Karen Craven Acupuncture

Patient Intake Form

Thank you for coming. Please help us provide you with a thorough evaluation by taking the time to carefully fill out this questionnaire. All your information will be confidential. If you have questions, please ask.

Date							
Full name							
Date of birth			Age				
Sex	□ F	□ M	Marital Status	□ S	□ M	□ D	□ W
Address							
Street							
City			State		Zip Code		
E-mail Address							
Please check preferred contact method							
□ Home phone #							
□ Cell phone #							
□ Work phone #							
Emergency contact information							
Contact name							
Contact phone #			Relationship to patient				
How did you hear about us?							
Referred By:							
Other:							

Reason for visit
When did symptoms begin?
What are the precipitating factors?
Have you been given a diagnosis for this problem? If so, what?
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?
What kind of treatment have you tried?
What makes this problem worse?
What makes this problem better?
Is there anyone in your family with the same/similar problem?
Remarks and additional information:

Past medical history (Please include the month/year when the diagnosis was established)

Significant illness:	☐ Cancer	☐ Diabetes	☐ Hepatitis
	☐ Thyroid disease	☐ Seizures	☐ Fibromyalgia
	☐ Arthritis	☐ Tuberculosis	☐ Hypertension
	☐ Emotional imbalance	☐ Anemia	☐ Breathing problems
	☐ Heart disease	☐ Digestive disorders	☐ HIV/AIDS positive
	☐ Venereal disease	☐ Other (please specify)	
Surgeries:			
Hospitalization:			
Significant trauma:			

Family medical history (Please specify family member)

Significant illness	Family member(s)
☐ Alcoholism	
☐ Allergies	
☐ Asthma	
☐ Cancer	
☐ Diabetes	
☐ Heart disease	
☐ Hypertension	
☐ Miscarriage	
☐ Stroke	
☐ Other (please specify)	

Occupation _____

Do you usually work ☐indoors ☐outdoors?

Occupational stress (chemical, physical, psychological, etc.) _____

_____

Personal Height _____ Weight now _____ One year ago _____

Weight maximum _____ @ year _____

Habits Do you smoke? ☐Y ☐N

If so, what? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

_____

Do you exercise regularly? ☐Y ☐N

If so, Please describe your exercise program: _____

_____

_____

How many hours do you sleep in general? _____ When do you usually go to bed? _____

Diet How much coffee do you drink? ____ cups/day; colas ____ number/day; tea ____ cups/day

Do you drink alcoholic beverages? ☐Y ☐N

If so, what? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? ☐Y ☐N Do you eat a lot of spicy food? ☐Y ☐N

Please describe your typical daily diet (Please be as specific as possible):

Morning _____

Afternoon _____

Evening _____

Snacks _____

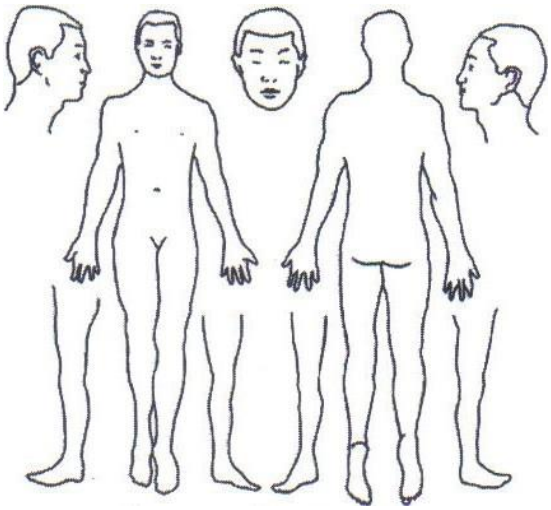
Remarks and additional information (e.g. diet) _____

_____

_____

Recent medical history

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

☐ Poor appetite	☐ Poor sleeping	☐ Fatigue	☐ Fevers	☐ Chills
☐ Night sweats	☐ Sweat easily	☐ Tremors	☐ Cravings	☐ Change in appetite
☐ Poor balance	☐ Bleed or bruise easily	☐ Localized weakness	☐ Weight loss	☐ Weight gain
☐ Peculiar tastes	☐ Desire hot food	☐ Desire cold food	☐ Strong thirst (cold or hot drinks)	
☐ Sudden energy drop (What time of day?)				
Favorite time of year?		Worst time of year?		

Skin and hair

☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching	☐ Eczema
☐ Pimples	☐ Dandruff	☐ Dry skin	☐ Recent moles	☐ Loss of hair
☐ Purpura	☐ Change in hair or skin textures		Other?	

Musculoskeletal

☐ Joint disorders	☐ Weakness in muscles	☐ Pain/soreness in muscles		☐ Tremors
☐ Difficulty walking	☐ Cold hands/feet	☐ Swelling of hands/feet		☐ Back pain
☐ Spinal curvature	☐ Hernia	☐ Numbness	☐ Tingling	☐ Paralysis
☐ Neck tightness	☐ Neck pain	☐ Shoulder pain	☐ Hand/wrist pain	☐ Hip pain
☐ Knee pain	☐ Joint sprain	☐ Other?		

Head, eyes, ears, nose, and throat

☐ Dizziness	☐ Concussions	☐ Migraines	☐ Glasses/lens	☐ Eye strain
☐ Eye pain	☐ Color blindness	☐ Night blindness	☐ Poor vision	☐ Cataracts
☐ Blurry vision	☐ Earaches	☐ Ringing in ears	☐ Poor hearing	
☐ Spots in front of eyes	☐ Sinus problems	☐ Nose bleeding	☐ Sore throat	☐ Grinding teeth
☐ Teeth problems	☐ Facial pain	☐ Jaw clicks	☐ Sores on lips/tongue	
☐ Difficulty swallowing		☐ Other?		

