

New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name _____

Date _____

General Information

Address		City	State
Home Phone		Occupation	Zip
Work Phone	Mobile Phone	Date of Birth	
Email Address			
We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:		Emails	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Texts	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mail	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact		Relationship	Phone
Have you had Acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Family Physician	Phone
What was your experience? <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> No change		<input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single	
Are you presently under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Who and what for? _____	
Are there any other therapies which you are involved in? <input type="checkbox"/> Yes <input type="checkbox"/> No		Who and what for? _____	

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities? Work Standing Sexually Other
 Sleep Emotional Recreation
 Walking Relationships Bending
 Sitting Social Life Stretching

What have you done about this?

Are you interested in: Pain Relief Holistic Health Stress Relief Other
 Preventative Care Stretching/Yoga Herbal Therapy
 Oriental Nutrition Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you have been or are currently involved in:

Medical History

Do you have any allergies? Yes No If so, to what? _____

Do you take medication? Yes No If so, what types and how often? _____

Do you take supplements? Yes No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Obesity | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Cancer | |

Do you sleep well? Yes No

Do you dream? Yes No

Do you have a high point during the day? Yes No When? _____ Do you have a low point during the day? Yes No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

Female Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? _____

PMS Clotting Vaginal sores Vaginal pain Discharge Other _____

Male Concerns

Testicle pain Penis pain Penis sores Discharge Premature ejaculation Nocturnal emission Impotence
Other _____

Signs/Symptoms

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Muscle cramps/pain | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Dark stools | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Night sweat | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Dry throat/mouth | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Irritable | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Teeth/gum problems |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Breast lump/pain | <input type="checkbox"/> Eye pain/strain/tension | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Chest pains | Color of _____ | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Rash | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Redness of eyes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas/belching | <input type="checkbox"/> Migraine | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Short temper | _____ |
| | <input type="checkbox"/> Headache | <input type="checkbox"/> Mucus in stools | <input type="checkbox"/> Shortness of breath | _____ |

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

No Pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Disturbed Very disturbed Cannot sleep

Work - Can do:

Usual work 50% of work 25% of work No work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem Moderate pain on trips Severe pain

Recreation - Can do:

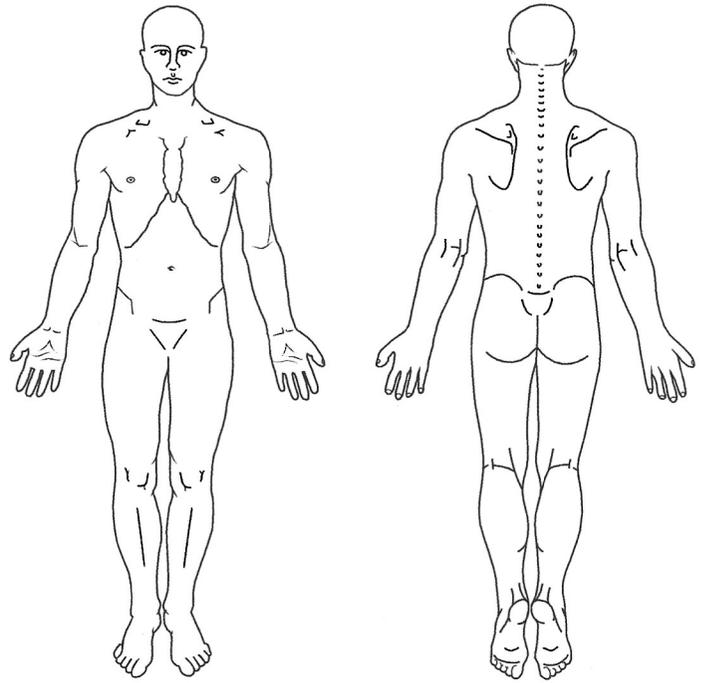
All activities Some activities No activities

Walking

Can walk fine Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Pain Key

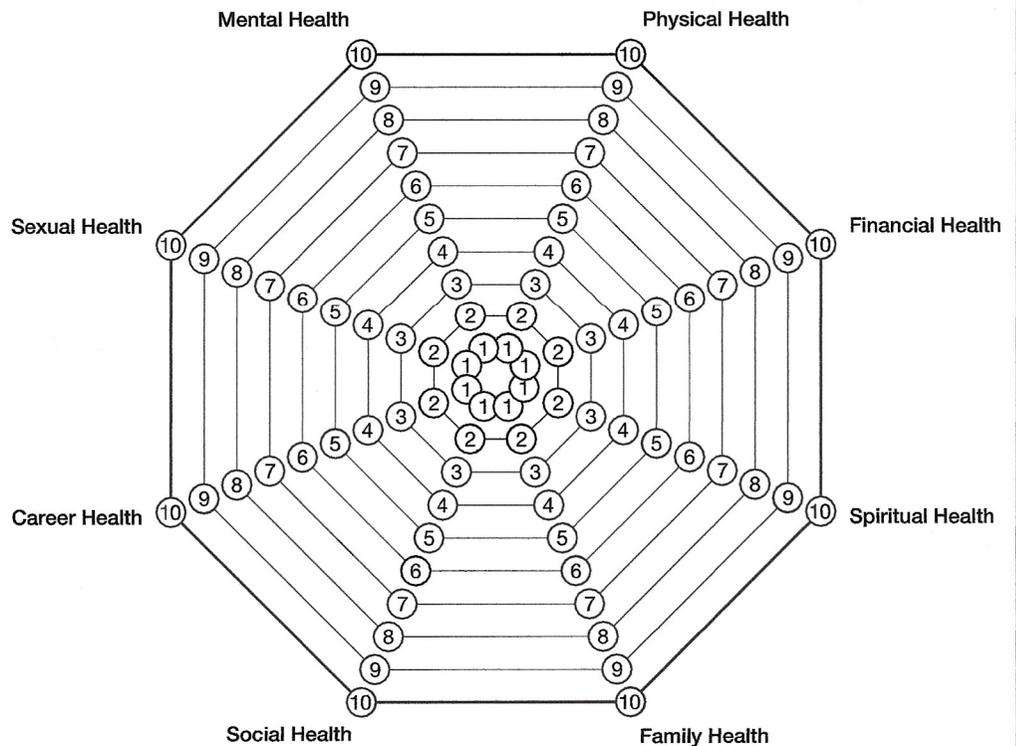
Ache ^ ^ ^ ^	Numbness ====	Pins & Needles 0 0 0 0	Burning X X X X	Stabbing / / / /
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Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

Acupuncture Solutions, LLC

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Plano, TX 75023
972-612-4900

6501 Wesley St #A-1
Greenville, TX 75402
903-213-3679

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture/acupressure 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 Steven R. Homoky 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 the acupuncturist named below, including those working at the clinic or office listed above or any office or clinic whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Nambudripad's Allergy Elimination Treatment (NAET), acupuncture/acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental 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 have 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 and 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 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 Oriental 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 of 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 know that the clinic staff assumes no responsibility for medical conditions that require the attention of a medical doctor, or the necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms. The clinic cannot guarantee that new allergies will not develop in the future. Where we can treat most forms of allergies, some cases do not respond to treatment. I also understand that the only known risk with allergy desensitization (including medical immunotherapy or NAET) is the possibility of increased sensitivity. I assume all responsibility for unpredictable immune reactions, which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention. I understand that the clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

I understand the clinical and administrative staff may review my patient records and lab report, but all my records will be kept confidential and will not be released without my written consent.

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 the 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.

(Print Patient Name)

(Signature of Patient)

(Date)

(Print Name of Clinic Staff)

(Signature of Clinic Staff)

(Date)