EDITH NUNEZ ACUPUNCTURE • NEW PATIENT INTAKE FORM

Name:		**Gender:**	**Today's Date:**
Legal Name if different from above [optional]:			**Date of Birth:**
Address:			
Phone:		**Email:**	
Height:	**Weight:**	**Usual Blood Pressure:**	
Employer:		**Occupation:**	
Physician Name & Phone:			
Emergency Contact Name & Phone:			
Current Relationship Status [single, married, partnered, etc]:			
Is this your first time having acupuncture?		**How did you hear about Edith Nunez Acupuncture?**	

MAIN COMPLAINTS

Please list your top three complaints/ concerns in order of importance to you.	Mark an X on the scale to indicate the severity of the condition.	When did this start?	Indicate by circling whether each of the following makes it Better, Worse, or No Change			
			Heat	Cold	Damp	Exercise
#1:	1 — 10		Better Worse No Change	Better Worse No Change	Better Worse No Change	Better Worse No Change
#2:	1 — 10		Better Worse No Change	Better Worse No Change	Better Worse No Change	Better Worse No Change
#3:	1 — 10		Better Worse No Change	Better Worse No Change	Better Worse No Change	Better Worse No Change

HEALTH HISTORY

Check the **YOU** box if you have or had the condition and note the year it began. Check the **FAMILY** box if there is a family history.

CONDITION	YOU	YEAR	FAMILY
Cancer (specify)	☐		☐
Diabetes	☐		☐
Hepatitis	☐		☐
High blood pressure	☐		☐
Heart Disease	☐		☐
Stroke	☐		☐
Seizure disorder	☐		☐
Thyroid disease	☐		☐
Asthma	☐		☐
Pacemaker	☐		☐
Eating disorder	☐		☐
Osteoporosis	☐		☐
STD (specify)	☐		☐
Rheumatic fever	☐		☐
Substance dependency	☐		☐
Allergies (specify)	☐		☐
Psychological (specify)	☐		☐
Kidney disease	☐		☐
Anemia	☐		☐
History of trauma	☐		☐

INJURIES & SURGERIES (including dental)

Please list what happened to what body area and when it occurred.

_____

_____

_____

MEDICATIONS

Please list any medications, herbs or supplements that you take regularly.

_____

_____

DIET & EXERCISE

Do you have a special diet now or have you had one in the past?

_____

Do you exercise regularly? If so, what and how often?

_____

Do you use or have you used any of the following? How often?

	Amount per week	If quit, how long ago?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Other drugs	_____	_____

HEALTH QUESTIONNAIRE

Mark an X on the scales and check any boxes of symptoms or conditions you have had, **in the past month**, in any applicable sections.

TEMPERATURE

How warm or cold you feel relative to other people.
Do you usually need to wear more layers or fewer?

COLD ——— HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Numbness
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst
- ☐ Night sweats
- ☐ Unusual sweats (specify when, where on body)

  _____

  _____
- ☐ Hot hands, feet, or chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry, brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose
- ☐ Nosebleeds
- ☐ Edema / swelling (where?_____)
- ☐ Rashes (where? _____)
- ☐ Itching (where? _____)
- ☐ Dandruff
- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain or loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____ x every _____ days

Stools keep shape? ☐ Yes ☐ No

- ☐ Alternating diarrhea & constipation / IBS
- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Excessive hunger
- ☐ Dry stools
- ☐ Tired after BM
- ☐ Pain with BM
- ☐ Foul-smelling stools
- ☐ Difficult to pass

ENERGY

LOW ——— HIGH

- ☐ Sudden energy drop (time of day? _____)
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine/stimulants
- ☐ Wired or ungrounded feeling
- ☐ Body or limbs feel heavy
- ☐ Body or limbs feel weak
- ☐ Shortness of breath
- ☐ Heart palpitations
- ☐ Blood pressure high / low
- ☐ Bleed / bruise easily
- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Dizziness / lightheadedness
- ☐ Headaches: ____ x per week

EMOTIONS

What emotions dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive Thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timidness / Shyness
- ☐ Indecisiveness

SLEEP

of hours per night: _____

- ☐ Difficulty falling asleep
- ☐ Wake ____ x per night @ _____ am / pm
- ☐ Wake to urinate: how often?

  _____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EYES, EARS, NOSE, THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in vision
- ☐ Sinus congestion
- ☐ Phlegm (color? _____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excessive earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting or stopping
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation on urination
- ☐ Cloudy urine
- ☐ Blood in urine

THE QUESTIONNAIRE CONTINUES ON THE NEXT PAGE

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Mark an X on the scales and check any boxes of symptoms or conditions you have had, **in the past month**, in any applicable sections.

