NeuroWellness, Inc.
Acupuncture/ Oriental Medicine Intake Form

Please complete all the fields below as accurately as possible, even if you feel certain questions don't pertain to your current condition. All information is kept confidential. Thank You.

Name: ____ Date: __________

Address: ____

City_______________________ State_______ Zip_________________

Email:____

Phone: (C) ______________________ (H) __________________ (W) _________________

Height: __________ Weight: ________ Sex: ________

Date of Birth: __________________ Age: __________

Employer: __________________________________

Occupation: _________________________ Single/Married/Divorced/Widowed/Other (circle)

Primary Physician:________________________________ Phone Number: _______________

Reason for last physician visit: __________________________ Date of last visit: ___________

Referred by: _________________________________ Phone Number: ___________________

In Emergency, Notify: ___________________________

Relationship: _________________ Phone: ______________________

Main problem/s you would like help with:

1.

2.

3.

When did the problem/s begin (be specific):

To what extent does the problem/s interfere with your daily activity (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem/s? If so, what?

What kind of treatments have you tried? Other concurrent therapies:

Medications
What medications are you currently taking? Please list name, reason, dosage.

Habits
Do you have a regular exercise program? Please describe.

Please indicate usage per day or per week:

Water _______ glasses per day
Coffee _______ cups per day/weel (circle)
Tea _______ cups per day/week (circle)
Alcohol _______ day/week Type liquor/beer/wine
Soft Drinks _______ day/week
Cigarettes _______ day/week
Sweets _______ day/week

Please describe your average daily diet: Be specific.

Morning:

Snack:

Lunch:

Snack:

Dinner:

Supplements/Herbs/Vitamins/Minerals: (Please list brand, product name, & reason for taking)

Please list your health goals or concerns:

1.

2.

3.

Muscles/ Bones/ Joints

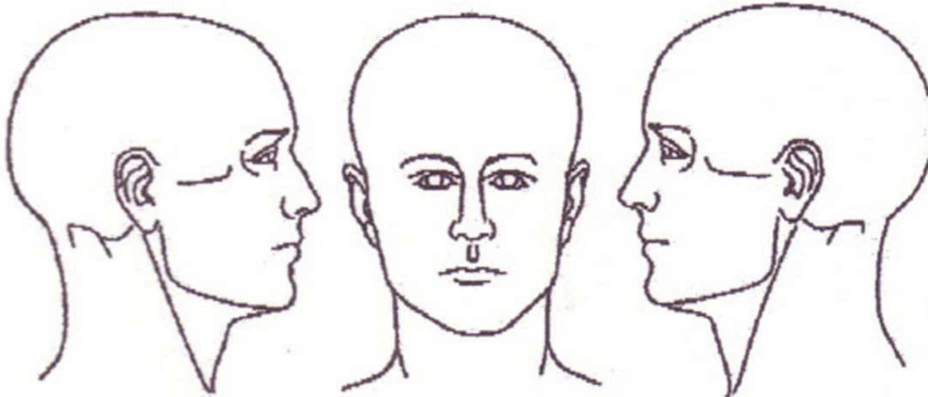
Do you have pain or tightness? No / Yes. If Yes, please indicate the location on the chart below.
The pain is (circle all that apply):

