Petson Chan Acupuncture

Initial Visit Intake Form

Note: Information provided on this form is confidential. It is very important that the information given is complete and accurate in order for us to provide you the best healing experience possible. Please PRINT your responses. If you have questions, please ask. Thank you!

Personal Information: Date: ____/____/20____

Name: ____
Date of Birth: ____/____/_____ Age: _____ Sex: ☐Male ☐Female ☐Transgender
SS #: ___________________________ Height: ______ Weight: ______
Marital Status: ☐Single ☐Married/Partnered ☐Divorced ☐Widowed ☐Separated
Address: ____City:_______________Zip:__________
Home Phone: _________________________ Cell Phone: ____________________________________
Email Address: ____
Employer: ____
Occupation: __________________________ Work Phone: __________________________________

Emergency Contact Person: ____
Relationship: _________________________ Telephone: __________________________________

Primary Physician: __________________________ Physician's #: ____________________________
Physician's Address: ____
How did you hear about Petson Chan Acupuncture? _______________________________________
Is this your first experience with Oriental Medicine and Acupuncture? ☐Yes ☐No
If no, when was your first experience? What was your experience like? What were you treated for?
____
____

Patient Insurance Information:

Insured's ID #: ___________________________ Insured's Policy #: _________________________
Insurance Plan Name or Program Name: ____
Patient Relationship to Insured: ☐Self ☐Spouse ☐Child
If insured is other than "self", what is insured's name? ____________________________________
Insured's Date of Birth: ___________________ Insured's SS #: ____________________________

Financial Agreement:

Payment for Clinic Services Rendered: Payment is **due at the time of service** and may be paid by cash, check or all major credit cards. Any checks returned due to insufficient funds will be charged an additional $35.

Cancellation Policy:
Please be respectful of the time set aside for your treatment. All scheduled appointments require a **24 hour cancellation notice** or the patient will be charged for a ***FULL*** office visit fee. **Your insurance is NOT responsible for this fee**, you are responsible.

Herbal Prescriptions:
I understand that **all herb sales are final** as herbal prescriptions are intended only for the patient for whom they have been prescribed and are individually customized to the patient. Herbal prescriptions cannot be resold to other patients.
By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

Patient/Guardian's Signature: ____________________________________ Date: ______________

Patient Name: ________________________________ Sex: _____ Age: _____ Date: _____________

For Women:

Pregnant? ☐Yes ☐No Trying to get pregnant? ☐Yes ☐No Breastfeeding? ☐Yes ☐No

☐Amenorrhea (no period) ☐Dysmenorrhea (painful period) ☐Excessive Flow ☐Scanty Flow

☐Vaginal Itching/Burning ☐Mid-cycle Spotting ☐Clots, if yes, color: _________

☐Oral Contraceptive Use ☐Vaginal Discharge, if yes, color ______________ ☐Cramping

Age at 1st Period: ______ # of Days in Cycle: ______ (first day to first day) ☐PMS

# of Days of Flow: ______ Color of Flow: __________

# of Pregnancies: ______ # of Live Births: ______

# of Miscarriages: ______ # of Abortions: ______

Average # of pads you use on: 1st Day: ___ 2nd Day: ___ 3rd Day: ___ 4th Day: ___ 5th Day: ______

Have you been diagnosed with: ☐Fibroids ☐Fibrocystic Breasts ☐Endometriosis

☐Ovarian Cysts ☐PID ☐Other: ______________________

Location of pain: ☐Lower abdomen ☐Lower back ☐Thighs ☐Other: ____________________

Nature of pain: (Please indicate before, during, or after menses)

Cramping: _________ Stabbing: __________ Burning: ___________ Aching: ______________

Dull: ______________ Bloating: ___________ Constant: __________ Intermittent: ___________

Symptoms experienced around menses:

☐Constipation ☐Decreased Libido ☐Diarrhea ☐Headache ☐Hot Flashes

☐Increased Libido ☐Insomnia ☐Mood Swings ☐Nausea ☐Night Sweats

☐Poor Appetite ☐Ravenous Appetite ☐Swollen Breasts ☐Vaginal Dryness

Other: ____

For Men:

Date of last prostate exam: ____________ PSA Results: _____________

Manual/Lab Results: ____

Frequent Urination? ☐Yes ☐No If frequent, when? ☐Daytime ☐Nighttime

Characteristics of urine: ☐Clear ☐Cloudy Color: ____________ Odors: _______________

