



CHINESE MEDICINE INTAKE FORM

Personal Information

Date: _____

Name: _____ Gender: _____ Age: _____

Home Address: _____

Home Phone: () _____ Cell Phone: () _____

May we leave a message on your home phone? Yes ___ No ___

E-mail Address: _____

Date of Birth: _____

Marital Status: single: ___ married: ___ partnership: ___ divorced: ___ widowed: ___

Partner's Name: _____

of Children: _____

Employer: _____ # of Years Retired: _____

Occupation: _____

Emergency Contact

Name: _____

Relationship to You: _____

Home Phone: () _____ Cell Phone: () _____

Referral Information

Who may we thank for referring you to this clinic?

CURRENT HEALTH

Main Purpose of this Appointment:

To what extent does this problem interfere with your daily activities?

Other Current Health Concerns:

What treatments have you received for these concerns?

Are there other members of your family with any of the same conditions? Yes ____ No ____

If Yes, Please explain:

Please list all medications, herbs, supplements and home remedies that you are taking (please include amount, frequency, and duration):

HEALTH HISTORY

Do you have any infectious diseases? Yes ___ No ___ If yes, please list:

Have you been treated for any health conditions during the last year? Yes: ___ No: ___

If yes, Please explain:

Please explain any history of major illnesses/injuries/traumas (include date):

Please explain any allergies (to drugs, chemicals, foods, etc.):

Family history of cancer or other significant illness (include who and type):

Do you smoke or chew tobacco products? Yes: ___ No: ___

If yes, what type and how much per day? _____

If you are a former tobacco user, what was your former usage and when did you quit?

Are you routinely exposed to second-hand smoke? Yes: ___ No: ___

If yes, how and how much per day? _____

Do you drink alcohol? Yes: ___ No: ___ If yes, what and how much/day?

Do you drink caffeinated beverages? Yes: ___ No: ___

If yes, what and how much/day? _____

Do you use recreational drugs? Yes: ___ No: ___

If yes, what and how much/day?

WOMEN ONLY

Please check all conditions that apply to you:

- Menstrual irregularities Menstrual cramps Excessive discharge
- PMS Breast lumps or pain Vaginal dryness
- Vaginal pain or infections Genital herpes Sexual difficulties

Have you ever had an abnormal PAP smear? Yes: No:

Date of last PAP: _____ Date of last mammogram: _____

Age when menstruation began: _____

Length of cycles (from day 1 of one period to day 1 of the next period): _____

Number of days of menstruation: _____

Is your typical flow light, medium or heavy? _____

Do you see clots in your menstrual flow? Yes: No:

Any unusual symptoms or difficulties with menstruation? Yes: No:

If yes, please explain:

Have you completed menopause? Yes: No: If so, when? _____

Please list all contraception methods ever used, including length of use:

Current method:

Please list:

Number of pregnancies: _____

Number of live births: _____

Number of abortions: _____

Number of Cesareans: _____

If you have received a Hysterectomy, when was the date of surgery? _____

Please explain any other reproductive or other female concerns not addressed:

Please CHECK the box next to any conditions you are currently experiencing, and UNDERLINE any conditions you have experienced in the past:

Emotional

- Mood Swings
- Stress
- Anxiety
- Frequent or Excessive Anger
- Frequent Fearfulness
- Frequent Sadness
- Feelings of Depression

Energy and Immunity

- Fatigue
- Difficulty Waking
- Energy Crashes
- Slow Wound Healing
- Chronic Infections
- Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, & Throat

- Impaired Vision
- Eye Pain/Strain
- Glasses/Contacts
- Tearing/Dryness
- Glaucoma
- Impaired Hearing
- Ear Ringing (Tinnitus)
- Earaches
- Headaches
- Sinus Problems
- Hay Fever
- Frequent Nose Bleeds
- Frequent Sore Throats
- Teeth Grinding
- TMD/Jaw Problems

Respiratory

- Allergies
- Frequent Colds
- Shortness of Breath
- Asthma
- Persistent Cough
- Emphysema
- Tuberculosis
- Pneumonia
- History of Smoking
- Other Respiratory Problems

