

**Integrative Acupuncture**

1624 Walnut St, Allentown, PA 18102

610-770-9476

[www.acupunctureallentown.com](http://www.acupunctureallentown.com)

**Integrative Acupuncture-Confidential Intake Form**

Date: \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ Gender \_\_\_\_ Age: \_\_\_\_ Date of birth \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_

Occupation: \_\_\_\_\_

**EXPERIENCE WITH ACUPUNCTURE**

Have you received acupuncture treatment before? YES NO

If yes, for what conditions and what was the outcome?

\_\_\_\_\_  
**DESCRIPTION OF MAJOR COMPLAINTS**

What are your main complaints?

Primary Complaint: \_\_\_\_\_  
\_\_\_\_\_

Secondary Complaint: \_\_\_\_\_

Please describe your goals, hopes, and expectation for your acupuncture treatment.

\_\_\_\_\_  
\_\_\_\_\_

**C. PRIMARY COMPLAINT:**

Please answer the following questions focusing on your Primary Complaint ONLY:

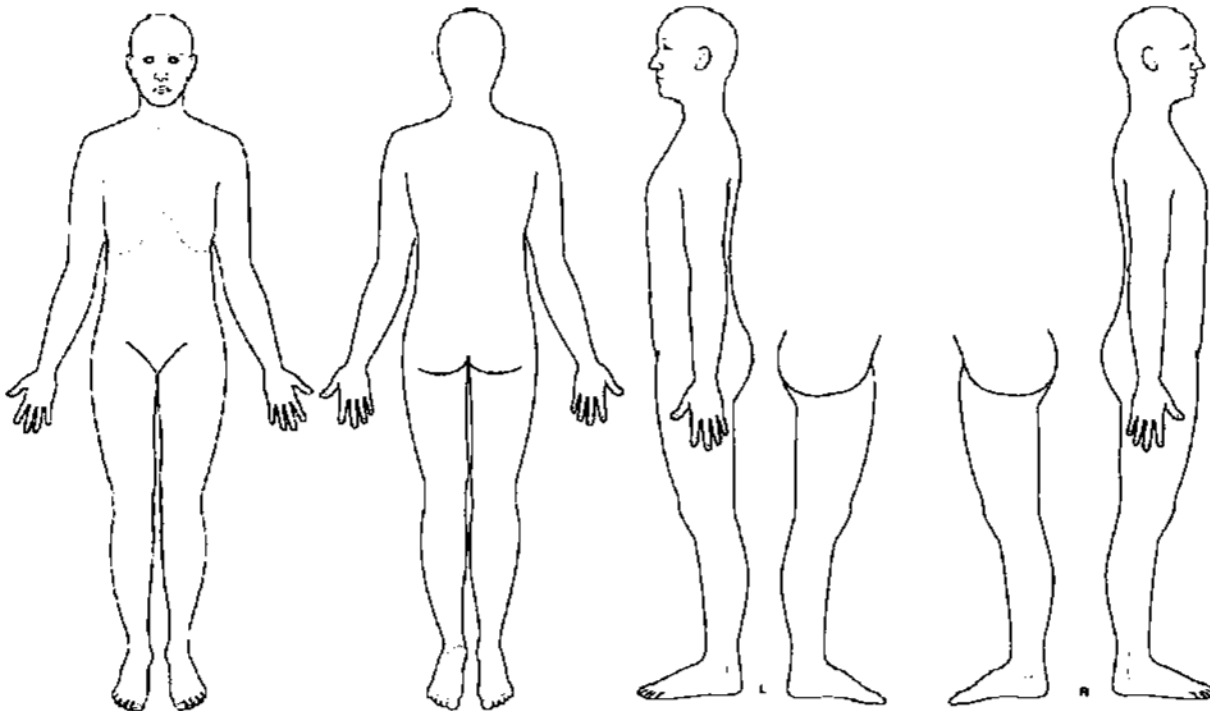
1. Briefly explain history of your Primary Complaint, i.e. how long have you had this condition; was the onset **SUDDEN** or **GRADUAL**; was there a significant event that lead to this condition?
2. Have you seen a physician (or other primary care provider) for your Primary Complaint? If yes, when and what diagnosis did you receive?
3. **Other Care:** what other therapies are you doing/ have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

