremors
▢ Poor Circulation
▢ Soft / Brittle Nails
▢ Bitter Taste in Mouth
▢ PMS / Menstrual Problems
▢ Tendonitis
▢ Pain Below Ribcage
▢ Do You Crave Sour?
▢ Tend to be Irritable / Angry

Heart / Small Intestine
▢ Heart Palpitations
▢ Rapid or Irregular Heartbeat
▢ Chest Pain
▢ High Blood Pressure
▢ Low Blood Pressure
▢ Insomnia / Sleep Problems
▢ Vivid Dreams / Nightmares
▢ Easily Startled
▢ Dark Urine
▢ Red Complexion
▢ Do you Crave Bitter?
▢ Anxiety / Nervous or Restless

Spleen / Stomach
▢ Body Heaviness
▢ Hard to Get Up in Morning
▢ Muscles Often Feel Tired
▢ Energy Level: _____ (1-10 low to high)
▢ Edema (▢ Hands ▢ Feet)
▢ Easily Bruising / Bleeding
▢ Bad Breath
▢ Sweetish Taste in Mouth

Symptoms, Cont.

▢ Lack of Taste
▢ Excess or Low Appetite (Circle Which)
▢ Excess or Lack of Thirst (Circle Which)
▢ Nausea / Vomiting
▢ Gas / Belching
▢ Hemorrhoids
▢ Organ Prolapse (i.e. Uterus)
▢ Chronic Loose Stools
▢ Abdominal Pain
▢ Indigestion / Heartburn
▢ Brain Foggy
▢ Mouth Ulcers
▢ Tendency to Gain Weight
▢ Do you Crave Sweet?
▢ Over-Thinking / Worry

Lung / Large Intestine
▢ Bloody Cough
▢ Dry Cough
▢ Chronic Cough
▢ Cough with Sputum
▢ Nasal Discharge (▢ White ▢ Yellow ▢ Green)
▢ Post Nasal Drip
▢ Sinus Infection / Congestion
▢ Itchy, Red, or Painful Throat
▢ Dry Mouth / Nose / Throat
▢ Skin Rashes / Hives
▢ Snoring
▢ Shortness of Breath
▢ Allergies / Asthma
▢ Low Immunity
▢ Catch Colds Easily
▢ Bronchitis
▢ Black or Bloody Stools
▢ Constipation
▢ IBS
▢ Diarrhea
▢ Colitis / Spastic Colon
▢ Do you Crave Pungent / Spicy?
▢ Grief / Sadness

Kidney / Urinary Bladder
▢ Urinary Problems (i.e. Night Time) _____
▢ Bladder Infection
▢ Incontinence
▢ Weakness / Pain in Low Back
▢ Osteoporosis

Symptoms, Cont.

▢ Feel Cold or Hot Easily (Circle Which)
▢ Cold Hands / Feet
▢ Low or Excess Sex Drive (Circle Which)
▢ Dark Circles Under Eyes
▢ Thyroid Problems_____
▢ Poor Memory
▢ Hair Loss / Grey Hair
▢ Hearing Problems / Tinnitus
▢ Cavities
▢ Hot Flashes / Night Sweats
▢ Impotence or Premature Ejaculation (Circle Which)
▢ Do you Crave Salt?
▢ Fear

Treatment Terms and Conditions

The following are specific policies that will govern our work together:

Cancellation Policy
In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hours. We will try to reschedule your appointment for the same week so that you don't miss your treatment. You will be charged the full fee for your session if you do not show up for your appointment or cancel your appointment with less than 24 hours notice (1 full day).

Late Policy
If you are going to be late, please call and let us know and we will want until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then, your appointment will be canceled and you will be responsible for the full payment of the session.

Phone Calls and Emails
You may phone or email us when necessary and we will respond as soon as possible, or within 24 hours. We are generally unavailable on weekends. Except for emergencies, phone and email contacts are limited to 10 minutes of our time. All contacts that require beyond 10 minutes of our time are considered session work and will be billed at a flat rate of $35.

Confidentiality and Privacy Practices
As a healthcare provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment, or practice operations, will be made only after obtaining your consent. Your right to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days of a request.
- You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays, seasonal greetings, announcements, and to inform you about my practice and its staff. A more complete description of our privacy practices can be requested.

Fees
It is my policy that you pay the entire session fee at the time of each session. If you would like to arrange another payment option, please discuss it with me. I will provide a minimum of one month's notice of any changes to my fees.

I am a partner in your healthcare. Your participation in your healing process is crucial. My goal is to get you well as soon as possible, which requires that you apply my health recommendations and comply with our treatment plan.

Agreement
I have read and understood the clinic's policies. I agree to all of the above treatment terms and conditions.

_____ _____
Patient Signature Date

Informed Consent and Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, antidepressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Frequent, regular treatment is what gives acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any internet risks and give my consent for treatment, payment, and healthcare operations received, incurred, or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental, and medical conditions and medications, and will keep my acupuncturist updated on any changes.

_____ _____

Patient Signature Date

Red Dragon Acupuncture Fee Schedule

Welcome!

My rate for a new patient visit (exam, diagnosis, and treatment) is $145 and follow-up acupuncture visits are $130. These fees are called "point of service fees" as they are paid at the time services are delivered. Understand that this is also a discounted fee because it does not involve the administration and processing of insurance. I have a few sliding-scale spots available in my practice. These are reserved for those with financial hardship / low-income that display a strong commitment to improving their health.

Other Fees

Herbal and Dietary Consultations (includes a prescription for an herbal formula or specific dietary program) - 30 minutes for $80 for an established patient.

Medical Qigong Treatments or Non-Insertion Treatments (no needles) - 1.25 hours for $160

Tui Na - 15 minutes for $30

Personal Coaching - $190 per hour

I have read and understood the fees charged at Red Dragon Acupuncture Clinic

_____ _____

Patient Signature Date