**Synergy Holistic Health Center**
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(859) 525-5000 | www.synergyholistichealth.com

# Acupuncture Intake Form

Date: _____

Name: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Drug Allergies:_____

Address: _____

City: _____State: _____ Zip: _____

Phone Number (___)_____ (___)_____ (___) _____
Home Cell Work

Please circle the phone number(s) above we may use to leave messages and confirm your appointments.

E-Mail Address: _____ Social Security Number: _____

How did you hear about me: _____

Friend/Family (who): _____ Healthcare Provider: _____

Internet: __ Yellow Pages: __ Other _____

I understand that T.C.M. may affect people on all levels: physical, emotional, mental, and spiritual, because it works within the entire body to restore balance. I understand that the duration of treatment varies person to person, depending on the specific illness and body constitution. I understand that treatment may include the use of acupuncture needles, cupping, mineral heat lamps, herbal formulas (raw and pill form), acupressure, psychological advice, Chinese massage (Tui Na), electrical stimulation, and diet and nutritional counseling. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. If I have heart problems, have an infectious disease, am taking herbs or any drugs, am pregnant or suspect that I am pregnant, I agree I will inform the acupuncturist and/or practitioners before beginning any treatments or services. I understand that slight bruising from cupping or needles is a normal side effect, and that the herbal treatment must be administered as prescribed by the practitioner. I state that I have completed the patient information form completely and accurately, and understand and accept the risks involved in the treatment.

I hereby authorize Synergy Holistic Health Center to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by Synergy and its practitioners. I direct my insurance carrier and/or its intermediaries to issue payment directly to Synergy. I am aware of the financial policy of Synergy and I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I have been advised that all attorney collection fees are my responsibility. A copy of this is as valid as the original.

**Signature:**_____ **Date:** _____

Who referred you to us? _____

Who is your primary health care provider? _____

In an emergency notify: _____
Phone: _____ Relationship to you: _____

Do you smoke? ☐ Yes ☐ No How much? _____ Do you drink? ☐ Yes ☐ No How much? _____
Are you pregnant? ☐ Yes ☐ No How far along? _____
Main problem you would like us to help you with? _____
How long ago did this problem begin? _____
Have you been given a diagnosis for this problem? If so, what? _____
What kinds of treatment have you tried? _____
Have they helped alleviate the condition/problem? _____
Are you currently receiving treatment for your problem? _____If so please describe. _____

**Past Medical History:**

Illnesses: _____

_____

Surgeries: _____

_____

Significant Trauma (i.e Motor Vehicle Accidents, Falls, etc)_____

_____

Do you have or have you ever had, any infectious disease? _____If so, please describe: _____

_____

Medicines: Include prescription, over the counter drugs, vitamins, herbs. etc. taken within the last three months.

_____

Average or typical Blood Pressure_____Average Pulse Rate: _____
Allergies: _____

**Family Medical. History (General Health):**

Mother's Side: _____
Father's Side: _____
Siblings _____

_____

If any of the above are deceased, what was the cause? _____
Personal Birth History (prolonged labor, forceps, Caesarean, etc.) _____
Childhood health: _____ Location of upbringing: _____
Current emotional health: _____ Current Quality of Life: _____
Current Relationship quality: _____ Current predominant emotion: _____
Occupation: _____ Stress level: _____
Have you had any unusual stresses recently? _____
Favorite time of year: _____ Worst: _____
Hobbies and recreational habits: _____
Do you have a regular exercise program? _____ Please Describe: _____
Have you traveled abroad in the past year? _____ Where? _____

# Personal Medical History

## Significant Illnesses

- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV (AIDS)
- ☐ Allergies
- ☐ Asthma
- ☐ Seizures
- ☐ Heart Disease
- ☐ Weight Problem
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Addictive Disorders
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Mental illness
- ☐ Other: _____

Please check if you have experienced any of the following in the last 3 months.