**D. SECONDARY COMPLAINT:**

Please answer the following questions focusing on your Secondary Complaint ONLY:

1. Briefly explain history of your Secondary Complaint, i.e. how long have you had this condition; was the onset **SUDDEN** or **GRADUAL**; was there a significant event that lead to this condition?
2. Have you seen a physician (or other primary care provider) for your Secondary Complaint? If yes, when and what diagnosis did you receive?
3. **Other Care:** what other therapies are you doing/ have you done to manage your Secondary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

- E. On the diagram, please shade in the areas where you feel symptoms associated with your complaints. PLEASE NUMBER THE COMPLAINTS (Primary Complaint = #1; Secondary Complaint = #2):**



**III. MEDICATIONS, SUPPLEMENTS AND HERBS**

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

*Medications, supplements, or herbs:*

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

*Indication/For treatment of:*

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

**LIST ANY ALLERGIES (to medications, supplements, herbs):**

\_\_\_\_\_

**IV. PERSONAL MEDICAL HISTORY**

II. **BIRTH:** Describe anything significant/traumatic about your birth.

III. **VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

III. **CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

IV. **ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

IV. **ADULTHOOD ILLNESSES (18 - 35 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

IV. **ADULTHOOD ILLNESSES (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

AGE: \_\_\_\_\_

## V. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER \_\_\_\_\_  
FATHER \_\_\_\_\_  
SIBLINGS \_\_\_\_\_  
MATERNAL GRANDPARENTS \_\_\_\_\_  
PATERNAL GRANDPARENTS \_\_\_\_\_

## VI. SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

- A = Acute (under 3 months)
- C = Chronic (over 3 months – experience at some point most days)
- F = Experience frequently (on & off)

### MUSCULOSKELETAL

- |                          |   |   |   |                         |
|--------------------------|---|---|---|-------------------------|
| <input type="checkbox"/> | A | C | F | Joint clicking          |
| <input type="checkbox"/> | A | C | F | Limitation of movement  |
| <input type="checkbox"/> | A | C | F | Stiffness               |
| <input type="checkbox"/> | A | C | F | Spasms or cramps        |
| <input type="checkbox"/> | A | C | F | Swelling                |
| <input type="checkbox"/> | A | C | F | Weakness                |
| <input type="checkbox"/> | A | C | F | Pain: Full body         |
| <input type="checkbox"/> | A | C | F | Pain: Facial (e.g. jaw) |
| <input type="checkbox"/> | A | C | F | Pain: Neck              |
| <input type="checkbox"/> | A | C | F | Pain: Upper Back        |
| <input type="checkbox"/> | A | C | F | Pain: Mid Back          |
| <input type="checkbox"/> | A | C | F | Pain: Low Back          |
| <input type="checkbox"/> | A | C | F | Pain: Shoulder          |
| <input type="checkbox"/> | A | C | F | Pain: Elbow             |
| <input type="checkbox"/> | A | C | F | Pain: Wrist             |
| <input type="checkbox"/> | A | C | F | Pain: Hand              |
| <input type="checkbox"/> | A | C | F | Pain: Hip               |
| <input type="checkbox"/> | A | C | F | Pain: Knee              |
| <input type="checkbox"/> | A | C | F | Pain: Ankle             |
| <input type="checkbox"/> | A | C | F | Pain: Foot              |
| <input type="checkbox"/> | A | C | F | OTHER (Please list)     |
- 

