

## Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Date
Date of birth	Age	Occupation
Main phone #	Other phone #	
E-mail address	Allow email contact by AOMA <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address: Street	City	State Zip
Relationship status	# of children	Family physician Chiropractor
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of insurance company		
Does your insurance cover acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? Who is your employer?		
Emergency contact name phone		
How did you find out about our clinic? <input type="checkbox"/> Friends/Relatives(name) _____		
<input type="checkbox"/> Direct mail <input type="checkbox"/> Location or walk by <input type="checkbox"/> Website <input type="checkbox"/> Referred by _____		
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Periodicals <input type="checkbox"/> Other (please specify) _____		

**Main problem(s):** \_\_\_\_\_

What diagnosis, if any, have you received for this problem? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_ What are the causes of this problem? \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? \_\_\_\_\_

What kind of treatment have you tried? \_\_\_\_\_

What makes this problem worse? \_\_\_\_\_ What makes this problem better? \_\_\_\_\_

Is there anybody in your family with the same/similar problems? \_\_\_\_\_ Remarks and additional information:

**Medical History** (Please include the month/year when the event occurred or when the diagnosis was established)

**Surgeries:** \_\_\_\_\_ **Hospitalization:** \_\_\_\_\_

**Significant trauma:** (auto accidents, sports injuries, etc) \_\_\_\_\_

**Allergies:** (drugs, chemicals, foods, environmental): \_\_\_\_\_

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

**Medicines** taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

\_\_\_\_\_

**Occupation** : \_\_\_\_\_ Do you usually work  indoors  outdoors?  
Occupational stress (chemical, physical, psychological, etc): \_\_\_\_\_

**Personal** Height \_\_\_\_\_ Weight now \_\_\_\_\_ Weight one year ago \_\_\_\_\_  
Weight maximum \_\_\_\_\_ @Year \_\_\_\_\_

**Habits** Do you smoke ?  Yes  No What? \_\_\_\_\_ How many per day? \_\_\_\_\_ Since when? \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

Do you exercise regularly  Yes  No Please describe your exercise program: \_\_\_\_\_

How many hours do you sleep in general? \_\_\_\_\_ When time do you usually go to bed? \_\_\_\_\_

**Diet** How much coffee do you drink? \_\_\_\_\_ cups/day Colas \_\_\_\_\_ number/day Tea \_\_\_\_\_ cups/day

What kind of alcoholic beverages do you usually drink, if any? \_\_\_\_\_ Average number of drinks/week? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

Are you a vegetarian?  Yes  No  Yes, but not so strict Do you eat a lot of spicy food?  Yes  No

Remarks and additional information (e.g. diet) \_\_\_\_\_

Please describe your average daily diet (Please be as specific as possible):

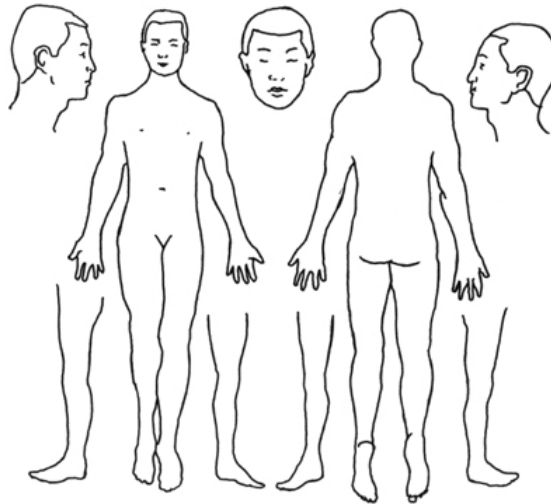
Morning \_\_\_\_\_

Afternoon \_\_\_\_\_

Evening \_\_\_\_\_

Snacks \_\_\_\_\_

**Indicate painful or distressed areas:**



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

<b>General</b>	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Tremors	<input type="checkbox"/> Cravings	<input type="checkbox"/> Change in appetite	
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Bleed or bruise easily	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	
<input type="checkbox"/> Peculiar tastes	<input type="checkbox"/> Desire hot food	<input type="checkbox"/> Desire cold food	<input type="checkbox"/> Strong thirst (cold or hot drinks)		
<input type="checkbox"/> Sudden energy drop (What time of day) _____		Favorite time of year _____		Worst time of year _____	
<b>Skin &amp; hair</b>	<input type="checkbox"/> Rashes	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching	<input type="checkbox"/> Eczema
<input type="checkbox"/> Pimples	<input type="checkbox"/> Acne	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Recent moles	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Purpura	<input type="checkbox"/> Change in hair or skin texture		<input type="checkbox"/> Other?		
<b>Musculoskeletal</b>	<input type="checkbox"/> Joint disorders	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Pain/soreness in the muscles	<input type="checkbox"/> Tremors	
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Swelling of hands/feet	<input type="checkbox"/> Spinal curvature	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hernia
<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Neck tightness	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain
<input type="checkbox"/> Hand/wrist pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Joint Sprain	<input type="checkbox"/> Other?	
<b>Head, eyes, ears, nose, and throat</b>	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Concussions	<input type="checkbox"/> Migraines	<input type="checkbox"/> Glasses/lens	
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Earaches	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Spots in front of eyes	
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeding	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Sores on lips/tongue	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Other?		
<b>Cardiovascular</b>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Fainting
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Other?	
<b>Respiratory</b>	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Difficulty breathing	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Production of phlegm – What color? _____		
<b>Gastrointestinal</b>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gas
<input type="checkbox"/> Belching	<input type="checkbox"/> Black stools	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Abdominal pain/cramps	<input type="checkbox"/> Gallbladder problems	<input type="checkbox"/> Parasites	<input type="checkbox"/> Chronic laxative use	
Bowel movements: Frequency _____		Color _____	Odor _____	Texture/ Form _____	
<b>Neuro-psychological</b>	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Concussion		
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stress	<input type="checkbox"/> Bad temper	<input type="checkbox"/> Bi-polar	
<b>Genital-urinary</b>	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Urgency to urinate	
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Pause of flow	<input type="checkbox"/> Frequent urinary tract infection	
<input type="checkbox"/> Genital pain	<input type="checkbox"/> Genital itching	<input type="checkbox"/> Genital rashes	<input type="checkbox"/> STD	<input type="checkbox"/> Other?	

