Dr. Poria TCM - New Patient Intake Form

Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Cell Phone #:** _____ **Text?** ☐Y ☐N

Date of Birth: _____ **Blood Pressure:** _____/_____ **Height:** _____ **Weight:** _____

Relationship Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Living with partner ☐Other _____

Other Health Care Providers: _____

Are you or may you be currently pregnant? ☐Y ☐N **How did you hear of our clinic:** _____

Have you been treated by Acupuncture or Oriental Medicine Before? ☐Y ☐N If yes, when? _____

Employer: _____ **Occupation:** _____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=unbearable)

1.

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise/Activity: better no change worse
How much does this affect your life?
1 2 3 4 5 6 7 8 9 10

2.

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise/Activity: better no change worse
How much does this affect your life?
1 2 3 4 5 6 7 8 9 10

3.

When did this start? _____ ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise/Activity: better no change worse
How much does this affect your life?
1 2 3 4 5 6 7 8 9 10

EXERCISE

Do you exercise regularly? If so, what types? What frequency/duration?

HEALTH HISTORY

Check D if you have / had the condition and note the year it started.
Check O if there is a family history of the condition

	You	Year	Family		You	Year	Family
Cancer type(s):	D		O	Osteoporosis	D		O
				Seizure Disorder	D		O
Diabetes	D		O	Thyroid Disease	D		O
Hepatitis	D		O	Rheumatic Fever	D		O
Anemia	D		O	Venereal Disease	D		O
Stroke	D		O	Allergies type(s):	D		O
Aids/HIV	D		O				
Gastritis / Pancreatitis	D		O	Mental Illness	D		O
				Kidney Disease	D		O
Asthma	D		O	Chronic Fatigue	D		O
Pacemaker	D		O	Chronic Pain	D		O
Arthritis	D		O	Diverticulitis/IBS	D		O
Herpes	D		O	Emphysema	D		O
Raynaud's Disease	D		O	Hypo/ Hyperglycemia	D		O
Alcoholism	D		O	Heart Disease	D		O
Lyme Disease	D		O	Addiction	D		O
Elevated Cholesterol	D		O	High Blood Pressure	D		O
Infertility	D		O	Other:	D		O

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American
Current or past eating disorder? ☐Y ☐N

Typical Breakfast:	
Typical Lunch:	
Typical Dinner:	
Typical Snacks:	

HABITS

	Amt/Wk	If quit, yr?		Amt/Wk	If quit, yr?
Coffee/Tea			Alcohol		
Soda			Drugs		
Tobacco			Other:		

Dr. Poria TCM : Health History Form

MEDICATIONS

Please list all Medications, Herbs, and Supplements that you take regularly.

INJURIES & TRAUMAS (PHYSICAL / EMOTIONAL)

When?	What happened?

SURGERIES

When?	What surgery?

CHILDHOOD HEALTH HISTORY

☐Allergies ☐Frequent Earaches ☐Scarlet Fever ☐Forceps Delivery
☐Asthma ☐Frequent Sore Throat ☐Premature Birth ☐Other Birth Trauma: _____
☐Chicken Pox ☐Frequent Cold/Flu ☐Prolonged Labor ☐Other: _____

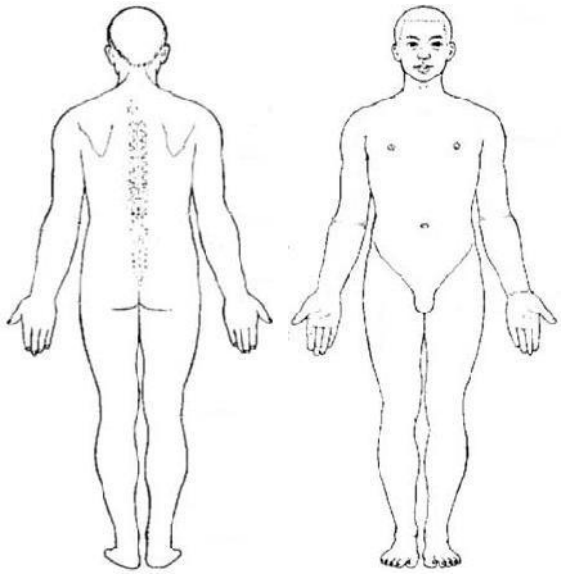
MUSCULOSKELETAL/EXTREMITIES

Pain, Weakness, Numbness in:

☐Head ☐Wrists ☐Legs
☐Neck ☐Hands ☐Knees
☐Shoulders ☐Fingers ☐Ankles
☐Arms ☐Back: U/M/L ☐Feet
☐Elbows ☐Hips ☐Toes

