DEBRA PARDEE, AP, Dipl. AC
Acupuncture & Integrative Medicine
(NCCAOM)®

New Patient Intake Form

Today's Date: _____ / _____ / _____

Name: _____ Birthdate: _____ / _____ / _____

Address: _____ City / State: _____ Zip: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Work Phone: _____

☐ Male ☐ Female Ht _____ Wt _____ Occupation: _____

Referred by: _____

Reason for visit today: _____

How long have you had this condition? _____ Is it getting worse? □ Yes □ No

Does it bother your ☐ Sleep ☐ Work ☐ Other? _____

Have you ever had acupuncture before? ☐ Yes ☐ No

Have you ever had Chinese Herbal Medicine? ☐ Yes ☐ No

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

What hour of the day is it worse? _____ What hour of the day is it better? _____

Are you under a physician's care? ☐ Yes ☐ No

If yes, for what? _____

Your physician's name: _____ Phone: _____

Other concurrent therapies: _____

_____

Medicines taken in the last two months: _____

_____

Vitamins: _____

Herbs: _____

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FAMILY MEDICAL HISTORY

☐ Alcoholism ☐ Arteriosclerosis ☐ Cancer ☐ Heart Disease
☐ Allergies ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Seizures ☐ Stroke

Comments: _____

PAST MEDICAL HISTORY

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Asthma
☐ Birth Trauma (Your own birth)
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Major Trauma
☐ Measles
☐ Multiple Sclerosis
☐ D Surgery (list)
☐ Mump
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever (Car, fall, etc.)
☐ Scarlet Fever
☐ Seizures
☐ Stroke
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping Cough
☐ Other (Specify)

Comments: _____

DIET

Appetite: ☐ Low ☐ High
☐ Coffee ☐ Soft Drinks
☐ Sugar ☐ Salty
☐ Artificial Sweetener
☐ Thirst for water: Number of glasses per day

Comments: _____

AVERAGE DAILY MENU

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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LIFESTYLE

☐ Alcohol ☐Marijuana ☐ Stress
☐ Tobacco ☐ Drugs ☐ Occupational Hazards

Regular Exercise
Type _____ Frequency _____
Type _____ Frequency _____

Comments: _____

GENERAL SYMPTOMS

☐ Poor appetite	☐ Dream-disturbed sleep	☐ Sweat easily	☐ Vertigo or dizziness
☐Heavy appetite	☐ Poor sleep	☐ Night sweats	☐ Muscle cramps
☐Strongly like cold drinks	☐ Heavy sleep	☐ Lack of strength	☐ Poor circulation
☐ Strongly like hot drinks	☐Fatigue	☐ Fever	☐Bodily heaviness
☐ Recent weight loss	☐ Shortness of breath	☐ Chills	☐ Peculiar taste
☐ Recent weight gain	☐ Bleed easily	☐ Bruise easily	

Comments: _____

HEAD, EYES, EARS, NOSE THROAT

☐ Recurrent sore throat	☐Sores on lip or tongue	☐ Glasses	☐ Headache
☐ Eye Strain	☐ Night blindness	☐ Glaucoma	☐ Excessive saliva
☐ Swollen glands	☐ Migraine	☐ Eye pain	☐ Cataracts
☐ Lumps in throat	☐Dry mouth	☐ Concussions	☐ Teeth problems
☐Enlarged thyroid	☐Earaches	☐ Itchy eyes	☐ Grinding teeth
☐ Other head/neck problems	☐ Sinus problems	☐ Red eyes	☐Poor hearing
☐ Spots in eyes	☐ Excessive phlegm	☐ TMJ	☐ Nose bleeds
☐ Poor vision	☐ Facial pain	☐ Gum problems	☐ Ringing in ears
☐ Blurred vision	☐ Color of phlegm: _____		

Comments: _____

RESPIRATORY

☐ Difficulty breathing	☐ Tight chest	☐ Cough: wet or dry	☐ Cough: thick or thin
☐ Difficult when lying down	☐ Asthma / wheezing	☐ Shortness of breath	☐ Coughing blood

Comments: _____

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CARDIOVASCULAR

☐ High blood pressure ☐ Irregular heartbeat ☐ Difficulty breathing ☐Heart palpitations
☐ Low blood pressure ☐ Fainting ☐ Chest pain ☐ Tachycardia
☐ Phlebitis ☐ Blood pressure numbers: _____