**Female**     Frequent vaginal infections     Pelvic infection     Endometriosis     Vaginal/genital discharge  
 Fibroids     Ovarian cysts     Irregular periods     Clots     Pain/cramps prior/during periods  
 Breast tenderness     Breast Lumps     Fertility Problems     Hot flashes     Moodiness related to periods  
\_\_\_\_\_ Number of pregnancies    \_\_\_\_\_ Number of births    \_\_\_\_\_ Miscarriages    \_\_\_\_\_ Abortions  
\_\_\_\_\_ Premature births    \_\_\_\_\_ C-section    \_\_\_\_\_ Difficult delivery  
First date of last period \_\_\_\_\_ Age of first period \_\_\_\_\_ Duration of periods \_\_\_\_\_ days, cycle \_\_\_\_ days  
Do you practice birth control ?     Yes     No. If yes, what type and for how long? \_\_\_\_\_  
If you're on birth control pills, what are you taking and for how long? \_\_\_\_\_

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**Male**     Prostate problems     Discharge     Erectile dysfunction     Ejaculation problems  
 Frequent seminal emission     Fertility problems     Painful/swollen testicles     Other

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I have completed this form correctly to the best of my knowledge.

**Signature:**     Adult Patient     Parent or Guardian     Spouse

**Are there any other health issues you want to discuss with us?**

**Signature**

**Date**

## Notification Form Regarding Evaluation of Patient by Physician

*In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, AOMA is required to have you respond affirmatively to the following statements before you may be treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to all of these statements is no.*

(Pursuant to the requirements of section 183.10(a)(11) of this title and section 205.302 V.A.C.S article 4495b, governing the practice of acupuncture)

I (patient's name) \_\_\_\_\_  
am notifying the AOMA Graduate School of Integrative Medicine of the following:

Yes  No I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

**OR**

Yes  No I have received a referral from my chiropractor within the last 30 days for acupuncture. The date of the referral is \_\_\_\_\_, and the most recent date of treatment prior to acupuncture treatment is \_\_\_\_\_. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, 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 and choice whether to follow this advice.

**OR**

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

- OR**
- Chronic Pain
  - Smoking addiction
  - Weight loss
  - Alcoholism
  - Substance abuse

Should I return for treatment for any condition other than my original condition(s) treated at this clinic, I understand it is my responsibility to be evaluated by a physician prior to acupuncture.

\_\_\_\_\_  
Patient Signature Required

\_\_\_\_\_  
Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

\_\_\_\_\_  
Patient Signature Required

\_\_\_\_\_  
Date

\_\_\_\_\_  
Acupuncturist's Signature

\_\_\_\_\_  
Date

## HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the AOMA Graduate School of Integrative Medicine (AOMA) "Notice of Privacy Practices". I understand that I have the right to review AOMA's "Notice of Privacy Practices" prior to signing this document.

I understand that AOMA staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by AOMA or individuals authorized by AOMA. All information that can identify me personally will be removed.

By signing this form, I am giving AOMA authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at AOMA Clinics will be held confidential except in the instance where my safety or the safety of others may be at risk

\_\_\_\_\_  
Patient Name (print) Date

\_\_\_\_\_  
Patient Signature AOMA Privacy Rep/Date

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### Authorization for Release of Health Information (Optional)

I, \_\_\_\_\_, hereby authorize the AOMA Graduate School of Integrative Medicine the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

*Persons/Organizations authorized to receive information: (please print)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Patient's Signature Date

## 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 the student interns and/or the licensed acupuncturists on staff at the AOMA Graduate School of Integrative Medicine (AOMA) who now or in the future treat me while employed by, working or associated with or substituting for AOMA, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my student interns, professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine 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 conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment

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 and conditions of treatment. 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 at the AOMA clinic.

\_\_\_\_\_  
Patient's name (please print)

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Print Name of Patient's Representative (if applicable)

\_\_\_\_\_  
Relationship or Authority of Patient's Rep.

\_\_\_\_\_  
Signature of Patient's Representative (if applicable)

\_\_\_\_\_  
Date Signed