Livonia Acupuncture

36616 Plymouth Rd. | Livonia, MI 48150 | Tel: (734) 421-7100 | contact@Livoniaacupuncture.com

Patient Name: **DOB:** **Date:**

NEW PATIENT INTAKE FORMS

Sex: ❑ Male ❑Female	**Height:**	**Weight:**	**State:**	**Zip:**
Address:			**City:**	
E-mail *(only if you would like to be on our mailing list):*				
Phone #: (H)	(W)	(C)	**Can we leave a message, if you are not available?** ○ Yes ○ No	
Occupation:			**Can we call you at work?** ○ Yes ○ No	

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

EMERGENCY CONTACT: Name: **Relationship:** **Phone #:**

How did you hear about us? ❑ Newspaper ❑ Drive-by ❑ Facebook ❑ Google Ads ❑ Yelp ❑ BNI

○ internet search: ___________________________________ ❑ Referral/Other: ____

HEALTH HISTORY

MAIN COMPLAINTS	Intensity	
If you could get rid of any health problems what would you want to get rid of. (please list in the order of importance below), and we will let you know if we can help.	On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = ***no discomfort,*** 10 = ***extreme discomfort***)	
	on **AVERAGE** your complaint is	at **WORST** your complaint is:
1.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
6.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

	Onset	What have you tried doing to resolve these problems that DID NOT work?
	For each condition listed above, please mark when it first began, or when you started experiencing them?	The definition of "did not work" is you tried a treatment and you still experience the symptom(s) or still have the health problem or your labs/tests are only normal because you are taking medication(s) or the treatment did not restore your body's own ability heal itself.
1	Date began:	
2	Date began:	
3	Date began:	
4	Date began:	
5	Date began:	
6	Date began:	

	Frequency	Duration
	Please check the box that best represents how frequent you feel your chief complaint(s):	when you are feeling your symptoms, how long do your symptoms last?
1	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
2	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
3	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
4	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant
5	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant

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6	❑ daily ❑ ___ day(s) per week ❑ ___ day(s) per month ❑ ___ times per month ❑ Other:	❑mins ❑hours ❑days ❑constant

What Aggravates or Alleviates your Chief Complaints?		
	What AGGRAVATES each of the complaints above?	What ALLEVIATES each of the complaints above?
1		
2		
3		
4		
5		
6		

How are your health problems interfering with the following areas of your life?	
Work	
Family	
Hobbies	
Life	

How have you taken care of your health in the past?

Medications	Dietary Modifications	Chiropractic
Surgery	Vitamins & Supplements	Arrosti / Active Release Therapy
Injections	Acupuncture	Massage
Exercise	Chinese Herbal Medicine	Other: ____

How did the previous methods work for you? ____

____

ARE YOU HERE VISITING US, BECAUSE YOU: (please choose one)

a) Just want to get some Relief from your symptoms, and then you'll manage the rest with medication(s)

b) Want to Find & Correct the Root Cause of your Health problem(s), if possible, and Re-train your body to heal itself again so that you can be less dependent upon medications.

c) Other: ____

If we were to sit down and discuss your life <u>3 years</u> from now and look back at today, what would have to have happened for you to be happy with your progress? *(Please take your time and don't sell yourself short!)*

____

____

____

What potential barriers do you foresee that would prevent you from achieving your Health Goals? ___________________________________

____

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Rate on a scale of 1-10 *(1 being lowest, 10 being highest):*

_____ How important is it for you to resolve your health concerns?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

ARE YOU PREGNANT? : ○Yes ○No ○If yes, how far along? ______________________________________

Do you exercise: ○Never ○Daily ○Weekly ○Monthly Explain:____

____

Do your work activities mostly involve: ○ Sitting (time:) ○ Standing (time:) ○ Light Labor ○ Heavy Labor

What is your daily/weekly intake of the following: Caffeine ____________ Alcohol ____________ Nicotine/Tobacco ____________

Illicit Drugs: ○Yes ○No Comments ____

IMAGING & TESTS	DATE (S)	RESULTS *(list area that was imaged)*
X-ray (s)		
MRI (s)		
CT (CAT) Scan (s)		
Ultrasound (s)		
Cholesterol		
Blood Sugar		
Mammagram		
PAP Smear		
Blood Tests (which?)		
Nerve Conduction		

Please check to indicate if you have ever had any of the following:

