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New Patient Intake Form Today's date _____/_____/_______

Thank you for taking the time to complete the following information which will help me assess your health needs. You can be as brief or thorough as you like. All information is confidential.

General Information

Name____Birthdate_____/_____/______Age______Gender___________

Address_____________________________________City________________________State______Zip__________

Phone numbers (please mark * next to best number):

Home__________________________Cell__________________________Work______________________________

E-mail address____

Would you like to receive our e-newsletter with supportive health information (only once per season)? ☐ Y ☐ N

Marital Status____________________________# of children ___________their age(s)_________________________

Your Educational level _____________Occupation ________________________________Hrs per week___________

Employer & commute time _____________________________________

How did you hear about us? ______________________________If via person, name:__________________________

May we send a thank you card? ☐ Y ☐ N

Emergency Contact

Name____________________________________Ph_________________________Relationship_________________

Under 18 ---Responsible Party Information

Name______________________________________ Relationship to Patient__________________________________

Healthcare Providers ---please list those you work with.

Physicians: GP/Primary Care: ______________________________ seeking one? ☐ Y ☐ N

OB-GYN: ________________________________ seeking one? ☐ Y ☐ N

Specialist (describe): ___________________________ seeking one? ☐ Y ☐ N

Chiropractor: ____ seeking one? ☐ Y ☐ N

Massage Therapist:_______________________________ seeking one? ☐ Y ☐ N

Physical Therapist:______________________________ seeking one? ☐ Y ☐ N

Psychotherapist:________________________________ seeking one? ☐ Y ☐ N

Personal Trainer:_______________________________ seeking one? ☐ Y ☐ N

Midwife:______________________________________ seeking one? ☐ Y ☐ N

Other:____

May I contact these providers to ensure coordination of your care (I usually don't unless requested)? ☐ Y ☐ N

Previous experience with acupuncture? ☐ Y ☐ N With whom and results__________________________________

Health History

Please list your major health concerns in order of importance to you: ____
____
____
____

Check those that apply to your past medical history:

- ☐ Adverse reaction to medical treatment
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Asthma
- ☐ Attempted suicide
- ☐ Birth Trauma
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Immune disorder
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme's disease
- ☐ Lymph nodes removed
- ☐ Mental illness
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease/STD
- ☐ Other___________________

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:
____
____
____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).

Date____/______Event_______________________Date____/______ Event________________________
Date____/______Event_______________________Date____/______ Event________________________
Date____/______Event_______________________Date____/______ Event________________________

Family History (List any family physical or mental illnesses and age of death):

Mother____
Father____
Grandparents____
Siblings____
Children____

Medications, Herbs, Supplements (List those you are currently taking):

Name____________________________Reason _________________________How long and Dose_____________
Name____________________________Reason _________________________How long and Dose_____________
Name____________________________Reason _________________________How long and Dose_____________
Name____________________________Reason _________________________How long and Dose_____________
Name____________________________Reason _________________________How long and Dose_____________
Name____________________________Reason _________________________How long and Dose_____________

Lifestyle Habits

Describe your typical daily diet:

Breakfast____ Lunch____

Dinner____ Snacks____

Special diet______________________________ 3 unhealthy foods you eat______________________________________

Do you:	Yes	No	
Average 6-8 hours sleep?			What is the major source of joy in your life? ____________________
Have a supportive relationship?			
Have a history of abuse?			
Enjoy your work?			What is the major source of stress in your life? __________________
Take vacations?			
Spend time outside?			
Exercise?			Describe exercise: ____
Watch TV?			How many hours weekly?
Read Books?			How many hours weekly
Computer games/browsing?			How many hours weekly
Spiritual/religious practice?			Describe:
Smoke cigarettes?			How much?
Smoke cigarettes in the past?			How many years? How many packs?
Eat out often?			How many meals a week?
Drink coffee?			How many cups a day?
Drink tea?			How many cups a day?
Drink soft drinks?			How many a day?
Add sugar?			How much?
Drink alcohol?			How many drinks a week?
Use recreational drugs?			What and how often?
Have an addiction?			To what and how long?
Been outside the U.S. in past 12 months?			Where?

What are your goals for your health?