### RESPIRATORY

- |                          |   |   |   |                                |
|--------------------------|---|---|---|--------------------------------|
| <input type="checkbox"/> | A | C | F | Chest pain &/or tightness      |
| <input type="checkbox"/> | A | C | F | Bluish discoloration of skin   |
| <input type="checkbox"/> | A | C | F | Cough                          |
| <input type="checkbox"/> | A | C | F | Coughing up blood (hemoptysis) |
| <input type="checkbox"/> | A | C | F | Shortness of breath (dyspnea)  |
| <input type="checkbox"/> | A | C | F | Sore throat                    |
| <input type="checkbox"/> | A | C | F | Sputum production              |
| <input type="checkbox"/> | A | C | F | Voice changes                  |
| <input type="checkbox"/> | A | C | F | Wheezing                       |
| <input type="checkbox"/> | A | C | F | OTHER (Please list)            |
- 

### CARDIOVASCULAR

- |                          |   |   |   |                                     |
|--------------------------|---|---|---|-------------------------------------|
| <input type="checkbox"/> | A | C | F | Changes in skin temperature & color |
| <input type="checkbox"/> | A | C | F | Chest pain &/or pressure            |
| <input type="checkbox"/> | A | C | F | Edema                               |
| <input type="checkbox"/> | A | C | F | Fainting (syncope)                  |
| <input type="checkbox"/> | A | C | F | Fatigue                             |
| <input type="checkbox"/> | A | C | F | Palpitations                        |
| <input type="checkbox"/> | A | C | F | Skin ulceration                     |
| <input type="checkbox"/> | A | C | F | Swelling of the ankles &/or legs    |
| <input type="checkbox"/> | A | C | F | OTHER (Please list)                 |
- 

### EYES, EARS, NOSE & THROAT

- |                          |   |   |   |                                      |
|--------------------------|---|---|---|--------------------------------------|
| <input type="checkbox"/> | A | C | F | Loss of vision                       |
| <input type="checkbox"/> | A | C | F | Eye pain                             |
| <input type="checkbox"/> | A | C | F | Tearing or eye dryness               |
| <input type="checkbox"/> | A | C | F | Eye discharge                        |
| <input type="checkbox"/> | A | C | F | Eye redness                          |
| <input type="checkbox"/> | A | C | F | Ear discharge                        |
| <input type="checkbox"/> | A | C | F | Ear itching                          |
| <input type="checkbox"/> | A | C | F | Ear pain &/or infections             |
| <input type="checkbox"/> | A | C | F | Loss of hearing                      |
| <input type="checkbox"/> | A | C | F | Ringing or buzzing in ears           |
| <input type="checkbox"/> | A | C | F | Problems with balance (vertigo)      |
| <input type="checkbox"/> | A | C | F | Olfaction (sense of smell) impaired  |
| <input type="checkbox"/> | A | C | F | Nose obstruction (stiffness)         |
| <input type="checkbox"/> | A | C | F | Nose bleeds                          |
| <input type="checkbox"/> | A | C | F | Sinus pain, pressure &/or infections |
| <input type="checkbox"/> | A | C | F | OTHER (Please list)                  |
- 

### DIGESTIVE

- |                          |   |   |   |  |
|--------------------------|---|---|---|--|
| <input type="checkbox"/> | A | C | F | Abdominal distention/bloating            |
| <input type="checkbox"/> | A | C | F | Abdominal mass                           |
| <input type="checkbox"/> | A | C | F | Abdominal pain                           |
| <input type="checkbox"/> | A | C | F | Acid regurgitation &/or Heartburn        |
| <input type="checkbox"/> | A | C | F | Alternating constipation/diarrhea        |
| <input type="checkbox"/> | A | C | F | Rectal bleeding                          |
| <input type="checkbox"/> | A | C | F | Constipation                             |
| <input type="checkbox"/> | A | C | F | Diarrhea                                 |
| <input type="checkbox"/> | A | C | F | Gas                                      |
| <input type="checkbox"/> | A | C | F | Eating disorder                          |
| <input type="checkbox"/> | A | C | F | Indigestion                              |
| <input type="checkbox"/> | A | C | F | Jaundice (yellow tint to skin &/or eyes) |
| <input type="checkbox"/> | A | C | F | Nausea                                   |
| <input type="checkbox"/> | A | C | F | Vomiting                                 |
| <input type="checkbox"/> | A | C | F | OTHER (Please list)                      |
-