Other Symptoms:

☐Back Pain ☐Decreased Libido ☐Delayed Stream ☐Dribbling

☐Erectile Dysfunction ☐Groin Pain ☐Hemorrhoids ☐Impotence

☐Incontinence ☐Increased Libido ☐Low Testosterone ☐Premature Ejaculation

☐Prostate Problems ☐Testicular Pain ☐Urine Retention Other: _______________

Chief Complaint:

What condition are you seeking treatment for today? ____________________________________

How long have you had this condition? ____

What diagnosis have you received from a *medical doctor*? ______________________________

Is there pain? ☐Yes ☐No Where is the pain? ____

Quality of pain? ☐Sharp ☐Shooting ☐Radiating ☐Dull ☐Achy ☐Intermittent ☐Constant

Please rate the severity of the symptoms. Circle one. 1(mild) 2 3 4 5 6 7 8 9 10(severe)

Symptoms are relieved and worsened by? ____

Please list medications and the dosages that you are taking for this condition. ______________________

____

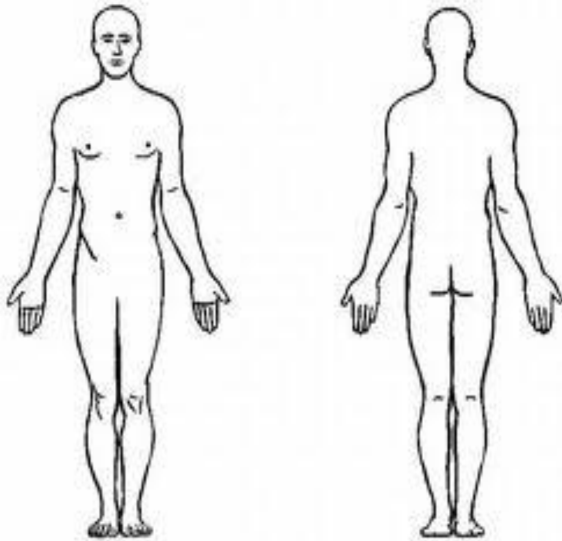
Patient Name: ________________________________ Sex: _____ Age: _____ Date: ______________

Medical History: (Please list or check all that apply.)

General:	☐Blood Thinner Use ☐Hemophiliac ☐Pacemaker ☐Limb Precautions ☐Seizures ☐Pregnancy
Past Illnesses:	
Sexually Transmitted Infections:	
Circulatory Conditions:	
Immune Conditions:	
Skin Conditions:	
Emotional Conditions:	
Neurological Conditions:	
Respiratory Conditions:	

Have you had any accidents, illnesses, injuries, surgeries, or traumas that have affected your health in a manner that you've never been totally well as a result? ☐Yes ☐No
If yes, please explain: ____
____

Please place a "**S**" on areas you had **surgery** and place a "**P**" on areas you have **pain.**



Please give more details regarding those marked areas: ___________________________
____
____
____
____
____
____

Taking any medications for the marked areas?
____
____
____
____

Patient Name: ________________________________ Sex: ____ Age: ____ Date: _________

Family History:

Any family members who may have the following health issues?

Asthma: ☐Yes ☐No Who? ____

Cancers: ☐Yes ☐No Who? ____

Diabetes: ☐Yes ☐No Who? ____

Genetic Diseases: ☐Yes ☐No Who? ____

Heart Disease: ☐Yes ☐No Who? ____

Hypertension: ☐Yes ☐No Who? ____

Mental Illnesses: ☐Yes ☐No Who? ____

Stroke: ☐Yes ☐No Who? ____

Suicide: ☐Yes ☐No Who? ____

Other: ____________________ Who? ____

Current Medications or Supplements:

Name	Dosage	For	How Long	Prescribed by

How do you *FEEL* about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Diet	☐	☐	☐	☐	☐	________________
Exercise	☐	☐	☐	☐	☐	________________
Family	☐	☐	☐	☐	☐	________________
Self	☐	☐	☐	☐	☐	________________
Sex	☐	☐	☐	☐	☐	________________
Significant Other	☐	☐	☐	☐	☐	________________
Spirituality	☐	☐	☐	☐	☐	________________

Anything else that you would like to share with us? ____________________________________

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