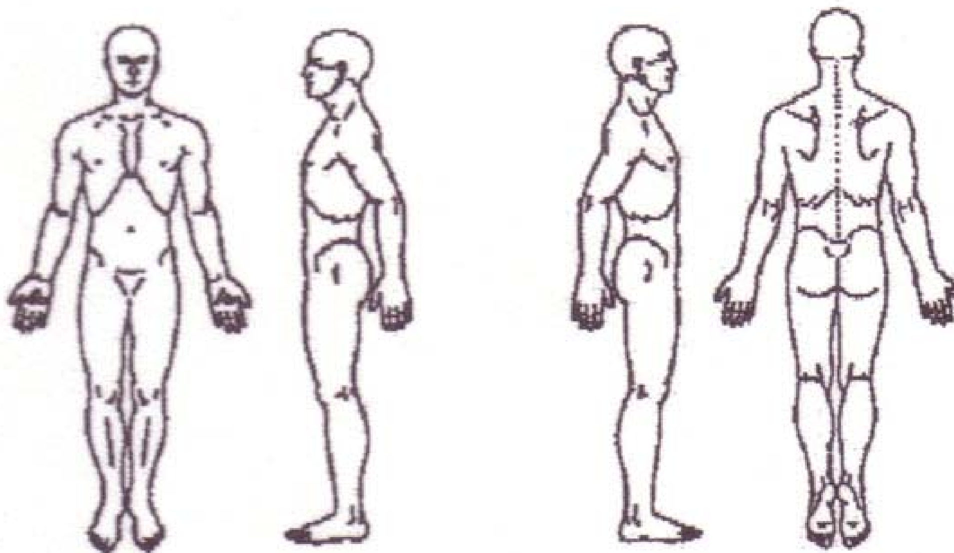
Sharp	Dull	Aching	Numb	Superficial Pain
Burning	Tingling	Shooting	Deep Pain	Pain worse in am/pm
Pain worse/better with heat		Pain worse/better with cold		Pain worse/better with pressure

I have (circle all that apply):

Swollen joints	Arthritis/joint pain	Tendonitis	Muscle cramping
Muscle pain	Repetitive Strain Injury	Bone Pain	Fractured Bone(s) Where?_______________

Please explain any injuries in the space provided:
Date of onset:
Location:
Duration of pain:
What makes the pain worse:
What makes the pain better (circle all the apply): Heat Cold Massage Movement Rest
Treatments: (ex. Ibuprofen, chiropractic)
What number best describes your pain now? *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain*
Please indicate areas of pain or distress:





Medical History (Check all that apply):

__AIDS/HIV	__Alcoholism/Substance Abuse	__Thyroid Disease
__Allergies	__Hepatitis A / B / C	__Asthma
__Cancer	__Herpes	__Epilepsy
__Emphysema	__Lyme Disease	__Endocrine Disorder
__Diabetes	__Multiple Sclerosis	__Gout
__Heart Disease	__Pacemaker	__High Blood Pressure
__Seizures	__Polio	__Surgeries (please list)
__Tuberculosis	__Varicose Veins	

Energy:
How is your energy? Please circle. *Low* 1 2 3 4 5 6 7 8 9 10 *High*
What time of day is your energy:
Highest: 6am-12pm/1pm-5pm/6pm-12am & **Lowest**: 6am-12pm/1pm-5pm/6pm-12am
Do you fatigue easily? Yes/ No

Emotions & Sleep:
How do you feel emotionally?
Do you have (circle all that apply):

Panic attacks	Depression	Anxiety	Bad temper
Nervousness	Fear attacks	Poor memory	Difficult concentration

Are you in a relationship? Yes / No
How do you feel about your relationship? Good/ Fair/ Poor
How do you handle stress?
How do you relax?
How do you feel about your work?
How long do you normally sleep? _________hours per night
I have difficulties with (circle all that apply):

Falling asleep Staying asleep Dream-disturbed sleep
Waking up at about _____am/pm and not being able to fall asleep again

Gastrointestinal:
I have (check all that apply):

Belching	Nausea	Vomiting	Ulcers	Bloating
Heartburn	Hernia	Acid Reflux	Severe stomach pain	Other:__________________

Bowel movements: How often? _________time(s)/day or _________days/week Use Laxatives? _______
I have (circle all that apply):

Irregular Bowel Movements	Constipation	Diarrhea	Undigested food in stool
Burning sensation	Hemorrhoids	Itchiness	Painful bowel movements
Loose stool	Hard stool	Blood in stool	Gas

Urination:
Urination: How often?______(times per day) Color: Pale yellow / Dark yellow / Orange / Other ________
I have or had (circle all that apply):

Trouble starting stream	Frequent urination	Incontinence	Dribbling when sneezing
Burning	Pain	Blood in urine	Kidney stones
Urinary tract infections	Other_____________		

Women Only:
Are you pregnant: Y / N Are you trying to get pregnant: Y / N
Age of first menses: _____ Pre-Menopausal: Y / N Menopausal: Y / N Post-Menopausal: Y / N
Number of days between cycles:______
Number of flow days:_____ Typical Color: dark red/ bright red/ pale red

