

## 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.

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	\$210	Follow Up Acupuncture	\$105
Double Acupuncture	\$160	Acupressure	\$105
Moxibustion	\$50	Cupping	\$50
Gua Sha/ 7- Star needle	\$50	Reflexology Visits	\$150
Reiki Massage	\$80/ 1 hour	\$110/ 1 ½ hour	

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**