- ○ Aids/HIV
- ○ Alcoholism
- ○ Allergy Shots
- ○ Anemia
- ○ Anorexia
- ○ Autoimmune Disorder
- ○ Bladder Diseases (UTI, IC)
- ○ Bleeding Disorders
- ○ Blood pressure (too high / too low)
- ○ Bulimia
- ○ Cancer
- ○ Chemical Dependency
- ○ Chicken Pox
- ○ Diabetes (Type 1 / 2)
- ○ Epilepsy
- ○ Gall Bladder Disease
- ○ Goiter
- ○ Gonorrhea
- ○ Gout
- ○ Heart Disease
- ○ Hepatitis
- ○ Infertility
- ○ Kidney Disease
- ○ Liver Disease
- ○ Low Blood Sugar
- ○ Lung Disease (bronchitis, pneumonia, emphysema)
- ○ Measles
- ○ Mononucleosis
- ○ Multiple Sclerosis
- ○ Mumps
- ○ Neuropathy
- ○ Pacemaker, Defibrillator
- ○ Paralysis / Semi-paralysis
- ○ Parkinson's Disease
- ○ Polio
- ○ Prostate Problems
- ○ Prosthesis
- ○ Psychiatric Care
- ○ Scarlet Fever
- ○ Skin Disorders (rash, eczema, psoriasis)
- ○ Stomach Ulcers
- ○ Stroke
- ○ Suicide Attempt
- ○ Thyroid Disease (hyperthyroid, hypothyroid)
- ○ Tuberculosis
- ○ Typhoid Fever
- ○ Whooping Cough

Please list ALL health care providers (family physicians, surgeons, specialists, chiropractors, etc.) currently treating you:

____

____

List ALL disorders you are CURRENTLY being treated for (include the dates of when you were diagnosed):

____

____

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Patient Name: **DOB:** **Date:**

List ALL disorders you have had or been diagnosed with (include the dates of when you were diagnosed):

____

____

List ALL types of Surgeries you have had in the past (Include Dates):

____

____

List ALL Accidents and/or Hospitalizations you have had in the past (Include Dates):

____

____

List ALL Allergies (Food, Medications, Pollen, etc):

____

List ALL Medications (prescription & over-the-counter) you are CURRENTLY taking (include duration of use & Dosage):

____

____

List ALL Nutritional Supplements, Herbs, or vitamins you are currently taking:

____

____

LIST ALL MEDICAL CONDITIONS OF YOUR IMMEDIATE FAMILY:

	MOTHER	FATHER	BROTHERS	SISTERS
age if living				
if deceased, cause of death				
Cancer (s)				
Diabetes				
Heart Disease				
Stroke				
Autoimmune Disorders				
Mental Illness				
Other				

We find that when all of your healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here? ❏ yes ❏ no

IMPORTANT: Complete these documents as thoroughly as possible, please be honest with yourself. Some of the questions that follow may seem unrelated to your condition, BUT they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

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please check all symptoms that you experience either ACUTELY or CHRONICALLY

PAIN SENSATION

- Sharp / Stabbing
- Moving / Shooting
- Burning / Alleviated by cold
- Alleviated by Warmth
- Cramping / Aching
- Numbness / Tingling / Pins & Needles
- Alleviated by pressure
- Fixed
- Sensation of Heaviness, Joint Swelling

PAIN LOCATION

- Headache (top of the head)
- Headache (sides of the head)
- Headache (front, sinuses)
- Headache (Back part of head)
- Chest
- Abdomen (upper)
- Abdomen (lower)
- Sides of Body
- Neck / Shoulder / Upper Back
- Lower Back / Hips
- Arms / Legs / Hands / Feet

DIGESTION

- Abdominal Bloating after eating / Abdominal Bloating and Pain
- Abdominal Discomfort worsened by oil / fatty foods
- Upper abdominal (epigastric) pain, bloating OR Burning
- Lower Abdominal pain radiating into testicles / scrotum
- No Thirst
- Thirsty frequently
- Hiccups, Belching
- Acid Regurgitation / Acid Reflux
- Poor Appetite
- Appetite is Excessive / Constant Hunger
- Nausea / Vomiting

BOWELS

- Constipated w/ dry stools
- Constipation / Difficult defecation
- Diarrhea / Loose Stool
- Diarrhea w/ Foul Smell or spasms
- Watery Stool w/ undigested food
- Frequent Bowel movements but in small quantity
- Borborygmus (rumbling noise in intestines)
- Bloody Stool w/ pus & spasms
- Anus Burning, swelling, itching & pain