____

____

____

Please circle your level of commitment to correcting your health issues? (10 = highest level)

1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:

Chest X-ray ________ Sigmoidoscopy ________ EKG ________ Stool Blood Test ___________

Mammogram ________ TB Skin Test _________ Pap Smear ________ Complete Physical ___________

GI Series _________ Flu Shot ____________ Pneumonia Shot ________ Other ____________________

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑
If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder

☐ Depression / Stress
☐ Headaches / Migraines
☐ Red / Dry / Itchy Eyes
☐ Visual Problems / Blurred Vision
☐ Dizziness
☐ Gall Stones
☐ Feeling of Lump in Throat
☐ Clenching Teeth at Night
☐ Muscle Cramping / Twitching
☐ Neck/Shoulder Pain / Tightness
☐ Seizures/Tremors
☐ Poor Circulation
☐ Soft/Brittle Nails
☐ Bitter Taste in Mouth
☐ PMS/Menstrual Problems
☐ Tendonitis
☐ Pain Below Ribcage
☐ Do you crave: Sour
☐ Tend to be Irritable / Angry

Heart/Small Intestine

☐ Heart Palpitations
☐ Rapid or Irregular Heartbeat
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Insomnia / Sleep Problems
☐ Vivid Dreams / Nightmares
☐ Easily Startled
☐ Dark Urine
☐ Red Complexion
☐ Do you crave: Bitter
☐ Anxiety / Nervous or Restless

Spleen/Stomach

☐ Body Heaviness
☐ Hard to get up in Morning
☐ Muscles Often Feel Tired
___ Energy Level: 1-10 (low to high)
☐ Edema (☐ Hands ☐ Feet)
☐ Easily Bruising / Bleeding
☐ Bad Breath
☐ Sweetish Taste in Mouth
☐ Lack of Taste
☐ Excess or Low Appetite (circle which)
☐ Excess or Lack of Thirst (circle which)
☐ Nausea / Vomiting
☐ Gas / Belching
☐ Hemorrhoids
☐ Organ Prolapse (i.e. uterus)
☐ Chronic Loose Stools
☐ Abdominal Pain
☐ Indigestion / Heartburn
☐ Brain Foggy
☐ Mouth Ulcers
☐ Tendency to Gain Weight
☐ Do you crave: Sweet
☐ Over-thinking / Worry

Lung/Large Intestine

☐ Bloody Cough
☐ Dry Cough
☐ Chronic Cough
☐ Cough with Sputum
☐ Nasal Discharge
☐ White ☐ Yellow ☐ Green
☐ Post Nasal Drip
☐ Sinus Infection / Congestion
☐ Itchy, Red, or Painful Throat
☐ Dry Mouth / Nose / Throat
☐ Skin Rashes / Hives
☐ Snoring
☐ Shortness of Breath
☐ Allergies / Asthma
☐ Low Immunity
☐ Catch Colds Easily
☐ Bronchitis
☐ Black or Bloody Stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis / Spastic Colon
☐ Do you crave: Pungent / Spicy
☐ Grief / Sadness

Kidney/Urinary Bladder

☐ Urinary Problems (i.e. night-time) ________________
☐ Bladder Infection
☐ Incontinence
☐ Weakness / Pain in Low Back
☐ Osteoporosis
☐ Feel Cold or Hot Easily (circle which)
☐ Cold Hands / Feet
☐ Low or Excess Sex Drive (circle which)
☐ Dark Circles under Eyes
☐ Thyroid Problems ___________________________
☐ Poor Memory
☐ Hair Loss / Grey Hair
☐ Hearing Problems / Tinnitus
☐ Cavities
☐ Hot Flashes / Night Sweats
☐ Impotence or Premature Ejaculation (circle which)
☐ Do you crave: Salt
☐ Fear

Women's Health History Form

Age of first menses: Date of last menstrual period: Usual # of days bleeding:

Blood clots: yes no when: Usual length between cycles (i.e. 28 days):

Color of menstrual blood: (please circle) pale bright red dark red brown other __________

Texture of menstrual blood: thick thin watery normal

Pain/Cramps: yes no when:

Irregular periods (describe):

PMS: moodiness breast tenderness bloating constipation other_________________

Current method(s) of contraception: Past method(s) of contraception:

Are you currently pregnant? yes no Are you trying to get pregnant? yes no

Number of pregnancies: Number of live births:

Number of miscarriages: Number of abortions: Any premature births:

Breast (lumps, cysts, tenderness, etc.):

Urinary tract infections: How frequent?

Vaginal infections/ discharges (describe color and/or smell):

Pain/itching of genitalia:

Date of last Pap smear: Pap smear: normal abnormal

Date of last mammogram: Mammogram: normal abnormal

Uterine fibroids: Endometriosis: PID: Other:

Menopause (date of onset): Symptoms: Any bleeding since?

Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose:

How long have you been on HRT? Any side effects?

Anything else we should know about your gynecological history?

____

____

TREATMENT TERMS AND CONDITIONS

The following are specific policies that will govern our work together:

Cancellation Policy

In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hours notice (you can change and cancel appointments through our online scheduling system). We will try to reschedule your appointment for the same week so that you don't miss your treatment. You will be charged the full fee for your session if you do not show up for your appointment, or 50% of the fee for your session if you cancel your appointment with less than 24 hours notice.

