New Patient Health Information

Red Dragon Acupuncture

Please take the time to answer the following questions as thoroughly as possible. This will help us to better address you main symptoms while allowing us to create a more in-depth personalized treatment plan. If the question does not apply to you, please write “none” or “NA” in the field provided.

Name *

Address *

City *

State *

Postal Code *

Telephone Number *

Phone Type

- [ ] Home
- [ ] Cell
- [ ] Work

Ok to leave messages and/or text reminders? Copy

- [ ] Yes
- [ ] No

Email *

Ok to leave messages and/or send reminders?

- [ ] Yes
- [ ] No

Date of Birth *

Gender

- [ ] Male
- [ ] Female

If you were reffered to us, who can we thank? *

Please list your most important health concerns. Include how long the issue has been going on.

Health Concern #1 *

Please rate the intensity of Concern #1 on a scale of 0-10.

(0 being that it doesn't affect your life at all, 10 being that it causes extremel adverse affects to your quality of life.)

Health Concern #2

Please rate the intensity of Concern #2 on a scale of 0-10.

(0 being that it doesn't affect your life at all, 10 being that it causes extremel adverse affects to your quality of life.)

Health Concern #3

Please rate the intensity of Concern #3 on a scale of 0-10.

(0 being that it doesn't affect your life at all, 10 being that it causes extremel adverse affects to your quality of life.)

General Health

Do you have a pacemaker? *

- [ ] Yes
- [ ] No

Have you ever had acupuncture? *

- [ ] Yes
- [ ] No

Are you, or is there any chance, that you are pregnant? *

- [ ] Yes
- [ ] No

If you are pregnant, please include:

1) Your due date and 2) General information about how your pregnancy is going so far

Do you have any known communicable diseases at this time? *

- [ ] MRSA
- [ ] HIV
- [ ] Hepatitis A, B, C, D or E
- [ ] TB
- [ ] other
- [ ] NONE

Please list any communicable disease not listed above

Height *

Weight *

Preferred Weight

Typical Bedtime

Hours of Sleep Per Night

Medications/Supplements/Herbs

Please list any ALLERGIES. If none, please say none. *

Please list all PRESCRIPTION MEDICATIONS and over-the-counter DRUGS.

Please including dose, how often, when you began, and reason for taking.

Please list all VITAMINS, HERBS and SUPPLEMENTS

Please including dose, how often, when you began, and reason for taking.

Diet and Lifestyle

Do you follow a prescribed diet or have food restrictions? If so, please describe.

Please describe a typical day of meals.

Have you ever taken antibiotics?

- [ ] Yes
- [ ] No

If yes, please describe:

Medical History

Please list all major traumas/accidents: *

Please include surgeries, breaks/fractures, potentially fatal bites/stings, cuts requiring stitches, scars longer than 1/2 inch, root canals/fillings/tooth extractions/etc, episiotomy or severe tearing, epidural or other spinal procedure, dislocated joints (including spinal vertebra), head trauma, car/bike/pedestrian accident, etc. If no major traumas, state "none".

Please list any major illnesses or diseases, including those that you may have had in childhood

Please include any cancer, kidney disease, tuberculosis, alcoholism or other drug addiction, diabetes, epilepsy, stroke, obesity, reproductive problems, sexually transmitted diseases, heart disease, arthritis, anemia, cholesterol, blood pressure, mental illness, blood disorders and problems with sense organs.

Please include any recent tests (and results) that you've had in the last year.

Family History

Mother: Current age, Health Problems?

Father: Current age, Health Problems?

Siblings: Current Age, Health Problems?

Review of Systems

Respiration

- [ ] Asthma
- [ ] Allergies
- [ ] Chronic bouts of bronchitis
- [ ] Frequent colds
- [ ] Deep, shallow, unusual breathing
- [ ] Phlegm, sputum
- [ ] Feels like something is stuck in the throat
- [ ] Emphysema
- [ ] Cough
- [ ] Chest tightness

Smoker? Yes or No? (If yes, please include the number of packs smoked per day and the total number of years you have smoked.) *

Any other notes on respiration?

Headaches

- [ ] Stuffy and through the whole head
- [ ] Sinus related
- [ ] Sides of the head
- [ ] Top of the head

- [ ] Back of the head
- [ ] Brow area, near the bridge of the nose
- [ ] Forehead area
- [ ] Temples, at the outer part of the eye

Any other notes on headaches?