Cardiovascular

- Chest Pain
- Palpitations/Fluttering
- Heart Murmurs
- Arythmia
- High Blood Pressure
- Swelling of Ankles
- Stroke
- Heart Disease
- Varicose Veins

Gastrointestinal

- Low Appetite
- Excessive Appetite
- Nausea/Vomiting
- Epigastric Pain
- Abdominal Pain
- Ulcers
- Frequent Gas
- Frequent Belching
- Heartburn
- Gall Bladder Disease
- Liver Disease
- Hepatitis B or C
- Hemorrhoids

Genito-Urinary Tract

- Painful Urination
- Frequent Urination
- Impaired Urination
- Incontinence
- Frequent UTIs
- Blood in Urine
- Kidney Stones
- Kidney Disease

Female Reproductive

- Irregular Cycles
- Painful Periods
- Heavy Flow
- Clotting
- Premenstrual Symptoms
- Bleeding between Cycles
- Breast Lumps/Tenderness
- Nipple Discharge
- Excessive Vaginal Discharge
- Menopausal Symptoms
- Difficulty Conceiving

Male Reproductive

- Sexual Difficulties
- Prostrate Problems
- Testicular Pain/Swelling
- Penile Discharge

Musculoskeletal

- Neck/Shoulder Pain
- Muscle Spasms/Cramps
- Muscle Pain (if so, where?) _____

- Joint Pain (if so, where?): _____

Neurological

- Vertigo/Dizziness
- Numbness/Tingling
- Poor Balance
- Paralysis
- Seizures/Epilepsy

Endocrine

- Hypothyroid
- Hyperthyroid
- Diabetes
- Hypoglycemia
- PCOS
- Other Endocrine Problem

Skin

- Rashes
- Eczema
- Frequent Hives
- Dry Skin
- Oily Skin
- Acne

Other

- Anemia
- Easy Bruising
- Cold Hands/Feet
- Night Sweats
- Feeling Hot or Cold
- Cancer (if so, what kind?): _____

PRENATAL, INFANCY, AND CHILDHOOD HISTORY

Please provide as much information as you are able. You can talk to family members to fill in gaps.

How old were your parents when you were born? Mother _____ Father _____

How many siblings do you have and how close are you in age to each of them?

Was there anything notable about your mother's experience during pregnancy? (Did she have any illnesses, adequate nutrition, emotional shocks, take any medications, smoke or drink, etc.?)

Please describe any unusual or notable circumstances surrounding your birth (were you early or late, was the birth natural or induced, etc.)

Were there any physical or emotional traumas in your infancy? _____

Did you have any recurrent health issues during childhood, or major illnesses, surgeries, or traumas? _____

As a child, did you experience any abuse? Physical ___ Emotional ___ Sexual ___

If so, please briefly describe, including your age at the time: _____

GENERAL COMMENTS

If you have any comments or additional information, please use this space:



YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. **It is important that you understand that your information can be used and shared in the following ways:**

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- Obtain payment from third party payers

In order to provide you with service that best meets your privacy needs, please tell us how to best contact you when needed. If you have no specific requests we will use your information provided on the intake form. Please check all that apply:

- Please do not phone me at _____ Use this alternate phone number: _____
- Please do not leave messages at/on: Cell phone Work Home
- Please do not contact me by email.
- Please send mail, including my bills, to this alternate address:

Signature

Date

Printed Name

Date



OFFICE POLICIES & FINANCIAL AGREEMENT

Please read and **initial** the following statements:

- _____ Payment for all services and medicinary items is due at the time of the your visit. In the event that your insurance company denies benefits or makes a partial payment, you are responsible for any balance due.
- _____ We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a \$35.00 NSF fee.
- _____ Most insurance companies do not cover pharmacy items that may be prescribed and/or dispensed at Flow Natural Health Care or elsewhere.
- _____ You will be charged a Missed Appointment Fee of \$40.00 for any missed appointments or cancellations of less than 24 hours notice. Insurance companies do not cover late cancellation fees.

I have read and understand the above stated policies of Flow Natural Health Care LLC and will comply with them in all respects.

_____ Patient Name (Please print. Parent or guardian if patient is a minor).

_____ Date

_____ Patient signature (Parent or guardian if patient is a minor)

For Patients with Insurance:

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Flow Natural Health Care.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature: _____ Date: _____

