Bonnie Diamond, Licensed Acupuncturist
Patient Intake Form

All information on this form will be completely confidential. This information will provide the best treatment plan possible. Please print.

Name_____ Phone No. (____)_____ Work No.(____)_____
Address_____City_____State____Zip_____
Date of Birth:_____ Place of Birth_____ Occupation_____
Age____ Height_____ Weight_____ Family Physician_____
Type of Health Insurance_____
In Emergency Notify (list name and phone #)_____
Referred By_____ Other Concurrent Therapies? _____
To receive my electronic newsletter print your email address:_____

Main reason for seeking treatment_____
When did this problem begin? _____
To what extent does this problem interfere with your daily activities? _____
_____
Have you been given a diagnosis? _____

Medical History:
Childhood Illnesses Including Surgery or Accidents:
Age: _____
Age: _____
Adolescence Illnesses Including Surgery or Accidents:
Age: _____
Age: _____
Adult Illness Including Surgery or Accidents:
Age: _____
Age: _____
Age: _____
Age: _____

All **medications** taken within last two months (include vitamins, over-the-counter drugs, herbs, etc.)
_____
_____

Location of all operation or injury scars (even minor ones): _____
_____
_____

Family Medical History (Include all major illness in immediate family such as : Alcoholism, Allergies, Asthma, Cancer, Diabetes, High Blood Pressure, Heart Disease, Hepatitis, Orthopedic Disorders, Rheumatic Fever, Psychological Disorders, Thyroid Disease, Seizures, Stroke)
Family Member: _____
Family Member: _____
Family Member: _____
Family Member:_____

Lifestyle (please list the foods that you eat):
Morning Meal: _____
Afternoon Meal: _____
Evening Meal: _____
Snacks: _____

Do you exercise regularly? What type and how often? _____
How many cups of coffee do you drink per day? _____ tea? _____ cola?_____
How many packs of cigarettes do you smoke per week? _____ for how long?_____
Do you drink alcohol?_____ How many drinks per week?_____
Have you ever been alcohol or drug dependent? _____ when?_____
Please describe any non-medical drug use: _____

Symptom List: Please circle any problem that you have now. Underline items that have affected you in the past

General:

frequent colds or flu	frequent fatigue	loss of appetite
recurrent fevers	easily fatigued	often thirsty
chills	fluctuating energy	rarely thirsty
night sweats	recent weight gain	bruises easily
sweats easily	recent weight loss	tends to feel warm
no perspiration	change in appetite	tends to feel cold

sudden energy drop at what time?_____ strong thirst (hot/cold drinks)?_____

Skin and Hair:

rashes	acne	hives
itching	recent moles	cold sores
eczema	psoriasis	dandruff
loss of hair	warts	fungal infections

change in texture of hair or skin(specify)_____

Head, Eyes, Ears and Throat:

headaches	allergies	sore throats
migraines	sinus congestion	swollen lymph glands
seizures	diminished smell	difficult swallowing
jaw tension	nosebleeds	dry mouth
dental problems	hearing loss	copious saliva
dizziness	ringing in ear	poor vision
gum problems	ear congestion	floaters
night blindness	bleeding gums	other(specify)_____

Respiratory:

cough	shortness of breath	pneumonia
bronchitis	asthma	emphysema
coughing blood	tight chest	wheeze

production of phlegm(specify nose, throat and include color)_____

Cardiovascular:

high blood pressure	heart murmur	edema
fast pulse(>100 beats/min)	low blood pressure	angina/chest pain
dizziness	slow pulse (< 60 beats/min)	fainting
irregular heartbeat	varicose veins	Raynaud's Disease
palpitations	anemia	cold hands/feet
dizzy when standing quickly	other(specify)_____	

Sleep:

diff. falling asleep	shallow sleep	dream disturbed sleep
diff. waking in a.m.		

average number of hours of sleep_____ waking up at night, specify time_____

Gastrointestinal:

nausea	tender abdomen	diarrhea
vomiting	pain or cramps	loose stools
gas	loss of appetite	constipation
belching	heartburn	hard stools
rectal pain	bloody stools	black stools
hemorrhoids	"incomplete" bowel movement	alt. constipation and loose stools

bowel movement: frequency_____ color_____ odor_____ texture/form_____
other(specify)_____

Urinary-Genital:

pain on urination	blood in urine	genital sores
unable to hold urine	scanty urine	prostate problems
frequent urination	cloudy urine	impotence
dribbling urine	profuse urine	kidney stones
bed wetting	bladder infection	kidney infection
wake to urinate; how often_____/night; times_____		other(specify)_____

Pregnancy and Gynecology:

long cycle	light or pale blood	cramps before menses
short cycle	painful periods	cramps during menses
heavy flow	missed periods	irritable before menses
light flow	vaginal discharge	hot flashes
breast lumps	vaginal sores	
number of pregnancies_____	number of births_____	premature births_____
miscarriages_____	infertility_____	trying to conceive_____
currently pregnant_____	morning sickness_____	hysterectomy(date)_____
age at first menses_____	age at start of menopause_____	last menses_____
length of cycle_____	duration of flow_____	
birth control (type and duration)_____		other(specify)_____

Are you currently pregnant?_____

Muscularskeletal:

stiff neck/shoulders muscle aches
back pain(where)_____
joint pain(where)_____
tingling, numbness(where)_____
other(specify)_____

Neuropsychological:

