**Bula Wellness**
**Ancient Medicine for a Modern Lifestyle ®**
**Dr. Jodi Knauer, D.Ac., L.Ac.**
**228 S. Washington St, #350, Alexandria, VA 22314**
**571.419.2637 | www.bulawellness.com**

# New Patient Intake Form

## Confidential Information

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process. Download and fill out form online or print first, fill out by pen and bring to your first appointment.

## Patient Information

| | | | |
|---|---|---|---|
| Patient Name: | | Today's Date: | |
| Street Address: | | City/State/Zip: | |
| Age and Date of Birth: | | Gender Identity: | |
| Email: | | Telephone: | |
| Emergency Contact Name: | | Emergency Contact Phone: | |
| Primary Care Provider: | | PCP Phone: | |
| Date of Last Visit to PCP: | | Who can I thank for the referral to Bula Wellness? | |

## Medical History

| | |
|---|---|
| Major complaint/health problem: | |
| How did this condition develop? | |
| Have you received treatment for this? Where? What was the diagnosis? | |
| How long has this condition persisted? | |
| Is there anything that makes it better? Is there anything that makes it worse?: | |

## Significant Trauma, Hospitalizations, Surgeries, Special Studies

| | | | |
|---|---|---|---|
| Trauma: | | Date: | |
| Hospitalizations: | | Date: | |
| Surgeries: | | Date: | |
| Special Studies: | | Date: | |

***Please include auto accidents, falls, illness and well as emotional along with month/year***

**SIGNIFICANT ILLNESSES/PERSONAL HISTORY (PLEASE CHECK ALL THAT APPLY)**

☐ Alcohol/Drug Addiction ☐ Alzheimer's ☐ Arthritis ☐ Anemia ☐ Asthma ☐ Autoimmune Disease

☐ Aids/HIV Positive ☐ Blood Clotting Disorder ☐ Cancer ☐ Chronic Fatigue ☐ Chronic Pain

☐ Connective Tissue Disease ☐ Diabetes ☐ Eating Disorder ☐ Gallstones ☐ Heart Disease

☐ Hepatitis ☐ High/Low Blood Pressure ☐ Kidney Stones/Disease ☐ Prolapsed Organ

☐ Rheumatic Fever ☐ Ruptured Appendix ☐ Seizures ☐ Stroke ☐ Thyroid Disease ☐ Ulcer

☐ Venereal Disease ☐ Other: _____ Do you smoke? (Tobacco/Marijuana) For how long? _____

How much a day? _____

## Allergies

| | | | |
|---|---|---|---|
| Allergy: | | Date of Onset: | |

***Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances?***

## Medications and Supplements

| | | | |
|---|---|---|---|
| Medication: | | Dose: | |
| Supplement and Brand: | | Dose: | |

***Bring all supplement bottles to your first appointment. List under dose how many per day, total dosage amount and how long you have been taking this medication or supplement.***

**OTC/PRESCRIPTION MEDICATIONS TAKEN IN PAST OR CURRENTLY (PLEASE CHECK ALL THAT APPLY)**

☐ Allergy Medication ☐ Antacids ☐ Antibiotics ☐ Anti-Depressants ☐ Birth Control (Pills/IUD) ☐ Cortisone

☐ Heart/Blood Medication ☐ Hormones ☐ Laxatives ☐ Pain Relievers ☐ Sleeping Pills ☐ Thyroid medication

## Exercise, Energy and Dietary

| | | | |
|---|---|---|---|
| How much exercise per week? | | Length of workout? | |
| Activities: | | How is your energy level?: | |
| When is your energy highest?: | | When is your energy lowest?: | |

**TYPICAL DAILY FOOD INTAKE:**

Meals per day ____ # of Snacks per day ____ Caffeinated Drinks per week ____ Alcohol per week ____

| | | | |
|---|---|---|---|
| Breakfast: | | Lunch: | |
| Dinner: | | Snacks: | |
| What foods are your weakness?: | | Prefer warm or cold drinks?: | |
| Excessively thirsty?: | | Special Diet/Eliminate any foods?: | |

## Personal Products and Household Cleaners

| | | | |
|---|---|---|---|
| List all personal products brands including toothpaste and deodorant. | | Do you use organic personal products? | |
| List all household cleaning products. | | Do you use organic household cleaners? | |

## Family Medical History

***Please check any condition that applies to your immediate family:***

☐ Asthma [Parent_____] ☐ Cancer [Parent_____] (type) _____

☐ Diabetes [Parent_____] ☐ Genetic Disorder [Parent_____] ☐ Heart Disease [Parent_____]

☐ High Blood Pressure [Parent_____] ☐ Infertility [Parent_____] ☐ Stroke [Parent_____]

☐ Seizures [Parent_____] ☐ Other Serious Condition _____

## Childhood Illness

**Have you had any of the following Childhood Illnesses (check if yes)**

☐ Diptheria ☐ German Measles ☐ Measles ☐ Mumps ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Negative reactions to immunization/s

## General

Height _____Weight_____ lbs. Weight one year ago _____lbs. Maximum Weight _____lbs. When _____ Blood Type _____

Most recent blood pressure reading? _____/_____Taken When?_____

Most recent blood work/stool analysis/functional medicine lab analysis/imaging? (please email or bring a copy to your first appointment) _____

What goals do you have for your acupuncture treatments?_____

_____

Other Past Treatments Please indicate any other forms of past treatment, both conventional and alternative

_____

Do you have any other comments, concerns, or issues that you would like to discuss?