REPRODUCTIVE

Are you sexually active? ☐ Yes ☐ No
Any recent changes in sex drive? ☐ Yes ☐ No

☐ Sores on genitals
☐ Genital discharge
☐ Genital pain
☐ Pain with orgasm
☐ Pain on penetration

Penile & Prostate (If applicable):
☐ Erectile dysfunction
☐ Premature ejaculation
☐ Jock itch ☐ Vasectomy
☐ Prostate disease

MENOPAUSE

If applicable

Age at last menses: _____
Year changes began: _____
☐ Hot flashes:
_____ x per day

☐ Vaginal dryness
☐ Loss of sex drive
☐ Night sweats:
_____ x per week

MENSES & PREGNANCY

if applicable

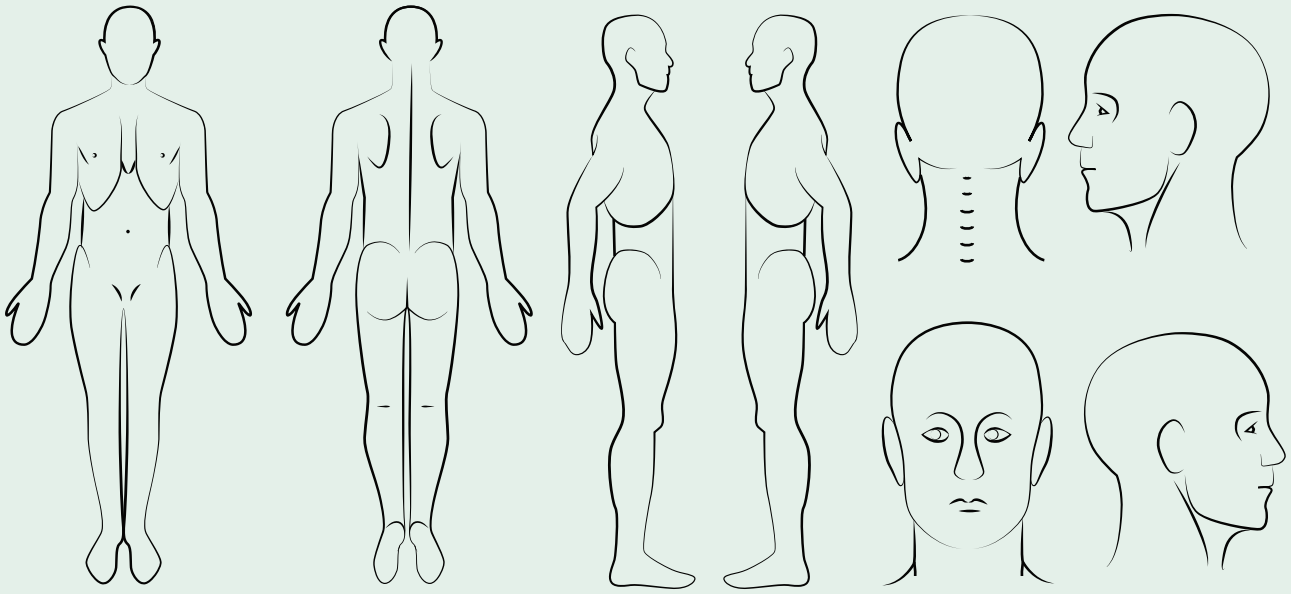
Age at first menses: _____
Average length of full cycle: _____ days (i.e. 28)
Average length of menses: _____ days (i.e. 3-4)
Last menses start date: _____
# of pregnancies: ____ # of births: ____ premature: ____
# of abortions or miscarriages: ____
Do you take hormonal birth control pills? _____

Periods
☐ Heavy
☐ Light
☐ Painful
☐ Irregular

Cramps
☐ before bleeding
☐ first day
☐ during period

☐ Changes in body/psyche prior to menstruation
☐ Clots ☐ Fatigue
☐ Breast tenderness
☐ Mood changes
☐ Digestive changes
☐ Mid-cycle spotting

Please indicate the locations and sensation of your body pain using the following symbols:
^^^^^ Numbness **ooooo** Pins and Needles **xxxxx** Burning ***** Aching/Dull ///// Stubbing/Sharps **EEEEE** Electrical



_____

_____

_____

Right to Obtain a Copy of the Notice:
You have the right to ask for and get a paper copy of the notice of privacy practices, and any revisions we make to the notice at any time.

As indicated by my signature below I hereby acknowledge receipt and understanding of the Notice of Privacy Practices.

Print Patient's Name: _____

Signature of Patient or Person Authorized to Consent: _____ **Date:** _____

Voluntary Consent

I agree to receive acupuncture treatments and related therapies by Dr. Edith Nuñez Baza, DAOM, L.Ac. Treatment methods may include, but not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, herbal medication, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

Possible Side Effects/Healing Reactions

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Infection is also a possible risk. However, I understand Dr. Edith Nuñez Baza, DAOM, L.Ac. uses only sterile disposable needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large dosages, and some herbs may be inappropriate to take during pregnancy. I will notify Dr. Edith Nuñez Baza, DAOM, L.Ac. immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Dr. Edith Nuñez Baza, DAOM, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgement during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I will notify Dr. Edith Nuñez Baza, DAOM, L.Ac. if I become pregnant.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

If I am unable to make a pre-scheduled appointment, I agree to cancel at least 48 hours in advance. X_____
initial

I understand that failure to do so will result in my being **charged the full amount** of treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of my slot may be given to another client.

I understand that Dr. Edith Nuñez Baza, DAOM, L.Ac. has the right to refuse treatment to any patient at any time.
Reasons for refusal of treatment include crude behavior or inappropriate conduct.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask quesions. This consent for treatment form shall cover the entire course of treatment for my present condition and for any future condition which I seek treatment.

I have read this information and consent to treatment by Dr. Edith Nuñez Baza, DAOM, L.Ac.:

_____
Print Name of Patient (and Representative)

Dr. Edith Nuñez Baza, DAOM, L.Ac.
Print Name of Practitioner

X _____
Patient Signature

X _____
Dr. Edith Nuñez Baza, DAOM, L.Ac.

_____
Today's Date