

Patient Intake Form

HOLMDEL ACUPUNCTURE & HERBAL MEDICINE CENTER
721 North Beers Street, Suite 2E
Holmdel, NJ 07733
732-888-4910

Please fill in as much information as you can provide

Today's Date _____

PERSONAL INFORMATION

Name _____ Date of Birth _____

Age _____ Gender _____ Marital Status _____ Occupation _____

Phone # (W) _____ (H) _____ (Cell) _____

Email Address _____

Mailing Address _____

Name and phone number of the emergency contact person _____

How did you hear about us? _____

Primary physician's name, phone #, and address _____

Have you had acupuncture treatment before? Y _____ N _____

If yes, with who and when _____

Are you seeking other health care professional's help for your current condition?

Y _____ N _____

If yes, please list their names, specialties, phone #s, and addresses _____

PAST MEDICAL HISTORY

Please list all past medical conditions and hospitalizations.

FAMILY HEALTH HISTORY

Describe your mother's health briefly _____

Describe your father's health briefly _____

What illnesses are prominent in your family? _____

Are you taking any medications? If yes, please list them: _____

Are you taking any supplements or herbs? _____

CURRENT HEALTH CONDITION

Please check ALL that apply to you.

- | | | |
|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> lupus |
| <input type="checkbox"/> allergies | <input type="checkbox"/> frequent urination | <input type="checkbox"/> lyme's disease |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> feeling cold | <input type="checkbox"/> menstrual disorders |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> feeling hot | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> foot pain | <input type="checkbox"/> numbness & tingling |
| <input type="checkbox"/> back pain | <input type="checkbox"/> gastrointestinal disorder | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> gout | <input type="checkbox"/> palpitation (heart) |
| <input type="checkbox"/> breathing difficulties | <input type="checkbox"/> glaucoma | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> cancer | <input type="checkbox"/> hepatitis | <input type="checkbox"/> poor coordination |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> hot flashes | <input type="checkbox"/> persistent cough |
| <input type="checkbox"/> chest pain (or tightness) | <input type="checkbox"/> headache | <input type="checkbox"/> restlessness |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> heart problems | <input type="checkbox"/> shoulder pain |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hives | <input type="checkbox"/> spinal misalignment |
| <input type="checkbox"/> depression | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> skin problem |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> immune deficiency | <input type="checkbox"/> sport injury |
| <input type="checkbox"/> difficult concentrating | <input type="checkbox"/> itchiness | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> digestion problems | <input type="checkbox"/> insomnia | <input type="checkbox"/> stress |
| <input type="checkbox"/> dizziness/ light headedness | <input type="checkbox"/> lack of clarity | <input type="checkbox"/> tendonitis |
| <input type="checkbox"/> other (please specify) | | |

Please describe in detail the health concern (s) you want us to help with

LIFE STYLE AND NUTRITION

Do you have a regular eating habit? Y ___ N ___

Do you usually feel hurried for your meals? Y ___ N ___

Do you snack? Y ___ N ___

Do you crave for certain taste or foods? Y ___ N ___

If yes, what do you crave for? _____

Are you a vegetarian? Y ___ N ___

If yes, do you eat eggs? Y ___ N ___

Which of the following do you consume regularly?

Caffeine _____ Sugar _____ Dairy products _____

Fatty food _____ Salty food _____ Cold raw food _____

Do you tend to eat under stress or when you are depressed? _____

Do you exercise regularly? Y ___ N ___

What do you do to exercise? _____

Do you normally get enough sleep at night? Y ___ N ___
How many hours do you normally get each night? _____
How is the quality of your sleep? _____
Do you dream a lot? Y ___ N ___
If yes, do your dreams bother you? Y ___ N ___
Are you constantly under stress? Y ___ N ___
How do you manage your stress? _____

OTHER QUESTIONS

Is your skin sensitive to heat? _____
Do you bruise easily? _____
How are your emotions? _____
Do you get nervous a lot? Y ___ N ___ Do you get upset easily? Y ___ N ___
Do you feel sad easily? Y ___ N ___ Do you get angry easily? Y ___ N ___
Do you get scared easily? Y ___ N ___ Do you get excited easily? Y ___ N ___
Do you ever feel a lump in your throat? Y ___ N ___
If you are a woman, are you pregnant? Y ___ N ___
If you are a woman, please describe your menstrual cycle in detail (frequency, color, quantity of flow, any cramps, PMS, backaches etc.)

If you are a man over 50 years old, do you suffer from frequent urination?

Do you indulge in the following substances? If you do, how often?
Tobacco _____ Alcohol _____ Recreational drugs _____

Informed Consent

Acupuncture is a technique in which sterile, stainless steel, disposable needles are inserted into specific points on the body to cause a desired healing effect via regulating the flow of Chi (vital energy) in the body. Acupuncture points have been mapped out by Chinese over 3,000 years ago. Techniques may include manual stimulation of the needles, electro-acupuncture, cupping, and moxibustion. The benefits of acupuncture may include alleviation of pain or other symptoms, an overall sense of well being, improved sleep, and increased energy level. Risks may include feeling weak, nauseated, faint, infection or bruising at the site of the needle insertion, and worsening of symptoms occasionally.

Moxibustion is a heat treatment using the herb mugwort placed near the body. There is possible risk of burning due to fallen ashes. There is also possible risk of burn due to the use of heat lamps, although this is very rare.

With this knowledge, I voluntarily consent to have acupuncture treatments.

Signature of patient or Parent/Guardian if minor

Date

The fees for acupuncture and related modalities are as follows:

Initial Visit	\$195	Follow Up Acupuncture	\$95
Double Acupuncture	\$150	Acupressure	\$95
Moxibustion	\$50	Cupping	\$50
Electrical Acupuncture	\$120	Gua Sha/ 7- Star needle	\$50
Traditional Massage	\$80/hr	Reflexology Initial Visit	\$125
		Reflexology Follow Up	\$100

We request payment to be made at the time services are provided regardless of insurance coverage unless other arrangements have been made in advance.

Authorization and release

I certify that the above information is correct to the best of my knowledge. I will not hold any providers or any staff members of *Holmdel Acupuncture & Herbal Medicine Center* responsible for any error or omissions that I may have made in the completion of u form. I hereby authorize *Holmdel Acupuncture & Herbal Medicine Center* to furnish information to my insurance carriers and treating physicians concerning my (or my child's) illness, condition, and treatments. **I also agree to pay for any appointment cancelled or missed for which I didn't give 24 hours notice by telephone.**

Signature of patient or Parent/Guardian if minor

Date