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 Chinese 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:

Member ID #: _____ Group #: _____
Insurance Name and Provider Contact Number: _____
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 you will be charged a missed appointment fee of $125. **Your insurance is NOT responsible for this fee, you are.**

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. _____

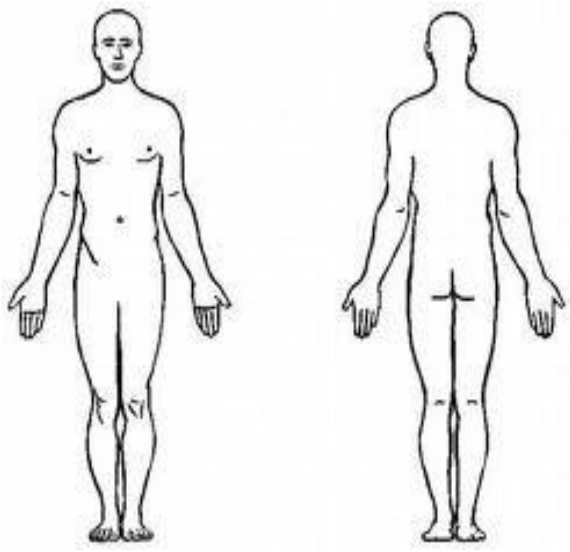
Patient Name: _____ Sex: _____ Age: _____ Date: _____

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? _____
_____
_____