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.

__asthma
__allergies
__anxiety
__AIDS/HIV
__arthritis
__back pain
__blurred vision
__breathing difficulties
__cancer
__carpal tunnel syndrome
__chest pain (or tightness)
__chronic fatigue
__constipation
__depression
__diabetes
__diarrhea
__difficult concentrating
__digestion problems
__dizziness/ light headedness
__other (please specify)

__fibromyalgia
__frequent urination
__feeling cold
__feeling hot
__foot pain
__gastrointestinal disorder
__gout
__glaucoma
__hepatitis
__hot flashes
__headache
__heart problems
__hives
__high blood pressure
__irritable bowel syndrome
__immune deficiency
__itchiness
__insomnia
__lack of clarity

__lupus
__lyme's disease
__menstrual disorders
__neck pain
__numbness & tingling
__night sweats
__palpitation (heart)
__poor appetite
__poor coordination
__persistent cough
__restlessness
__shoulder pain
__spinal misalignment
__spinal fusion
__skin problem
__sport injury
__sciatica
__stress
__tendonitis

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	$220	Follow Up Acupuncture	$120
Double Acupuncture	$180	Acupressure	$120
Moxibustion	$50	Cupping	$60
Gua Sha/ 7- Star needle	$50	Reflexology Visits	$200
Reiki Massage	$120/1 hour	$140 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**