Late Policy

If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be canceled and you will be responsible for the full payment of the session.

Confidentiality and Privacy Practices

As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, announcements and to inform you about our practice and its staff. A more complete description of our privacy practices can be requested.

Fees

It is our policy that you pay the entire session fee at the time of each appointment. We will provide a minimum of one month's notice of any changes to our fees.

We are partners in your healthcare.

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

Agreement

I have read and understood the clinic's policies. I agree to the all of the above treatment terms and conditions.

Signature: ____ Date: ________________________

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Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling.

I understand that these therapies are safe methods of treatment. As with all medical procedures, they involve potential but unlikely risks. Such uncommon risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very, very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible but highly unlikely (we've never witnessed this), as the clinic uses alcohol, sterile disposable needles, and a safe and clean environment. A burn is a possible but extremely rare side effect of moxibustion. Temporary bruising (not painful) or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Regular treatment and completing the prescribed treatment plan are what give acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible but rare side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and hives. I understand that I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

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Patient Signature   Date

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What to expect before & after treatment

- At your initial appointment, we will conduct a detailed evaluation. Using principles of Traditional Chinese Medicine, we identify causes associated with your individual condition. After determining your diagnosis, we develop a treatment plan incorporating an acupuncture prescription, Chinese herbs, supplements and nutritional and lifestyle recommendations.
- Sterile, superfine needles are placed at points that correspond to your specific needs.
- The needles are about the thickness of three hairs, are used only once and are disposed of immediately following your treatment.
- You will feel a light tap when the needles are applied. After a moment, you may feel warmth, heaviness, tingling or pressure around the needle. These sensations are normal and desirable.
- Acupuncture promotes marked relaxation such that most people fall asleep during the treatment. It is very common to experience a feeling of general well-being afterward.
- A typical follow-up appointment lasts about 1 hour and includes time to talk about your progress as well as receive an acupuncture treatment.
- Each person and medical condition respond to treatment at a different pace. Acute conditions usually can be treated within 6-12 sessions, and chronic conditions can often take longer. We will provide you with an estimate based on your health issue after the initial consultation.

Have a little food in your stomach when you arrive for treatment.
It's best not to receive acupuncture on an empty stomach. However, do not eat a heavy meal before or after the session. Also, refrain from using caffeine, drugs or alcohol for at least several hours before and after your treatment (this includes caffeine).

When you brush your teeth, please do not brush your tongue.
The color and texture of the tongue coating are important diagnostic clues in Oriental Medicine. Please avoid brushing your tongue for 24-48 hours before a visit.

In the hours after a treatment…
…your body is still going through a physiological re-balancing process. To maximize the treatment effect, take time to relax and avoid vigorous exercise for several hours after the treatment, and drink plenty of water to assist in your healing.

If you catch a cold or flu, please stop your herbs and supplements. Call us immediately so that we can prescribe an herbal formula that will specifically treat your cold/flu (we have very effective remedies and can help avoid the use of antibiotics and dramatically reduce the duration of your cold). If you continue to take "tonic" herbs while you're sick, they have the potential to make your cold/flu worse.

Scheduling/Changing your appointments online: We have a user-friendly online scheduling system that enables you to make, change, and cancel appointments 24 hours/day. Simply go to our website (www.cyclemy.com) and click on the "Appointments" tab. You will be re-directed to the yohga-360 Mind Body site for scheduling. To schedule or reschedule your acupuncture appointment, please use the free Yoga 360 app or give us a call at 815.806.0360 and we can assist you.

Give us a call or send us an email if you have any problems or questions. We're happy to help.

Other things to know:

- Wear comfortable clothes to your appointments that can be easily rolled up to your elbows and knees. For back treatments we provide you with a towel and sheets for draping.
- Please fill out your new patient paperwork in advance so that we can be prepared to offer the highest level of support for your needs and so that you have a chance to reflect on your healthcare goals prior to your session. If you are unable to print and complete in advance, we will have copies available for you to fill out upon your arrival. Make sure to allow 15-20 minutes prior to your scheduled appointment to allow time if you need to fill out paperwork beforehand.
- Bring any recent lab results, x-rays, scans, or other pertinent medical records that will help us to gain better insight into your health concerns.
- Please plan to arrive 10-15 minutes in advance of your scheduled appointment and take advantage of some extra time to decompress in our spa lounge with some herbal tea or fruit-infused water prior to your session.
- We accept cash, checks and credit cards for office visits and herbs/supplements

Your highest compliment is the referral of your family and friends, and our business is mostly generated by word-of-mouth. If you have a loved one who is struggling with their health, we would be honored to speak with them to see if we can provide support. If we're not the best fit, we will assist in finding someone who is.

Thanks so much and we look forward to working with you!

~Cyclemy Acupuncture and Functional Chinese Medicine