**UROGENITAL**

- A C F Difficulty with urine flow  
 A C F Incontinence  
 A C F Painful urination (dysurea)  
 A C F Rashes  
 A C F Red urine  
 A C F Urinary tract infection (UTI)  
 A C F OTHER (Please list)
- 

**NEUROLOGICAL**

- A C F Changes in consciousness  
 A C F Confusion  
 A C F Difficulty concentrating  
 A C F Dizziness  
 A C F Dysphasia (impaired ability to speak)  
 A C F Gait disturbance  
 A C F Headache  
 A C F Numbness and/or tingling  
 A C F Loss of consciousness  
 A C F Paralysis  
 A C F Post shingles pain  
 A C F Problems coordinating movements  
 A C F Severe forgetfulness  
 A C F Tremor  
 A C F Visual disturbance  
 A C F Weakness  
 A C F OTHER (Please list)
- 

**INTEGUMENTARY (SKIN)**

- A C F Changes in hair  
 A C F Changes in nails  
 A C F Changes in skin color  
 A C F Itching (prurites)  
 A C F Never sweat  
 A C F Rash and/or skin lesion  
 A C F Unusual sweating  
 A C F Wounds that will NOT heal  
 A C F OTHER (Please list)
- 

**PSYCHOLOGICAL**

- A C F Feelings of grief  
 A C F Feeling of sadness  
 A C F Feeling fearful/anxious/nervous  
 A C F Difficulty managing anger  
 A C F Feeling manic  
 A C F Feeling worried or overly pensive  
 A C F Feelings of panic  
 A C F Feeling overwhelmed  
 A C F Extreme mood swings  
 A C F Extreme lack of emotion  
 A C F OTHER (Please list)
- 

**SLEEP**

- A C F Difficulty falling asleep  
 A C F Dream disturbed sleep  
 A C F Wake up & cannot fall back asleep  
 A C F OTHER (Please list)
- 

**MISCELLANEOUS**

- A C F Extremely low energy/fatigue  
 A C F OTHER (Please list)
- 

**FOR WOMEN ONLY**

- A C F Abnormal vaginal bleeding  
 A C F Changes in hair distribution  
 A C F Fertility concerns  
 A C F Irregular menstruation  
 A C F Menopausal symptoms  
 A C F No menses  
 A C F Pain with menses (dysmenorrhea)  
 A C F Pain during or after sexual relations  
 A C F Pelvic pain  
 A C F Premenstrual symptoms  
 A C F Sexual dysfunction  
 A C F Unusual discharge  
 A C F OTHER (Please list)
- 

Are you pregnant OR trying to become pregnant?  
 YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: \_\_\_\_\_

# Births \_\_\_\_\_

# Miscarriages \_\_\_\_\_

# Abortions \_\_\_\_\_

**FOR MEN ONLY**

- A C F Fertility concerns  
 A C F Prostate problems  
 A C F Sexual dysfunction  
 A C F Unusual discharge  
 A C F OTHER (Please list)
-

**VII. MEDICAL DISEASES/CONDITIONS.** Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.

- C = Current condition
- P = Past condition, but is now resolved.