### General:

- ☐ Poor Appetite
- ☐ Fevers
- ☐ Fatigue
- ☐ Tremors'
- ☐ Cravings
- ☐ Headaches
- ☐ Localized Weakness
- ☐ Insomina
- ☐ Strong Thirst
- ☐ Poor Balance
- ☐ Chills
- ☐ Sudden Energy Drop
- ☐ Peculiar Tastes or Smells
- ☐ Bleeding
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Joint Pain
- ☐ Hearing Loss
- ☐ Sweat Easily
- ☐ Change in Appetite
- ☐ Night Sweats
- ☐ Depression
- ☐ Emotional Changes
- ☐ Bruising Easily

### Skin & Hair:

- ☐ Rashes
- ☐ Eczema
- ☐ Recent Moles
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in Hair Texture
- ☐ Change in Skin Texture
- ☐ Dandruff
- ☐ Hives
- ☐ Ulcers
- ☐ Acne
- ☐ Psoriasis

### ENT + Head & Eyes:

- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Gum Problems
- ☐ Night Blindness
- ☐ Facial Pain
- ☐ Color Blindness
- ☐ Eye Pain
- ☐ Glasses
- ☐ Sinus Problems
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Jaw Click
- ☐ Earaches
- ☐ Glaucoma
- ☐ Poor Vision
- ☐ Cataracts.
- ☐ Concussions
- ☐ Poor Hearing
- ☐ Migraine
- ☐ Eye Strain
- ☐ Grinding of Teeth
- ☐ Floaters
- ☐ Spots in Front of Eyes
- ☐ Nose Bleeds
- ☐ Recurrent Sore Throat
- ☐ Sores on Lips
- ☐ Mouth Ulcers
- ☐ Toothache

### Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Coughing Blood
- ☐ Bronchitis
- ☐ Phlegm
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Easily Winded
- ☐ Painful Breathing

### Cardiovascular:

- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Chest Pain
- ☐ Cold Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Swelling of Feet
- ☐ Palpitations
- ☐ Cold Hands or Feet
- ☐ Swelling of Hands
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Shortness of Breath
- ☐ Difficulty Breathing

### Gastrointestinal:

- ☐ Nausea
- ☐ Belching
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Bloating
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Parasites
- ☐ Blood in Stools
- ☐ Black Stools
- ☐ Bad Breath
- ☐ Intestinal Gas
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Gastric Ulcers

### Genito-Urinary:

- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Genital Sores
- ☐ Urgent Urination
- ☐ Impotence
- ☐ Kidney Stones
- ☐ Scanty Urination
- ☐ Unable to Hold Urine
- ☐ Discolored Urine
- ☐ Frequent Urination
- ☐ Frequent Night Urination

**Gynecology & Pregnancy (females only)**

| | | | |
|---|---|---|---|
| ___ Irregular period | ___ Duration of Flow __ | # of Pregnancies _____ | ___ Difficult Births |
| ___ Clots | ___ Painful Periods | # of Births _____ | ___ Fertility Problems |
| ___ Light Flow | ___ Age of First Menses | ___ Miscarriages, # of_____ | ___ Breast Lumps |
| ___ Heavy Flow | ___ Date of Last Menses | ___ Abortions # of _____ | ___ Vaginal Discharge |
| ___ PMS | ___ Last PAP | ___ Premature Births # ____ | ___ Vaginal Sores |

**Neuro-Psychological**

| | | | |
|---|---|---|---|
| ☐ Seizures | ☐ Areas of Numbness | ☐ Concussion | ☐ Loss of Balance |
| ☐ Dizziness | ☐ Lack of Coordination | ☐ Depression | ☐ Mood Swings |
| ☐ Stress | ☐ Poor Memory | ☐ Anxiety | ☐ Irritable |
| ☐ Disorientation | ☐ Migraines | ☐ Easily Angered | ☐ Headache |

