## 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	Pho	ne No. ()	Work No.()_	
Address		City	State Zip	)
Date of Birth:	Place of Birth	0	ccupation	
Age Height	Weight	Family Physic	cian	
Type of Health Insura	nce			
In Emergency Notify	(list name and phone #)			
Referred By	Other Co	oncurrent Therapies	?	
To receive my electro	nic newsletter print you	r email address:		
Main reason for seek	ing treatment			
When did this probler	n begin?			
To what extent does to	his problem interfere wi	th your daily activit	ies?	
	8			
Medical History:	Including Surgery or A	Lagidants.		
Age:				
Adelegação Illnega	s Including Surgery or	. A said anta		
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Age.				
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Age.				<del></del>
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Age				
			over-the-counter drugs, h	
Location of all opera	ntion or injury scars (e	ven minor ones): _		
Cancer, Diabetes, Hig Psychological Disord	gh Blood Pressure, Hearers, Thyroid Disease, Se	rt Disease, Hepatiti eizures, Stroke)	family such as: Alcohol s, Orthopedic Disorders, l	Rheumatic Fever,
Family Member:				
ramily Member:				
ranning Michiel.				
ramily Member:				
	the foods that you eat)			
Morning Meal:				
Ancinoon wicai.				
Livening Mear.				
Snacks:				

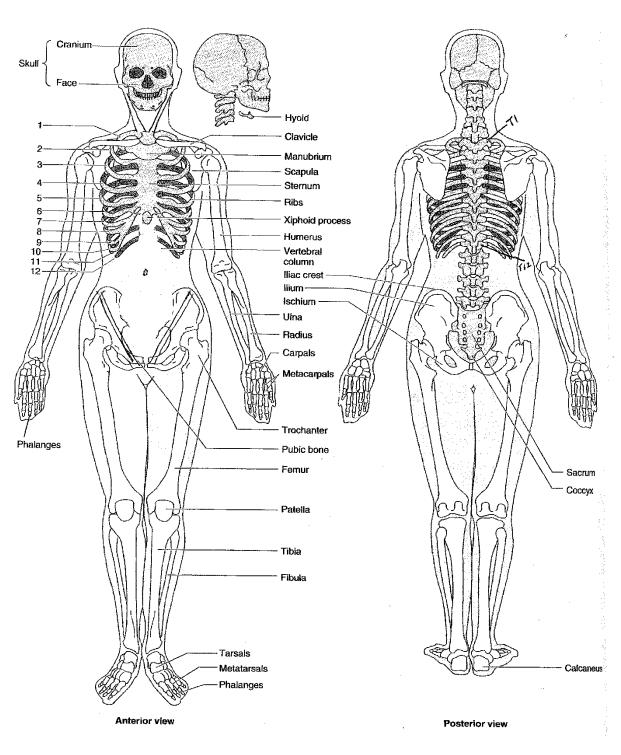
Do you exercise regularly? W	That type and how often?		
How many cups of coffee do	you drink per day? tea?	cola?	-
How many packs of cigarettes	s do you smoke per week?	for how long?	
5 1 1 1 1 10			
Have you ever been alcohol o	or drug dependent? when?		
Please describe any non-medi	cal drug use:		_
			- tad way in
•	e any problem that you have h	ow. Underline items that have affect	ieu you iii
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 thirs	t (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 Throa	nt:		
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 no			_
Cardiovascular:			
high blood pressure	heart murmur	edema	
fast pulse(>100 beats/min)	low blood pressure	angina/chest pain	
dizziness	*		
irregular heartbeat	slow pulse (< 60 beats/min) varicose veins	fainting Raynaud's Disease	
palpitations	anemia	cold hands/feet	
dizzy when standing quickly	other(specify)	cord nands/feet	
	· - • /	_	
Sleep:	1 11		
diff. falling asleep	shallow sleep	dream disturbed sleep	
diff. waking in a.m.		at night angaifuting	
average number of hours of sleep	o waking up	at night, specify time	

the past

vomiting pain or cramps loss of appetite constipation hearthurn hard stools black stools hencorrhoids bloody stools with more profession bloody stools blood	<b>Gastrointestinal:</b>			
loss of appetite   constipation   beloating   heartburn   hard stools   black s	nausea	tender abdomen	diarrhea	
belching heartburn bloody stools recteal pain bloody stools alternorrhoids "incomplete" bowel movement frequency color odor odor texture/form odor odor odor texture/form odor odor odor odor odor odor odor o	vomiting	pain or cramps	loose stools	
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1)	other(specify)			
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2)	1)			
/ <del></del>	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 1/4 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.** 

above consent. I have also had a the above named procedures. I a understand that no guarantee car	a right to refuse any form of treatment. I have rean opportunity to ask questions about its content, a lso understand there is always a possibility of an abe made concerning the results of treatment. I in ent for my present condition and for any future content.	and by signing below I agree to unexpected complication and I attend this consent form to
I give you consent to email or te	xt me appointment reminders & general health in	formationinitials
to coordinate medical treatment,	for my practitioner to contact another one of my to discuss an emergency situation and/or to share my practitioner permission to release my medica	e appropriate medical
I agree to pay the full charge for cancellationinitials	or any missed or forgotten appointments witho	out 24-hour notice of
Patient's Name:	Patient's Signature	Date
To be completed by the patient's Patient's Name	representative, if the patient is a minor, or physic Representative's Signature	cally/legally incapacitated. Date

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