☐Joint Swelling ☐Edema ☐Carpal Tunnel
☐Broken Bones ☐Tendonitis ☐Sprains/Strains
☐Bone Deformities ☐Muscle Pain ☐Rotator Cuff
☐Paralysis ☐Bursitis ☐Poor Balance
☐Whole Body Pain ☐Sciatica ☐Restricted Movement
☐Other _____

Please mark all places on the body where you have any concern →



HEAD, EYES, EARS, NOSE, THROAT

☐Migraines ☐Eye Strain ☐Poor Hearing ☐Sinus Problems ☐Dry Lips/Mouth
☐Poor Vision ☐Dizziness ☐Earaches ☐Sore Throat ☐Dry Throat
☐Blurry Vision ☐Eye Pain ☐Ear Ringing ☐Lip/Mouth Sores ☐Difficulty Swallowing
☐Night Blindness ☐Cataracts ☐Excess Ear Wax ☐Tongue Sores ☐Headaches
☐Glasses ☐Red/Itchy Eyes ☐Nose Bleeds ☐Grinding Teeth ☐Heavy-headed
☐Spots in Eyes ☐Color Blindness ☐Poor Smell ☐Jaw Locks/Clicks ☐Light-headed

CARDIOVASCULAR

☐Shortness of Breath ☐Irregular Heart Beats ☐Blood Clots ☐Bleed/Bruise Easily ☐Phlebitis
☐Slow Heart Rate ☐Palpitations ☐Spontaneous Sweating ☐Chest Pain/Pressure ☐High Blood Pressure
☐Fast Heart Rate ☐Varicose/Spider Veins ☐Fainting ☐Hands/Feet Swelling ☐Low Blood Pressure

RESPIRATORY

☐Cough/Wheezing ☐Pneumonia ☐Difficult Inhale/Exhale ☐Bronchitis
☐Frequent Colds ☐Coughing Blood ☐Pain on Deep Inhalation ☐Phlegm (color:_____)
☐Frequent Fevers ☐Asthma ☐Chest Tightness ☐Difficulty Breathing when lying down

Dr. Poria TCM : Health History Form

GASTROINTESTINAL

BM: How Often? x/ day(s) ☐Black Stools ☐Dry Stools ☐Hiatal Hernia ☐Poor Appetite ☐Excessive Hunger
Stools keep shape? Y/N ☐Bloating ☐Difficult to Pass ☐Hemorrhoids ☐Indigestion ☐Heartburn/Reflux
☐Bowel Incontinence ☐Belching ☐Tired after BM ☐Gas ☐Rectal Pain ☐Nausea/Vomiting
☐Feel a "lump in throat" ☐Bad Breath ☐Cramps w/ BM ☐Blood in Stool ☐Abdominal Pain
☐Peculiar Tastes/Smells ☐Excess Saliva ☐Unsatisfying BM ☐Stomachaches ☐IBS/Crohn'Disease
☐ Chronic Diarrhea ☐ Chronic Constipation

GENITO-URINARY

☐Clear Urine ☐Burning Urine ☐Urgent Urine ☐Fluid in = Fluid out ☐Erectile Dysfunction ☐Testicular Pain ☐Jock Itch
☐Cloudy Urine ☐Painful Urine ☐Frequent Urine ☐Incontinence ☐Decreased Libido ☐Excess Libido ☐Vasectomy
☐Dark Urine ☐Scanty Urine ☐Kidney Stones ☐Difficult Start / Stop ☐Premature Ejaculation ☐Prostate Disease ☐Herpes
☐Blood in Urine ☐Profuse Urine ☐Frequent UTI ☐Genital Pain ☐Nocturnal Emission ☐Genital Sores ☐Hernia

GYNECOLOGICAL

☐Vaginal Dryness ☐Fibroids ☐Cramps ☐Age of First Menses_____ ☐Time Between Cycles:_____ days
☐Vaginal Sores ☐PMS ☐Clots ☐Date of Last Menses_____ ☐Length of Menses:_____days
☐Vaginal Discharge ☐Infertility ☐Breasts Tender ☐Digestive Change w/ Period ☐Menopause: Age _____
☐Irregular Periods ☐Ovarian Cysts ☐Mood Changes ☐Fibrocystic Breast Tissue ☐Number of Pregnancies:_____
☐Painful Periods ☐Heavy Periods ☐Fatigue w/ Period ☐Polycystic Ovarian Disease ☐Number of Births: _____
☐Endometriosis ☐Light Periods ☐Spotting ☐Difficult / Painful Intercourse ☐Lost or Terminated Pregnancy

NEURO-PSYCHO-EMOTIONAL

☐Seizures ☐Nervousness ☐Bi-Polar ☐Angry ☐Concussion ☐Seasonal Affective Disorder
☐Loss of Balance ☐Anxiety ☐Poor Memory ☐Sad ☐Poor Concentration ☐Difficulty Expressing Emotion
☐Vertigo/Dizziness ☐Panic Attacks ☐Forgetful ☐Grief ☐Overthinking ☐Frequently Sigh/Yawn
☐Areas of Numbness ☐Irritable ☐ADD/ADHD ☐Joy ☐Tremors ☐Other:_____
☐Lack of Coordination ☐Depression ☐Indecision ☐Fearful ☐Easily Stressed

