ACUPUNCTURE & HOLISTIC CARE

2112 Bissonnet St, Houston, TX 77005 / Tel: (713) 960-7890 / Fax: (713) 583-3232

PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ Today's Date:_____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary Care Physician: ☐ Yes ☐ No Name of PCP: _____

Employee/School (Name/Location): _____ Occupation: _____

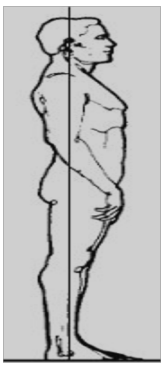
How did you hear about us? ☐ another client ☐ flyer ☐ internet ☐ office sign ☐ other: _____

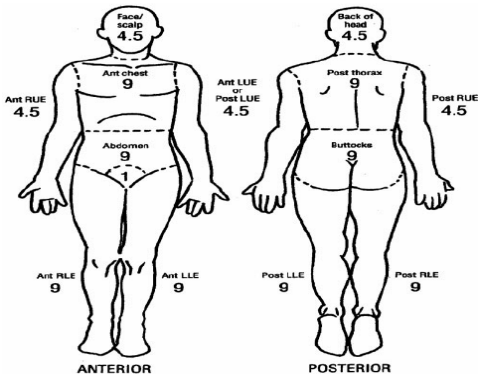
SYMPTOMS & HEALTH HISTORY

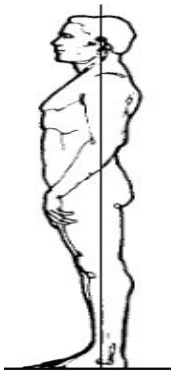
1. Is today's problems caused by: ☐ Personal ☐ Auto Accident ☐ Workmans' Compensation
2. Reason for your visit: _____
3. When did you first notice the symptoms? _____
4. How are your symptoms changing with time? ☐ getting worse ☐ staying the same ☐ getting better
5. Using a scale from 0-10, with 10 being the worst, how would you rate your pain level/symptoms? (please circle)

   0 1 2 3 4 5 6 7 8 9 10

6. Indicate on the drawings below where you have pain/symptoms







7. How would you describe the type of pain? (check all that applies)

   ☐ sharp ☐ dull ☐ diffused ☐ achy ☐ burning ☐ shooting ☐ stiff ☐ burning ☐ numb ☐ tingly

   ☐ sharp with motion ☐ shooting with motion ☐ stabbing with motion ☐ electric with motion

   ☐ other: _____

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8. Who else have seen you for your problem?

   ☐ Chiropractor ☐ E.R. Physician ☐ Neurologist ☐ Orthopedist ☐ Primary Care Physician

   ☐ Physical Therapist ☐ Massage Therapist ☐ Another Acupuncturist ☐ No One ☐ Other: _____

9. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

10. What aggravates your problem? _____

11. What is your: Height: _____ Weight: _____ Age: _____

12. How would you rate your overall health? ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

13. What type of exercise do you do? ☐ strenuous ☐ moderate ☐ light ☐ none

14. Indicate if you have any immediate family member with any of the following:

    ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Heart Problems ☐ Cancer ☐ Lupus ☐ ALS ☐ Other: _____

15. For each of the conditions listed below, please a check in the "past" column if you have had the condition in the past. If you presently have the condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ headaches	☐	☐ chronic sinusitis	☐	☐ visual disturbances
☐	☐ neck pain	☐	☐ high blood pressure	☐	☐ dizziness
☐	☐ upper back pain	☐	☐ heart attack	☐	☐ diabetes
☐	☐ mid back pain	☐	☐ chest pains	☐	☐ excessive thirst
☐	☐ low back pain	☐	☐ stroke	☐	☐ frequent urination
☐	☐ shoulder pain	☐	☐ angina	☐	☐ smoking/tobacco use
☐	☐ elbow/upper arm pain	☐	☐ kidney stones	☐	☐ drug/alcohol dependence
☐	☐ wrist pain	☐	☐ kidney disorders	☐	☐ allergies
☐	☐ hip pain	☐	☐ bladder infection	☐	☐ depression
☐	☐ upper leg pain	☐	☐ painful urination	☐	☐ systemic lupus
☐	☐ knee pain	☐	☐ loss of bladder control	☐	☐ epilepsy
☐	☐ ankle/foot pain	☐	☐ prostate problems	☐	☐ dermatitis/eczema/rash
☐	☐ jaw pain	☐	☐ abnormal weight gain/loss	☐	☐ HIV/AIDS
☐	☐ joint pain/stiffness	☐	☐ loss of appetite	☐	☐ pacemaker
☐	☐ jaw pain	☐	☐ abdominal pain	☐	☐ hormone replacement
☐	☐ arthritis	☐	☐ ulcer	☐	☐ pregnancy (females only)
☐	☐ rheumatoid arthritis	☐	☐ hepatitis	☐	☐ birth control (females only)
Past	**Present**	**Past**	**Present**	**Past**	**Present**
☐	☐ cancer	☐	☐ liver/gallbladder disorder	☐	☐ vasectomy (males only)
☐	☐ tumor	☐	☐ general fatigue		
☐	☐ asthma	☐	☐ muscular in-coordination		

16. Are you on any prescription medications and/or over-the-counter medications? ☐ Yes ☐ No

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17. What activities do you do at work?

☐ sit	☐ most of the day	☐ half of the day	☐ a little of the day
☐ stand	☐ most of the day	☐ half of the day	☐ a little of the day
☐ computer work	☐ most of the day	☐ half of the day	☐ a little of the day
☐ on the phone	☐ most of the day	☐ half of the day	☐ a little of the day

18. Have you ever been hospitalized? ☐ Yes ☐ No If Yes, why? _____

_____

19. Have you had significant past trauma? ☐ Yes ☐ No If Yes, what was the trauma? _____

_____

20. Anything else pertinent to your visit today? _____

_____

_____

CERTIFICATION & ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Patient's Printed Name: _____ Patient's Signature: _____

Today's Date: _____

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INFORMED CONSENT TO CHINESE MEDICAL HEALTH CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope and practice of Dr. Lianghui Peng, L.Ac., a licensed acupuncturist in the State of Texas. I have been informed that acupuncture is a safe method of treatment, but that may have side effects including bruising, numbness, or tingling near the needling sites that may last a few days and dizziness, or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. I understand that these risks include, but are not limited to: bleeding, bruising, puncture of organs, miscarriage, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, blisters, aggravation of current symptoms or healing crisis, appearance of new symptoms, general aches, fatigue, dark red or purple marks from cupping, skin itching, redness, discomforts from taking herbs, Infection is another possible risk, although the acupuncturist below uses sterile 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.

I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the treatment. I will notify the acupuncturist who is caring for me if I am pregnant, suspect to be pregnant, or become pregnant. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner, to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

By voluntarily signing below, I show that I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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 with Dr Lianghui Peng, L.Ac. through Acupuncture & Holistic Care.

Patient's name (please print)	Patient's signature
Date signed	Witness
Print name of patient's representative (if applicable)	Relationship or authority of patient's representative
Signature of patient's representative (if applicable)	Date Signed