Comments: _____

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Bloating ☐ Bad breath
☐ Mucus in stools ☐ Diarrhea ☐ Bloody stools ☐ Constipation
☐ Intestinal pain or cramping ☐ Anal fissures ☐ Gas ☐ Itchy anus
☐ Laxative use ☐ Burning anus ☐ Black stools ☐ Rectal pain
☐Acid regurgitation ☐Hiccup ☐Hemorrhoid

Bowl Movements

Frequency: _____ Texture/form: _____ Color: _____ Odor: _____

Comments: _____

MUSCULOSKELETAL

☐ Neck/shoulder pain ☐ Joint pain ☐ Muscle pain ☐ Rib pain
☐ Upper back pain ☐ Lower back pain ☐ Limited range of motion ☐Limited use

Other: _____

SKIN AND HAIR

☐ Rashes ☐ Dandruff ☐ Hives ☐Itching ☐ Ulcerations
☐ Hair loss ☐ Eczema ☐ Change in hair/skin ☐ Psoriasis ☐ Fungal infections ☐ Acne

Other hair or skin problems: _____

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Depression ☐ Abuse survivor ☐ Numbness
☐ Anxiety ☐ Considered/attempted suicide ☐ Irritability ☐ Poor Memory
☐ Easily stressed ☐ Tics ☐ Seeing a therapist

Other: _____

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GENITO-URINARY

☐ Pain in urination ☐Incomplete urination ☐ Decreased libido ☐ Kidney stone
☐ Frequent Urination ☐ Impotence ☐ Premature ejaculation ☐ Venereal disease
☐ Urgent Urination ☐ Bedwetting ☐ Blood in urine ☐ Wake to urinate
☐ Unable to hold urine ☐ Nocturnal emission ☐ Increased libido

Color of urine: ☐ Dark ☐ Light yellow ☐ Clear ☐ Orange

Comments: _____

GYNECOLOGY

Age menses began: _____ ☐ Clots
Length of cycle (day 1 to day 1): _____ ☐ Breast Lumps
Duration of flow: _____ ☐ Pregnancies: ____ Live births _____ Premature _____
☐ Irregular periods ☐ Painful periods ☐ PMS Age at menopause: _____
☐Vaginal sores ☐ Vaginal odor Date of last PAP: _____
☐ Vaginal discharge (color) _____ Date last period began: _____
☐Birth control: type used _____ Are you pregnant now? ☐ Yes ☐ No

PLEASE LIST ANY SURGERIES AND THEIR DATES

_____

ANY ADDITIONAL COMMENTS

_____

_____

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FINANCIAL POLICY

All patient/guarantors are responsible for payment at the time of service unless prior arrangements have been made.

Self-Pay
Payment for your acupuncture treatment is due at the time of service unless you are on a pre-arranged weekly pay schedule.

Herbal, Nutritional, and Homeopathic Products
All Herbal, Nutritional, and Homeopathic products will be paid at the time of service. No insurance billing will be done for these products.

Insurance
Debra Pardee, A.P., is not a participating provider with any insurance company.

Method of Payment
We accept cash, check, or debit & credit cards

I have read and agree to abide by this financial policy.

_____ _____
PATIENT SIGNATURE DATE

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CONSENT FOR ACUPUNCTURE TREATMENT

Name: _____ Phone: _____

Address: _____ City State: _____ Zip: _____

I hereby voluntarily consent to receive acupuncture treatment from Debra Pardee, A.P., Ph.D., DCN, C.C.P.A., an acupuncturist licensed by the State of Florida. Debra Pardee is not a M.D., I understand that I may be treated with the insertion of needles and/or the application of heat to the skin. If you want to go off of or decrease any medication prescribed by another doctor during your acupuncture treatment process, you must contact the doctor that prescribed them to you. I did not prescribe them to you and I cannot change it or take you off of them

I am aware that acupuncture may result in certain side effects, including temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. I understand that I am free to discontinue treatment at any time.

I will consult my personal physician or any other licensed physician if there is a worsening of the ailment or condition, or if a new condition appears. I will consult a physician if the course of treatment does not improve the condition during an estimated time provided by the acupuncturist at the initiation of treatment.

I have read this form carefully and I have felt free to ask any questions I have regarding this process.

_____ _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

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PRIVACY ACT

The Privacy Act states that the office personnel cannot discuss or give out information regarding your health status to anyone unless you have given prior permission for this office to do so.

If you would like to read the entire Notice of Privacy Practices of this office please ask the person at the front desk for a copy to read.

Please list below family members / friends that you give permission to access your health information.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

_____ _____
PATIENT SIGNATURE DATE

_____
PATIENT NAME (PLEASE PRINT)