ENERGY

☐Wired ☐Fatigue
☐Dependence on Caffeine ☐Body Feels Heavy
☐Energy Drop after Eating ☐Body Feels Weak
☐Sudden Energy Drop: Time of Day: _____
Low 1 2 3 4 5 6 7 8 9 10 High

SLEEP

☐Difficulty Falling Asleep ☐Sleep Walk/Talk ☐Not Rested on Waking
☐Difficulty Staying Asleep ☐Disturbing Dreams ☐Wake____x/night
☐ Excessive Sleep ☐Wake to Urinate ☐Sleep_____hours/night
☐Not Enough Sleep ☐Restless Sleep
Too Little (Insomnia) 1 2 3 4 5 6 7 8 9 10 Too Much (Hypersomnia)

SKIN, HAIR AND NAILS

☐Rashes ☐Eczema ☐Thick Skin ☐Dry Nails ☐Hair Loss ☐Ulcerations
☐Acne ☐Psoriasis ☐Scaly Skin ☐Discolored Skin ☐Dry/Brittle Hair ☐Weak Nails
☐Dandruff ☐Dermatitis ☐Thin Skin ☐Dark Under Eyes ☐Premature Greying ☐Ridged Nail
☐Itching ☐Face Flushing ☐Thin Nails ☐Nail Fungus ☐Recent Moles ☐Change in Skin/Hair Texture
☐Warts ☐Hives ☐Dry Skin ☐Abscesses/Infections ☐Lumps ☐Other _____

Low High

TEMPERATURE & THIRST

☐Cold Hands/Feet ☐Thirst for Cold Drinks ☐Excessive Thirst ☐Hot Flashes ☐Unusual Sweats:
☐Cold "In the Bones" ☐Thirst for Hot Drinks ☐Hot Hands ☐Hot in Afternoon Where on Body: _____
☐Areas of Numbness ☐Thirst, No Desire to Drink ☐Hot Feet ☐Hot at Night What Time:_____am/pm
☐Chills ☐Absence of Thirst ☐Hot Chest ☐Night Sweats ☐ Cold all the time
☐Hot all the time

Portia Barnblatt, DAOM, L.AC
2000 Van Ness Avenue, Suite 310
San Francisco, CA 94109
Phone: (415)828-9896

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of Acupuncture on me (or on the patient named below, for whom I am legally responsible) by Portia Barnblatt, DAOM, L.AC and/or other licensed health professionals who now or in the future treat me while employed by, working or associated with or serving as back-up for Portia Barnblatt. *(Patient Initials_____)*

I understand that methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese Herbal Medicine, and Nutritional/Lifestyle Counseling.

I have been informed that Acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is also a common side effect of cupping. There have been very rare instances reported in the literature of fainting, infections, scarring, spontaneous abortions and pneumothorax. SUCH SERIOUS PROBLEMS HAVE NOT OCCURRED IN THIS OFFICE. We use PRE-STERILIZED, DISPOSIBLE NEEDLES EXCLUSIVELY.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. If I become pregnant, I will inform you. If I experience any gastro-intestinal onset or allergic reaction the herbs/nutritional supplements, I will inform the office immediately. *(Patient Initials_____)*

I do not expect Portia Barnblatt to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. *(Patient Initials_____)*

I understand that all my records will be kept confidential and will not be released without my written consent.

In the event of a dispute regarding possible malpractice, I agree to use biding arbitration rather than the courts.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of Acupuncture and other procedures, and have had the opportunity to ask questions. 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.

PATIENT SIGNATURE	**X** (Date)

HIPAA CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and Physician certifications.

I have been informed by you; of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (please print): _____

Signature: _____

Relationship to Patient: _____ Date: ____/____/____

Portia Barnblatt, DAOM, L.AC.
2000 Van Ness Avenue., Suite 310,
San Francisco, CA 94109
(415) 828-9896

DRPORTIATCM.COM

Acupuncture Financial Policy

We accept cash, check, and credit / debit cards as payment methods. For credit card payment, there will be additional $5.00 charge.

We ask for your cooperation in providing 24-hour notice in advance if it is necessary to cancel or reschedule an appointment. All appointments that are rescheduled or cancelled with less than 24-hour advance notice, and appointments missed without notice, $90.00 fee will be charged.

Returned checks

There will be a $25 charge for any returned checks.

Thank you for your understanding,

Portia Barnblatt, DAOM, L.Ac

I have read and understood the above policies. My signature below constitutes my agreement with the foregoing:

Signature: _____ Date: _____

Printed Name: _____