Eyes

- [ ] Painful
- [ ] Itchy
- [ ] Swollen, puffy, tender
- [ ] Bloodshot, red
- [ ] Dry, gritty
- [ ] Blurry vision
- [ ] Night blindness
- [ ] Light sensitive
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Glasses, contacts
- [ ] Floaters

Other issues with the eyes?

Nose

- [ ] Frequent nosebleeds
- [ ] Clear, runny discharge
- [ ] Chronic sinusitis

Other issues with your nose?

Ears

- [ ] Ringing, high pitched
- [ ] Constant ringing
- [ ] Low buzz, cicada sounds
- [ ] Hearing loss
- [ ] Buildup of ear wax
- [ ] Frequent ear infections
- [ ] Ear pain
- [ ] Swelling

Other issues with your ears?

Mouth, Throat, Teeth

- [ ] Cavities

- [ ] Discoloration on teeth
- [ ] Tooth pain, sensitivity
- [ ] Grinding teeth
- [ ] Bad breath
- [ ] Bleeding gums
- [ ] Gum disease (periodontitis)
- [ ] Abscess
- [ ] Canker sores, ulcers
- [ ] Sore throat
- [ ] Tonsils removed
- [ ] Snoring

Other issues with your mouth, throat or teeth?

Skin

- [ ] Acne
- [ ] Boils
- [ ] Dry, often have to apply lotion
- [ ] Itching
- [ ] Rashes
- [ ] Hives
- [ ] Recent new moles or marks
- [ ] Warts
- [ ] Poor wound healing
- [ ] Lumps, nodules, cysts
- [ ] Bruise easily
- [ ] Cancers

Any other skin issues?

Hair

- [ ] Changing from curly to straight or vice versa
- [ ] Thinning
- [ ] Falling out in clumps
- [ ] Premature gray
- [ ] Dandruff
- [ ] Oily
- [ ] Dry

Other issues with your hair?

Nails

- [ ] Thin, brittle
- [ ] Ridges, pitting
- [ ] Fungus

- [ ] Discoloration
- [ ] White spots
- [ ] Clubbing
- [ ] "Spoon nails"
- [ ] Separating from nail beds

Other issues with your nails?

Blood/Cardiovascular

- [ ] Anemia
- [ ] Palpitations
- [ ] Irregular heartbeat
- [ ] Chest pain
- [ ] Heart disease
- [ ] Rheumatic fever
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Blood clots/thrombi/emboli
- [ ] Swelling hands/feet
- [ ] Stroke
- [ ] Shortness of breath
- [ ] Varicose veins
- [ ] Easy/frequent bruising
- [ ] Fainting

Other issues with blood/cardiovascular?

Do you give blood? How often?

Gastrointestinal

- [ ] Eating disorder
- [ ] Reflux, GERD, heartburn
- [ ] Pain after eating
- [ ] Abdominal pain, cramps
- [ ] Low appetite
- [ ] High appetite
- [ ] Hungry even after eating
- [ ] Gas, bloating, indigestion
- [ ] Bad breath, gas or stool
- [ ] Ulcers
- [ ] Nausea
- [ ] Vomiting

Food SENSITIVITIES (please include TRUE ALLERGIES at the top of the form)

Liver, Gallbladder, Pancreas

- [ ] Gallstones
- [ ] Diabetes
- [ ] Low blood sugar
- [ ] High blood sugar
- [ ] Liver disease
- [ ] Hepatitis

Any other liver, gallbladder or pancreas issues?

Elimination

- [ ] Constipation
- [ ] Loose stool
- [ ] Diarrhea
- [ ] Liquid diarrhea upon waking up
- [ ] Alternating constipation and diarrhea
- [ ] Floating stool
- [ ] Difficult, slow bowel movements
- [ ] Abnormal colored stool (green, white, clay colored, etc) - please include details in box below
- [ ] Sticky stool (hard to wipe)
- [ ] Bowel movements feel "incomplete"
- [ ] Undigested food in stool
- [ ] Stool like pebbles
- [ ] Pencil thin stool
- [ ] Mucus in stool
- [ ] Bright red blood in stool
- [ ] Coffee colored stool
- [ ] IBS, IBD, Colitis, Crohn's
- [ ] Polyps, fissures, prolapse
- [ ] Hemorrhoids

Anything else about your bowel movements?