Have you ever received psychiatric treatment? _____

_____

Any nervous habits? _____

_____

Do you smoke? ☐ Y ☐ N Intake? Mild Moderate Heavy

Any other problems you would like us to be aware of? _____

_____

_____

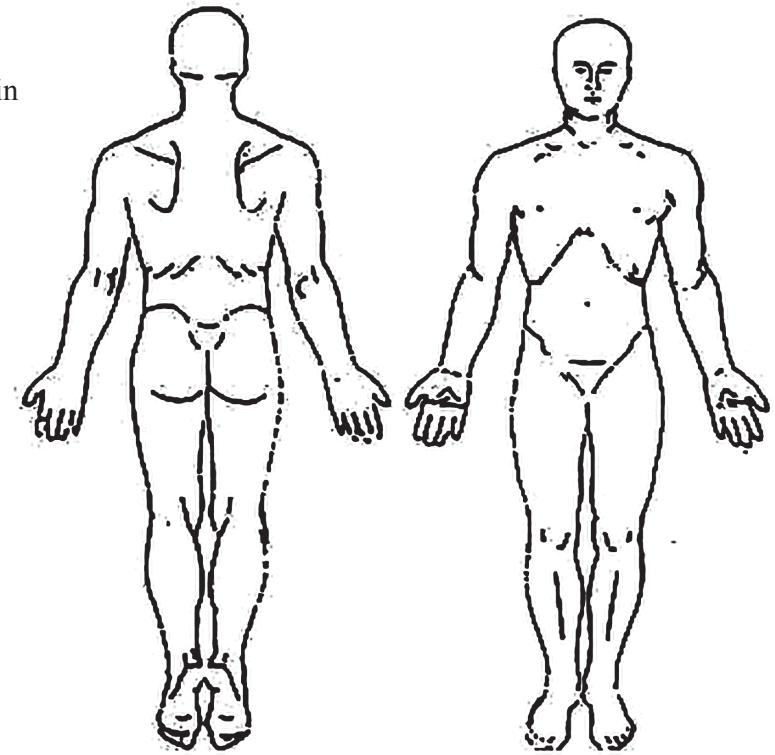
_____

**Musculo-Skeletal**

| | | | | |
|---|---|---|---|---|
| ☐ Neck Pain | ☐ Back Pain | ☐ Joint Pain | ☐ Muscle Spasms | ☐ Hand/Wrist Pain |
| ☐ Scoliosis | ☐ Shoulder Pain | ☐ Knee Pain | ☐ Muscle Cramping | |
| ☐ Hip Pain | ☐ Arthritis | ☐ Muscle Weakness | ☐ Muscle Soreness | |
| ☐ Recent Sprains | ☐ Weak Joints | ☐ Injuries | ☐ Foot/ Ankle Pain | |

Please circle areas of pain or injury

Please be prepared to describe the type and quality of pain



# PHYSICIAN CARE FORM

Date:_____

I have been diagnosed with the following condition(s): (Check all that apply)

__ Hypertension (high blood pressure)
__ Cardiac condition
__ Acute/severe abdominal pain
__ Undiagnosed neurological changes
__ Unexplained weight loss or gain of more than 15% of body weight in last 3 months
__ Suspected bone fracture or dislocation
__ Suspected systemic infection
__ Serious hemorrhagic (bleeding) disorder
__ Acute respiratory distress without a previous history
__ Pregnancy
__ Cancer
__ Other:_____

I am currently under the care of a physician for: (Check all that apply)

__ Hypertension (high blood pressure)
__ Cardiac condition
__ Acute, severe abdominal pain
__ Undiagnosed neurological changes
__ Unexplained weight loss or gain of more than 15% of body weight in last 3 months
__ Suspected bone fracture or dislocation
__ Suspected systemic infection
__ Serious hemorrhagic (bleeding) disorder
__ Acute respiratory distress without a previous history
__ Pregnancy
__ Cancer
__ Other:_____

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality.

Primary Care Physician's Name _____

Primary Care Physician's Phone # _____

Emergency Contact's Name _____

Emergency Contact's Phone # _____

Your Name _____
Please Print

Your Signature _____ Date _____