Bonnie Diamond, Licensed Acupuncturist
Roadmap to Health Intake Form

All information on this form will be completely confidential and will help create your Roadmap to Health. Please print.

Name______________________________ Phone No. (____)__________ Work No.(____)_________
Address____________________________________City__________________State____Zip________
Date of Birth:__________ Place of Birth__________________ Occupation______________________
Age____ Height___________ Weight__________ Family Physician___________________________
In Emergency Notify (list name and phone #)____
Referred By____________________ Other Concurrent Therapies? ______________________________
To receive my electronic newsletter print your email address:__________________________________

Please answer ALL questions as honestly as you can. (There are no right or wrong answers.)

What interested you in Roadmap to Health now?

____
____
____
____

What health issues are you looking to address?

____
____
____
____

How do these issues interfere with your life?

____
____
____
____

Is this something that you have worked on before?

____
____
____
____

If so, what was your experience?

____
____
____
____

Do you have a minimum of 15 minutes/day to add a healthy activity to your schedule? _______

Are you willing to give yourself 6 months to create a happier, healthier you? ________

Are you open to looking at a new way of being in the world? _________

Are you willing to be gentle with yourself if you slip back a little ________

Please list any questions you have about this program:

____
____

Any questions you might have (continued)

____
____
____
____

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): ______________________________
____
____

List any allergies that you have: ____
____
____

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: ____

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)____

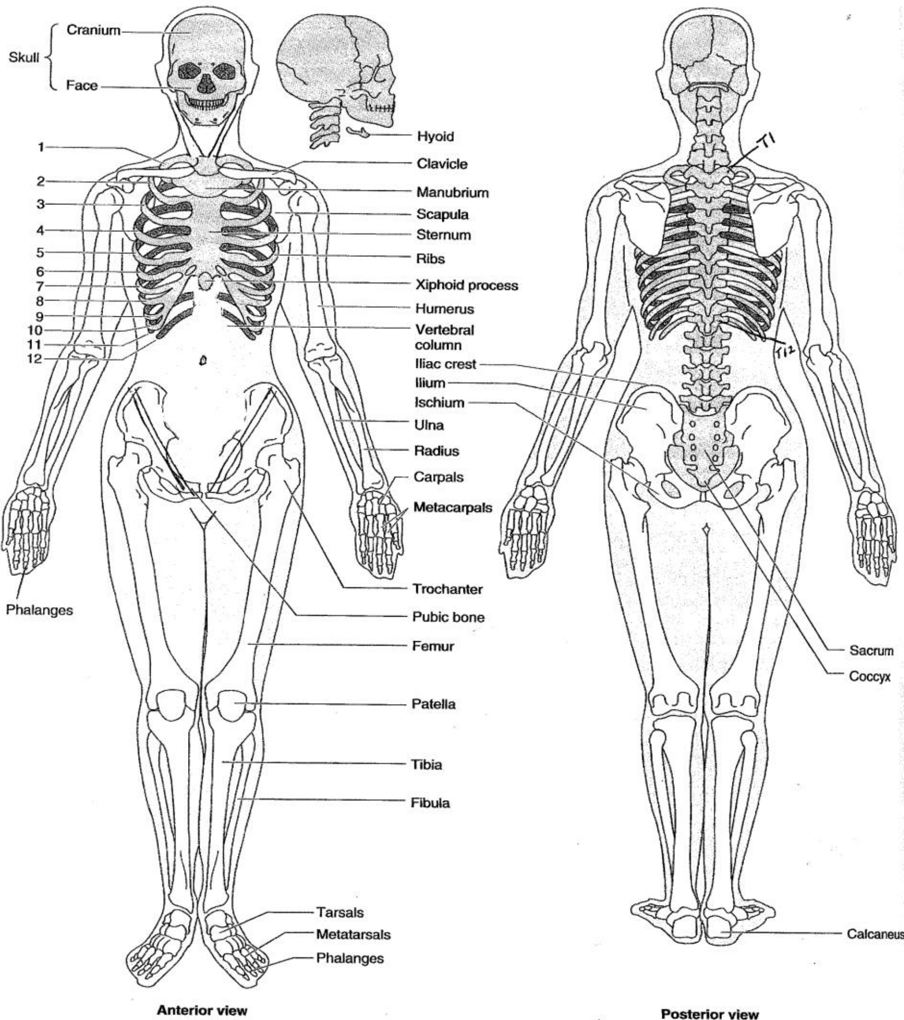
Muscularskeletal:

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
other(specify)____

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 1/2 hour for each visit.

- I agree to pay $99/month for a minimum of 6 months. At the end of each month we'll review how you are doing.

- 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 East Asian 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, 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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