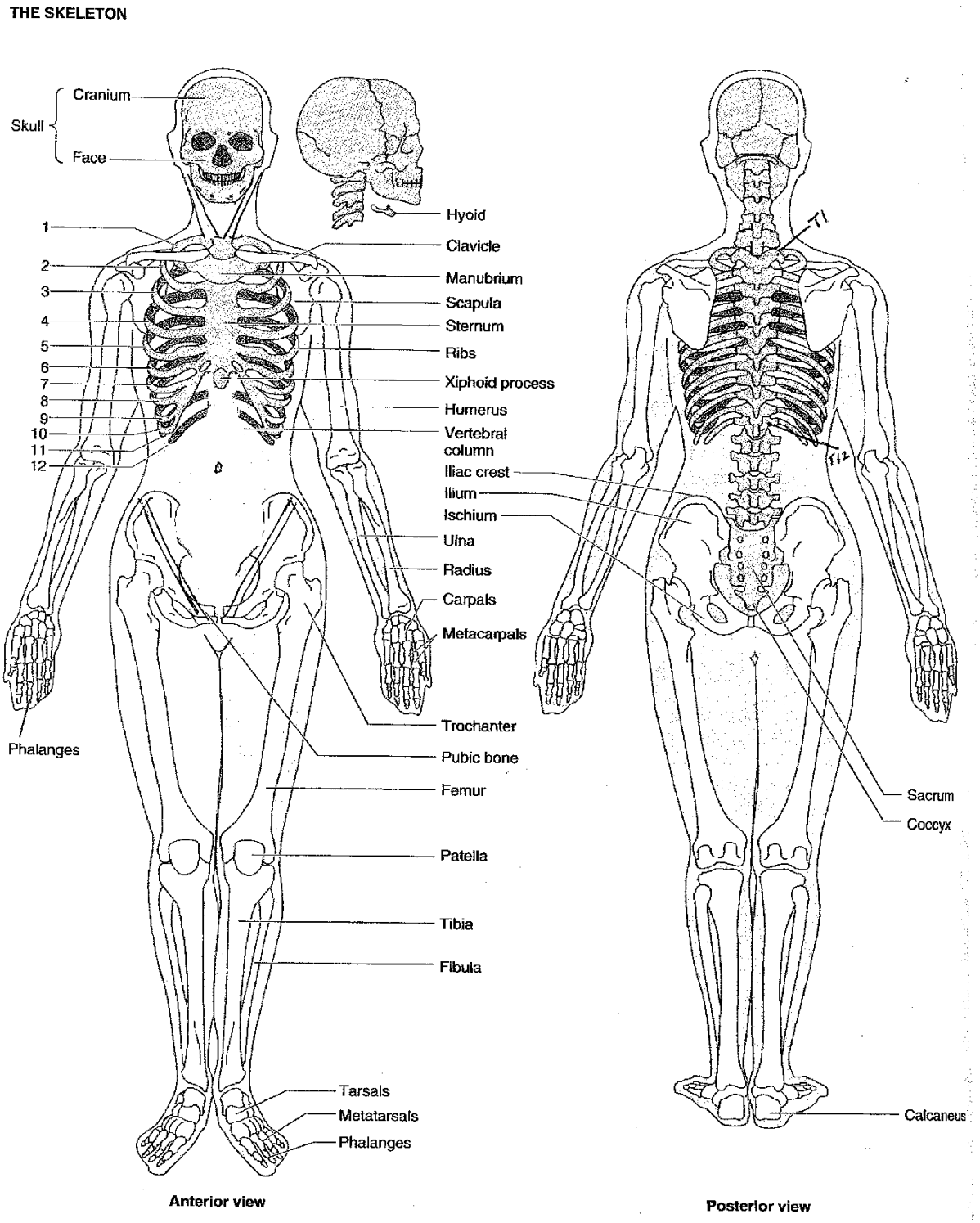
depression	anxiety or fear	concussion
poor memory	bad temper	easily stressed
sadness or grief	indecisive	poor concentration
suicidal feelings		

considered/attempted suicide_____
other(specify)_____

Please write 3 treatment goals:

1)_____
2)_____
3)_____

Please indicate any areas on the picture below where you experience pain or discomfort.



Bonnie Diamond, Licensed Acupuncturist
I am committed to providing quality health care. Health is a collaborative effort and it is my intention that we can work together to reduce symptoms, address the root cause of illness, strengthen the body's ability to heal itself and prevent future pain and suffering. These guidelines will help facilitate treatment.

- Please make it a point of arriving on time so that you have a chance to relax before your treatment. Allow 1 ¼ hours for each visit.
- Payment is due at each visit in the form of either check, cash or credit card. **There is a 48-hour cancellation policy if you cannot make an appointment.** (If are ill or cannot safely get to the office, please contact me before your appointment to reschedule.)
- If your health insurance covers acupuncture, I will provide you with a statement, which you can then submit to your insurance company and they will reimburse you directly.
- If you have any questions or concerns, please feel free to address them with me. Your input is important.

Consent:
I hereby request & consent to the performance of acupuncture treatments & other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by Bonnie Diamond, Lic.Ac.

While acupuncture is one of the safest modalities, I understand that it is possible to experience lightheadedness, minor bruises and occasional discomfort. (Bonnie makes every effect to make sure that your experience is one of relaxation and improved health.) I understand that methods or treatments may include but are not limited to the following kinds of treatments: **Acupuncture, Craniosacral Therapy, Moxabustion** (heating of acupuncture points with an herb), **Cupping** (suction cups used to release energy), **Interdermals & press tacks** (tiny needles left in body with tape for a few days to continue treatment), **Magnets, Electrical Stimulation, Exercise & nutritional recommendations.**

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results 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. _____initials

I give you consent to email or text me appointment reminders & general health information. _____initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____initials

Patient's Name:_____ Patient's Signature_____ Date _____

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.
Patient's Name_____ Representative's Signature_____ Date_____

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