



**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: \_\_\_\_\_



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

Comments: \_\_\_\_\_

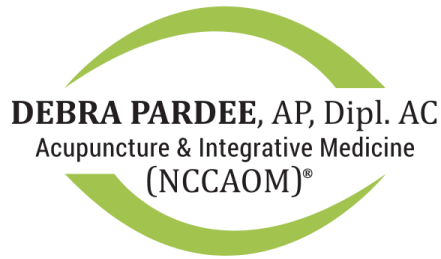
**DIET**

- 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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



**LIFESTYLE**

- |                                  |                                    |   |                  |                 |
|----------------------------------|------------------------------------|---|------------------|-----------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress               | Regular Exercise |                 |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs     | <input type="checkbox"/> Occupational Hazards | Type _____       | Frequency _____ |
|                                  |                                    |   | Type _____       | Frequency _____ |

Comments: \_\_\_\_\_

**GENERAL SYMPTOMS**

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

Comments: \_\_\_\_\_

**HEAD, EYES, EARS, NOSE THROAT**

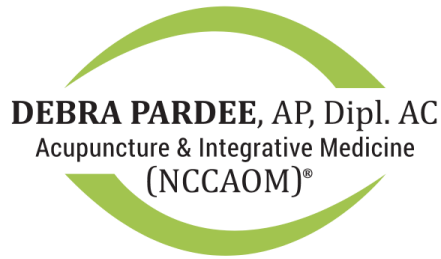
- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Recurrent sore throat    | <input type="checkbox"/> Sores on lip or tongue | <input type="checkbox"/> Glasses      | <input type="checkbox"/> Headache         |
| 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

Comments: \_\_\_\_\_

**RESPIRATORY**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Difficulty breathing      | <input type="checkbox"/> Tight chest       | <input type="checkbox"/> Cough: wet or dry   | <input type="checkbox"/> Cough: thick or thin |
| <input type="checkbox"/> Difficult when lying down | <input type="checkbox"/> Asthma / wheezing | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Coughing blood       |

Comments: \_\_\_\_\_



**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- Phlebitis
- Irregular heartbeat
- Fainting
- Blood pressure numbers: \_\_\_\_\_
- Difficulty breathing
- Chest pain
- Heart palpitations
- Tachycardia

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**

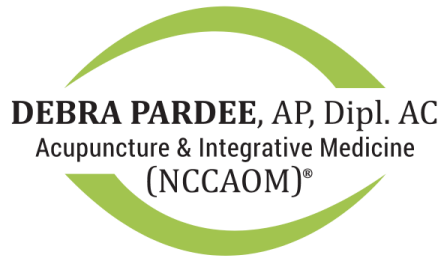
- Rashes
- Dandruff
- Hives
- Itching
- Ulcerations
- Hair loss
- Eczema
- Change in hair/skin
- Psoriasis
- Fungal infections
- Acne

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: \_\_\_\_\_



**GENITO-URINARY**

- Pain in urination
  - Frequent Urination
  - Urgent Urination
  - Unable to hold urine
  - Incomplete urination
  - Impotence
  - Bedwetting
  - Nocturnal emission
  - Decreased libido
  - Premature ejaculation
  - Blood in urine
  - Increased libido
  - Kidney stone
  - Venereal disease
  - Wake to urinate
- Color of urine:  Dark  Light yellow  Clear  Orange

Comments: \_\_\_\_\_

**GYNECOLOGY**

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

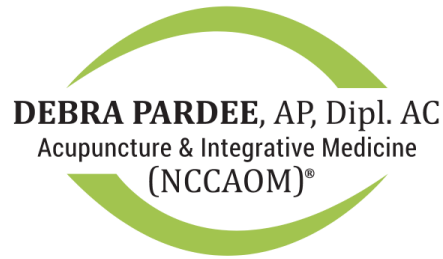
**PLEASE LIST ANY SURGERIES AND THEIR DATES**

\_\_\_\_\_

**ANY ADDITIONAL COMMENTS**

\_\_\_\_\_

\_\_\_\_\_



## 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.

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PATIENT SIGNATURE

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DATE



## 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

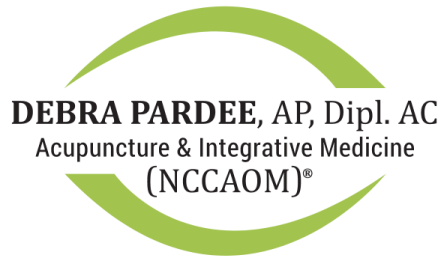
I am aware that acupuncture may result in certain side effects, including temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. I understand that I am free to discontinue treatment at any time.

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



## 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)