Recent medical history (continued)

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

Cardiovascular

☐ High Blood Pressure	☐ Low Blood Pressure	☐ Chest pain	☐ Palpitation	☐ Fainting
☐ Phlebitis	☐ Irregular heartbeat	☐ Rapid heartbeat	☐ Varicose veins	
☐ Other?				

Respiratory

☐ Cough	☐ Coughing blood	☐ Wheezing	☐ Difficulty breathing	☐ Bronchitis
☐ Pneumonia	☐ Chest pain	☐ Production of phlegm – what color?		

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Gas
☐ Belching	☐ Black stools	☐ Blood in stools	☐ Indigestion	☐ Bad breath
☐ Rectal pain	☐ Hemorrhoids	☐ Abdominal pain/cramps		
☐ Gallbladder problems		☐ Parasites	☐ Chronic laxative use	
Bowel movements:	Frequency _____	Color _____	Odor _____	Texture/form _____

Neuropsychological

☐ Loss of balance	☐ Lack of coordination	☐ Concussion	☐ Depression	☐ Anxiety
☐ Stress	☐ Bad temper	☐ Bi-polar		

Genitourinary

☐ Pain on urination	☐ Frequent urination	☐ Blood in urine	☐ Urgent to urinate	☐ Kidney stones
☐ Unable to hold urine	☐ Dribbling	☐ Pause of flow	☐ Frequent urinary tract infection	
☐ Genital pain	☐ Genital itching	☐ Other?		

Female

☐ Are you or is there any possibility that you could be pregnant?				
☐ Frequent vaginal infections		☐ Pelvic infection	☐ Endometriosis	
☐ Vaginal/genital discharge		☐ Fibroids	☐ Ovarian cysts	☐ Irregular periods
☐ Pain/cramping during periods		☐ Clots	☐ Breast tenderness	☐ Breast lumps
☐ Moodiness related to periods		☐ Fertility problems	☐ Hot flashes	
_____ Number of pregnancies	_____ Number of births	_____ Miscarriages	_____ Abortions	_____ Premature births
_____ Caesareans		_____ Difficult delivery		
First date of last period _____		Age of first menses _____		
Duration of periods _____ days, cycle _____ days				
Do you practice birth control? ☐ Y ☐ N If yes, what type and for how long? _____				
If you are on birth control pills, what are you taking and for how long? _____				
Are you trying to conceive? ☐ Y ☐ N If yes, methods tried? ☐ IUI ☐ IVF ☐ Other _____ How many attempts? _____				

Male

☐ Prostate problems	☐ Discharge	☐ Impotence	☐ Frequent seminal emission
☐ Fertility problems	☐ Ejaculation problems	☐ Painful/swollen testicles	
☐ Other?			

Recent medical history (continued)

Allergies / Sensitivities: ☐ Yes ☐ No (if No, skip this section)

☐ Food	☐ Environmental	☐ Chemicals	☐ Other

Have you had: ☐ Skin prick test ☐ Allergy blood test? When? _____

What symptoms do you experience?

☐ Itching	☐ Hives	☐ Rashes	☐ Sinus congestion
☐ Post nasal drip	☐ Swelling	☐ Yawning attacks	☐ Episodes of diminished hearing
☐ Digestive issues	☐ Joint pain	☐ Asthma attacks	☐ Mental fog
☐ Mood swings	☐ Other?		

Does anyone else in your family experience these issues? ☐ Yes ☐ No

Have you ever been hospitalized for an allergy attack? ☐ Yes ☐ No

Do you carry an epi pen? ☐ Yes ☐ No

Have you received allergy shots? ☐ Yes ☐ No

Please list medications taken within the last two months (including vitamins, OTC drugs, herbs, etc.)

Medication	Dosage	Frequency	Reason for taking

In consideration for our allergy patients, we ask everyone visiting our clinic to follow these rules of cooperation:

- **Do not bring outside food or drink other than water into the clinic**
- **Do not bring animals into the clinic**
- **Avoid wearing scented fragrances to the clinic**

If you need to cancel or reschedule an appointment, we would appreciate at least 24 hours' notice. We charge a fee of $40 for missed appointments or appointments cancelled with less than 24 hours' notice.

I understand the above information and confirm this form was completed correctly to the best of my knowledge.

Signature: _____ ☐Adult patient ☐Parent or Guardian ☐Spouse

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), traditional herbal medicine and nutritional counseling. I understand that most herbs will be in capsule form, but others may need to be prepared and consumed as an herbal tea according to the instructions provided orally and in writing. The herbal teas may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, or organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Traditional Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: Karen Craven, MAcOM, Dipl. OM, L.Ac.

(Date)

Patient Signature **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

Karen Craven Acupuncture

1404B McGavock Pike
Nashville, TN 37216
Phone: 615-228-3286 Fax: 855-217-9775

Karen Craven L.Ac.

Acknowledgement of Privacy Practices

I consent to the use or disclosure of my identifiable health information by Karen Craven Acupuncture (hereafter noted as KCA) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at KCA may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. KCA is not required to agree to the restrictions that I may request. However, if KCA agrees to a restriction that I request, the restriction is binding upon KCA.

I have the right to revoke this consent, in writing, at any time except to the extent that KCA has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review KCA's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Karen Craven Acupuncture. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at karencravenacupuncture.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and with respect to my identifiable health information.

Karen Craven Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Printed Name | (Indicate relationship if signing for patient)

If you wish to authorize Karen Craven Acupuncture to share your health information with any individual(s), please provide the name(s) below.

_____