- C P AIDS/HIV
- C P Alcoholism &/or substance addiction
- C P Allergies (If yes, pls indicate diagnosis & history)

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- C P Anemia
- C P Asthma
- C P Bell's Palsy
- C P Blood clotting disorder (If yes, pls indicate diagnosis & history)

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- C P Bipolar disorder
- C P Cancer (If yes, pls indicate diagnosis & history)

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- C P Chron's Disease &/or colitis
- C P Chronic Fatigue Syndrome (CFIDS)
- C P Depression (Major)
- C P Diabetes
- C P Eczema
- C P Endometriosis
- C P Fibroids
- C P Infertility
- C P Lung disease, e.g. COPD (If yes, pls indicate diagnosis & history)

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- C P Fibromyalgia
- C P Gallstones
- C P Heart disease (If yes, pls indicate diagnosis & history)

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- C P Hepatitis A / B / C
- C P Hernia
- C P Herpes
- C P Hypertension
- C P Hypoglycemia
- C P Irritable Bowel Syndrome (IBS)
- C P Joint Replacement (If yes, pls indicate diagnosis & history)

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- C P Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)

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- C P Lupus
- C P Lyme Disease
- C P Lymph node removal
- C P Mitral valve prolapse
- C P Mood Disorder
- C P Mononucleosis
- C P Multiple Sclerosis
- C P Organ removal or transplant (If yes, pls indicate diagnosis & history)

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- C P Osteoarthritis
- C P Osteoporosis
- C P Pacemaker (heart or stomach)
- C P Parkinson's Disease
- C P Pelvic Inflammatory Disease
- C P Polio
- C P Psoriasis
- C P PTSD (Post-Traumatic Stress Disorder)
- C P Reflux esophagitis (GERD)
- C P Rheumatic fever
- C P Rheumatoid arthritis
- C P Scarlet Fever
- C P Schizophrenia
- C P Scoliosis
- C P Seizures and /or epilepsy
- C P Shingles
- C P Sleep Disorder
- C P Stroke
- C P Schizophrenia
- C P Thyroid disease (If yes, pls indicate diagnosis & history)

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- C P Ulcer
- C P Trigeminal Neuralgia
- C P Tuberculosis
- C P Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

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- C P OTHER (pls list)

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## VII. LIFESTYLE INFORMATION

### A. Stress, Energy Level & Sleep

1. Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:
2. Do you have any problems with your energy level? If yes, please briefly describe:
3. Do you have any problems with sleep? If yes, please briefly describe:
4. Do you have any problems with your sexual drive? If yes, please briefly describe:

### B. Smoking, Alcohol & Drugs

1. Do you smoke tobacco? YES NO If yes, do you believe that this is a problem for you?
2. Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?
3. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO Do you believe that this is a problem for you?

### C. Diet and Nutrition

1. If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe that your diet has any impact on your complaints? YES NO
2. Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO

## VIII. LIFESTYLE COUNSELING OPTION

Would you be interested in developing an acupuncture treatment plan that includes helping you with lifestyle issues?

## **Integrative Acupuncture Consent to Treatment Form**

By signing below, I do hereby voluntarily consent to be treated with acupuncture by a licensed acupuncturist at Integrative Acupuncture. I understand that acupuncturists practicing in the state of Pennsylvania are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in any attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain, or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me that I am free to stop acupuncture treatment at any time.

**Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is risk of burning or scarring from its use. I understand that I may refuse this therapy.

**Acupressure/Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION**

I requested and received, in substantial detail, further explanation of the procedure of treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission to consent to treatment.

X \_\_\_\_\_  
X \_\_\_\_\_

Patient's Signature  
presence      Date

Date

Explained by me and signed in my

Integrative Acupuncture  
HIPPA  
Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Respect for patient privacy is highly valued at our office. As required by law, we will protect the privacy of your health information that may reveal your identity and provide you with a copy of this notice which describes the health information policy procedures of our office when providing health care services.

**REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct office operations. This general written consent will be obtained the first time we provide you with the treatment services. This general written consent is a broad permission that does not have to be repeated each time treatment is provided.

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

**Uses and Disclosures**

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of the care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may disclose identifiable health information about you without your authorization in some situations as required by law, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information on you.

**Your Rights**

In most cases, you have the right to look at or get a copy of health information about you at the office. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

**Our Legal Duty**

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice.

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Patient's Signature

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Date