Urination

- [ ] Frequent
- [ ] Weak stream
- [ ] Incomplete
- [ ] Incontinence
- [ ] Painful
- [ ] Urgent
- [ ] Waking to pee in the night
- [ ] Bed wetting

Kidney/Bladder

- [ ] Frequent bladder infections

- [ ] Urinary tract infections
- [ ] Kidney stones
- [ ] IC, cystitis
- [ ] Kidney disease
- [ ] Cysts
- [ ] Pain in mid-back

Any other issues with your kidney or bladder?

Immune

- [ ] Epstein Barr Virus
- [ ] MRSA
- [ ] Candidiasis
- [ ] Mononucleosis
- [ ] Frequent colds
- [ ] Complete lack of colds/flu - "never sick"
- [ ] HIV/AIDS
- [ ] Prolonged recovery from illness
- [ ] Chronic fatigue syndrome
- [ ] Swollen lymph nodes
- [ ] Chronic infections

Cancer: Please specify

Other immune issues

Endocrine/Energy

- [ ] Abdomen, cold
- [ ] Easily weak, dizzy
- [ ] Pituitary disorder
- [ ] Addison's disease
- [ ] Night sweating
- [ ] Easily overheated/chilled
- [ ] Spontaneous sweating
- [ ] Cushing's syndrome
- [ ] Weight gain
- [ ] Diabetes Mellitus Type I
- [ ] Diabetes Type II
- [ ] Hot feeling all over
- [ ] Cold feeling all over
- [ ] Significant, unintended weight loss
- [ ] Difficulty rising from bed in the morning
- [ ] Gestational diabetes
- [ ] Hypoglycemia
- [ ] Weakness after sex
- [ ] Hypothyroid

- [ ] Hyperthyroid
- [ ] Lethargy, desire to sleep a lot

Other endocrine/energy issues?

Neurological

- [ ] Concussion, history of
- [ ] Loss of balance, coordination issues
- [ ] Paralysis
- [ ] Dizziness
- [ ] Double vision
- [ ] Stuttering, speech problems
- [ ] Facial ticks
- [ ] Difficulty swallowing
- [ ] Numbness in extremities

Other neurological issues that you have or have had?

Mental-Emotional

- [ ] Agitation
- [ ] Easily frightened
- [ ] Anxiety, excitable
- [ ] Withdrawn socially
- [ ] Overly talkative
- [ ] Bored
- [ ] Panic attacks
- [ ] Insomnia
- [ ] Difficulty falling asleep
- [ ] Restless
- [ ] Stage fright
- [ ] Shy
- [ ] Joylessness, hopelessness
- [ ] Nervous
- [ ] Easily confused
- [ ] "Monkey mind," overly busy mind
- [ ] Apathetic
- [ ] Depression, deep and dark
- [ ] Depression, agitated
- [ ] Depression, grieving
- [ ] Depression, quiet rage
- [ ] Dull mind, forgetful
- [ ] Manic depressive
- [ ] Addictions
- [ ] Angry outbursts, bad temper, explosive
- [ ] Difficult decision making
- [ ] Frustrated easily

- [ ] Scared of the dark
- [ ] Sad
- [ ] Grief, unresolved
- [ ] Easily disappointed
- [ ] Poor self-esteem
- [ ] Poor self-confidence
- [ ] Overly sympathetic
- [ ] Constant worrying
- [ ] Obsessive compulsive
- [ ] Clingy
- [ ] Emotional Eating
- [ ] Want to fix other's problems
- [ ] Hoarding
- [ ] Decreased motivation
- [ ] Disturbing dreams
- [ ] Suicide, thoughts
- [ ] Suicide, attempted

Other mental/emotional comments?

Male reproductive

- [ ] Swollen testes
- [ ] Testicular pain
- [ ] Penile pain
- [ ] Penile discharge
- [ ] Penile sores
- [ ] Rashes, skin issues in groin
- [ ] Erectile difficulty
- [ ] Premature ejaculation
- [ ] Pain after sex
- [ ] Feeling of coldness in genitalia
- [ ] Feeling of numbness in genitalia
- [ ] Hernia
- [ ] Prostate disease
- [ ] Blunt trauma to groin
- [ ] Low libido
- [ ] High libido
- [ ] Lack of responsiveness/sensitivity
- [ ] Frequent (daily) bicycle riding
- [ ] Inability to conceive

Other male reproductive comments?