I have or had (check all that apply):

Irregular menstruation Heavy flow Light flow No flow Clots
Vaginal itching/burning Spotting between periods Discomfort/pain before period
Irritability Breast Tenderness Cravings Cramps
Vaginal discharge? No / Yes Color___________________

Number of pregnancies __________ Number of Children:_________

Men:

I have (circle all that apply):

Prostatitis Impotence Penis blood/mucous/discharge Reproductive problems
Other:____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? No / Yes _______ per day, for ________ years

I have (check all that apply):

Frequent colds Chronic runny nose Frequent sore throat Chronic cough
Coughing blood Cough up mucous Pain inhaling Clogged/popping in ears
Nose bleeds Painful/red eyes Poor vision See spots/floaters Dizziness
Bleeding gums Dry mouth Ear pain Ringing in ears
Shortness of breath on exertion/ or at rest Frequent headaches/migraines

Cardiovascular:

I have (circle all that apply):

Chest pain Palpitation Varicose veins Phlebitis Cold hands and feet
Irregular heart beat Poor circulation Hypertension High Cholesterol
Other:_____________________________________

Skin & Hair:

I have or often have (circle all that apply):

Dry skin Skin rashes Itching Acne Eczema Hives
Hair loss Premature graying Age spots Other:______________________________________

Are there any other health issues you want to discuss?

Jennifer McKeever, Licensed Acupuncturist (Lic # AC 01124)

Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Jennifer McKeever, L. Ac.:

- Acupuncture and other Oriental Medical procedures including diagnostic techniques such as questioning, pulse evaluation, tongue evaluation, abdominal evaluation, observation, range of motion, muscle or orthopedic testing
- Manual or physical therapy including cupping, direct moxabustion, Zen Shiatsu, Tuina, electrical stimulation, infrared heat therapy
- The prescription of herbal therapy, dietary supplements, dietary recommendations
- Exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with Jennifer McKeever, L. Ac. and/or other clinic personnel the nature and purpose of Acupuncture and Oriental Medicine. Although I am aware that Acupuncture and the other Oriental Medicine procedures have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are highly unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, burns, pain or other strong sensation at the location of needle insertion or radiating from that location, nerve pain, aggravation of current symptoms (healing crisis), appearance of new symptoms, or general aches and pains. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist's judgment during the course of my treatment.

I have read (or 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 from Jennifer McKeever, L. Ac

______________________________	______________________________
Patient's name (please print)	Patient's signature
______________________________	______________________________
Date signed	Witness
______________________________	______________________________
Print Name of Patient's Representative (if applicable)	Relationship of Patient's Representative
______________________________	______________________________
Signature of Patient's Representative (if applicable)	Date signed

NOTIFICATION FORM REGARDING EVALUATION OF PATIENT BY PHYSICIAN

In Texas you are required to have been seen by a physician or a chiropractor previous to seeing an acupuncturist, with a few exceptions. This form lets us know that you have done so, and your signature indicates that this is the case.

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) ____, am notifying the acupuncturist Jennifer McKeever, L. Ac. of the following:

Yes No (please circle) I have been evaluated by a physician or dentist for the condition treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: ____________

Yes No (please circle) I have received a referral from a chiropractor within the last 30 days for acupuncture.
Date of referral: __________________
Most recent date of chiropractic treatment: __________________
After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility to follow this advice.

_____ (initials of patient) Date: ____________

OR
I am seeking acupuncture treatment for one of the following conditions:
Chronic Pain
Smoking Cessation
Weight Gain
Substance Abuse
_____ (initials of patient) Date: ____________

____
Patient Signature (required) Date
(Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann. §205.351, governing the practice of acupuncture.)

If you answered no to both of the above questions, I, Jennifer McKeever, am requesting that you see a physician. It is the patient's responsibility and choice whether to follow this advice.

____
Patient Signature (required) Date

____
Acupuncturist’s signature Date

Jennifer McKeever, L. Ac. is not responsible for false statements made by patients.