CARDIOVASCULAR

- Palpitations / Heart Fluttering
- Chest Pain
- Edema / Fluid Retention in Lower Limbs

MENTAL ACUITY

- Mental Confusion
- Poor Memory
- Lack of Concentration, ADD
- Foggy Brain

PERSPIRATION

- Absence of Sweating
- Frequent & Spontaneous Sweating
- Night Sweats

IMMUNE SYSTEM / ENERGY

- Frequent Common Colds / Infections
- Fatigue, Low Energy
- Low Libido

EMOTIONAL HEALTH

- Anxiety
- Restlessness, Impatient, Irritable, Agitated
- Easily Startled / Frightened
- Depression / Mood Swings / Stressed
- Nervousness

EAR, NOSE, THROAT

- Mouth Ulcers & Sores
- Decreased Sense of Taste
- Sticky Sensation in Mouth
- Bitter Taste in Mouth
- Mouth is Dry / Parched
- Foul Breath
- Throat is Dry / Hoarse Voice / Loss of Voice
- Throat is Scratchy / Tickling
- Feeling of lump in the throat
- Throat is sore, red, swollen
- Loose Teeth / Bad Teeth / Cavities
- Gum Pain & Bleeding
- Sneezing, itchy Nose
- Nasal / Sinus Congestion / Runny Nose
- Nosebleeds / Nose is Dry

RESPIRATORY SYSTEM

- Suffocating sensation in chest
- Shortness of Breath
- Cough that is weak w/ clear thin sputum
- Cough that is dry, hacking
- Cough w/ thin, watery sputum / copious sputum
- Cough w/ thick, sticky, yellow sputum
- Difficulty Breathing esp. when lying down
- Chest Congestion w/ full feeling in chest, heaviness in chest
- Wheezing (Asthma)
- Tendency to Sigh
- Coughing up blood

BODY TEMPERATURE

- Cold hands & feet / Cold Body temp sensation
- Hot Flashes / Heat in hands, feet, chest, head / Hot body temp sensation
- Chills w/ low grade fever
- Fever w/ sweating

SKIN, HAIR, NAILS

- Skin & Hair are dry
- Flushed, red Face
- Pale Complexion
- Hair loss in Head
- Facial Swelling / Puffiness
- Fingernails are brittle

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- Tinnitus / Hearing Impaired / diminished hearing / Hearing Loss

EYE HEALTH

- Blurred Vision / Decrease in Vision / Night Blindness
- Dry Eyes
- Eyes are red, swollen, painful
- Floaters

SLEEP QUALITY

- Waking at 2 or 3 am w/ difficulty falling back asleep
- Difficult falling asleep
- Dream disturbed sleep, Excessive dreaming, wake frequently
- Easily Awakened
- Inability to stay asleep

NERVE HEALTH

- Dizziness
- Vertigo
- Muscle Weakness / Spasm / Numbness
- Tremors / Muscle Twitching
- Facial Paralysis / Partial Paralysis
- Partial Paralysis
- Muscle stiffness
- Unsteady Gait, feels unsteady, poor balance

URINATION

- Frequent & Excessive clear urination
- Scanty, dark, difficult urination, painful urination
- Urinary Incontinence, dribbling after urination
- Frequent, urgent, painful urination
- Sudden interruption to urine stream
- Urine is dark, yellow, cloudy
- Stones / sand in urine
- Blood in urine

MALE ORGAN

- Premature Ejaculation / Involuntary discharge of semen w/o orgasm (spermatorrhea)
- Impotence (inability to achieve erection)
- Testicular pain w/ swelling & burning sensation
- Eczema in Scrotum

FEMALE ORGAN

- Excessive Vaginal Discharge that is clear
- Vaginal Discharge that's yellow w/ foul smell
- Irregular Menses
- Dysmenorrhea (painful period)
- Breast Tenderness
- Menstrual Flow is light
- Menses arrives late
- Amenorrhea (absence of menses)
- Shrinking of the Vagina
- Itching in Vaginal Area

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INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

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, nutritional counseling, and physical medicine services. 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 be 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). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe 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 hereby authorize Guantong Li to release any information regarding my condition to the referring physician (if any) and/or to my insurance for the processing of any claim.

Prior to receiving care a health history and physical examination will be completed. These procedures will assist the practitioner in determining which modalities are needed, or if any further examinations or studies are required. 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.

I have read and understand the above consent form.

Patient's Signature: ____ Date: ____________________

Parent or Legal Guardian (if under 18) printed name: ____

Parent or Legal Guardian Signature: ____