Men are done here, the rest of the form is for Female Reproductive

Female Reproductive

Menstruation

- [ ] Bright red blood
- [ ] Brown blood
- [ ] Darkly colored blood
- [ ] Clots
- [ ] Excessive bleeding
- [ ] Very little bleeding
- [ ] Tampons
- [ ] Breast tenderness
- [ ] Moodiness beforehand

Age of first menses?

Average # of days of bleeding?

Average length of cycle (from first day of bleeding (Day 1) until the day before bleeding starts again).

Cramping/Pain during menses? If so, please rate on a scale of 0-10:

Ovaries, Uterus, Fallopian tubes, Vagina

- [ ] Ovarian cysts
- [ ] Uterine prolapse
- [ ] Vaginal discharge
- [ ] Yeast infections
- [ ] Vaginal odor
- [ ] Vaginal dryness
- [ ] Endometriosis

C-section? If so, how long ago?

Hysterectomy? If yes, reason and type.

Fibroids? If yes, size?

Breasts

- [ ] Tenderness
- [ ] Lumps
- [ ] Fibrocystic breast changes
- [ ] Discharge

Intercourse

- [ ] Sexually active
- [ ] Pain during intercourse
- [ ] Pain after intercourse

- [ ] Pain after intercourse
- [ ] High libido
- [ ] Low libido
- [ ] Lack of responsiveness/sensation

Fertility

- [ ] Difficulty conceiving?
- [ ] In-vitro fertilization
- [ ] Traumatic Birth
- [ ] Postpartum problems

Other female reproductive comments?

___

# of pregnancies?

___

Live births? Vaginal births? C-sections? VBAC?

___

Miscarriages?

___

Abortions?

___

Menopause

- [ ] Hot flashes
- [ ] Emotional swings
- [ ] Dizziness
- [ ] Fatigue
- [ ] Absent minded
- [ ] Restless sleep, insomnia
- [ ] Cold pain at waist or knees
- [ ] Headaches
- [ ] Breast distention
- [ ] Thirst
- [ ] Vaginal dryness
- [ ] Hot palms and soles of feet
- [ ] Cold limbs
- [ ] Tinnitus
- [ ] Loose teeth
- [ ] Night sweats

Age at which menopause started?

___

Other menopausal symptoms you experienced or are experiencing?

___

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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infectionisanotherpossiblerisk,althoughtheclinicusessteriledisposableneedlesandmaintainsacleanandsafe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff 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. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 an 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.

Signature for Informed Consent to Treat *

Your typed name for electronic signature *

Today's Date *

PRIVACY POLICY

This notice is to inform you that we are in compliance with the law concerning privacy of your health information, HIPAA. This is a short summary; the full length explanation of HIPAA is available to you upon request. If you are concerned about how we may use your information, please read the long version called, “Notices of Privacy Practices.” By signing this form, you acknowledge the understanding of this Notice.

We, at this clinic, do not share your protected health information (PHI) with anyone other than with an entity that you agree to share information with. By signing this form, you agree to allow us to use your information for pertinent reasons: products and services, healthcare operations, and billing for payment of products and services. These reasons are fully described in the “Notices of Privacy Practices.” This type of information includes your name, social security number, birth date, address, insurance company, phone numbers, your health history questionnaire, and any and all related medical charting in regards to products or services we provide to you.

Patients can request to have anyone accompany them in the room during treatment. The patient then acknowledges that personal health information may be shared with this person. We do not share your PHI with anyone else in the clinic other than pertinent staff of the clinic for the purpose of clinic operations.

We have the right to contact you by phone, mail, or email if you list this information in your consent form. This contact could be regarding scheduling, promotions, or other pertinent reasons of the clinic, but we will not give PHI to anyone else as a result of these types of contact.

Please check one *

Please sign here *

Signature for Privacy Policy *

Office Policy

If you need to change or cancel your appointment, please do so with 24 hours notice. Failure to do so will result in being charged the full price of your visit.

Please sign below to indicate that you understand the office policy.

Signature for office policy *

Provider electronic signature

Keith Garofalo, L.Ac.

Form updated 7/28/2016;

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