_____

_____

## Review of Systems

**Mark any symptom you currently experience with a check.**

**GENERAL**

☐ Poor or Change in Appetite ☐ Chills ☐ Bleed/Bruise Easily ☐ Colder than those around you ☐ Weight loss or gain

**NOSE AND SINUSES**

☐ Frequent Colds ☐ Frequent Runny Nose ☐ Loss of Smell ☐ Nose Bleeds ☐ Chronic Infections ☐ Hay Fever ☐ Sinus Congestion ☐ Sinus Problems

**IMMUNE**

☐ Chronic Fatigue Syndrome Glands ☐ Cravings ☐ Night Sweats or Hot Flashes ☐ Warmer than those around you ☐ Fatigue / Low Energy ☐ Slow Wound Healing ☐ Fevers ☐ High Stress ☐ Sweat Easily

**HEAD / NECK**

☐ Headaches ☐ Migraines ☐ Teeth Grinding

**SKIN AND HAIR**

☐ Goiter ☐ Acne, Boils ☐ Fungal Infections ☐ Dry Skin/Scalp ☐ Night Sweats ☐ Recent Moles ☐ Eczema or Psoriasis ☐ Itching ☐ Hair Loss ☐ Change in Hair texture ☐ Weak or ridged nails ☐ Rashes ☐ Redness of Skin ☐ Skin Discoloration ☐ Greasy Hair ☐ Slow healing ulcerations

**MOUTH AND THROAT**

☐ Sore Throat ☐ Sore Tongue/Lips ☐ Copious Saliva ☐ Gum Problems ☐ Trouble Swallowing ☐ Hoarseness

☐ Swollen Glands ☐ Recurrent Sore Throats/Colds

**RESPIRATORY**

☐ Chest Congestion ☐ Difficulty inhale/exhale ☐ Cough ☐ Wet or Dry ☐ Asthma ☐ Pneumonia ☐ Bronchitis

☐ Coughing Blood ☐ Phlegm

**NEUROLOGIC**

☐ Seizures or Tremors ☐ Numbness or tingling ☐ Loss of Balance ☐ Paralysis

**CARDIOVASCULAR**

☐ Chest Pain or Pressure ☐ Palpitations at Rest ☐ Palpitations/ Fluttering ☐ Vertigo or Dizziness ☐ Irregular Heart Beat ☐ Irregular Heart Beat ☐ Varicose Veins ☐ Deep Leg Pain ☐ Shortness of Breath ☐ Easily Stressed

**EYES AND EARS**

☐ Itchy Eyes ☐ Swollen/painful eyes ☐ Spots in Front of Eyes ☐ Double Vision ☐ Ringing ☐ Dry Eyes ☐ Blurred Vision ☐ Color Blindness ☐ Hearing Difficulty ☐ Watery Eyes ☐ Red Eyes ☐ Cataracts ☐ Glaucoma ☐ Earaches/ Infection

**DIGESTION**

☐ Abdominal Pain/Cramps ☐ Change in Appetite/Thirst ☐ Gas/Bloating ☐ Constipation ☐ Heartburn/Acid Reflux ☐ Vomiting ☐ Diarrhea ☐ Mucous in Stools ☐ Nausea ☐ Belching or Passing Gas ☐ Hemorrhoids ☐ Strong Smelling Stools ☐ Crohns ☐ Itchy/Burning Anus ☐ Food in Stools ☐ Excessive Hunger ☐ Black/Bloody Stool ☐ Bad Breath ☐ IBS ☐ Daily Bowel Movements ☐ Stools ☐ Hard ☐ Firm ☐Soft ☐ Loose ☐ Undigested Food ☐ Small Pebbles

**CIRCULATION**

☐ Faintness ☐ Easy Bleeding or Bruising ☐ Cold hands/feet ☐ Dizziness ☐ Anemia ☐ Spontaneous Sweating ☐ Heat or Cold Intolerance ☐ Excessive Thirst ☐ Chest Tightness ☐ Swelling of Hands or Feet ☐ Blood Clots

**ENDOCRINE**

☐ Hypothyroid ☐ Hyperthyroid ☐ Diabetes ☐ Hypoglycemia

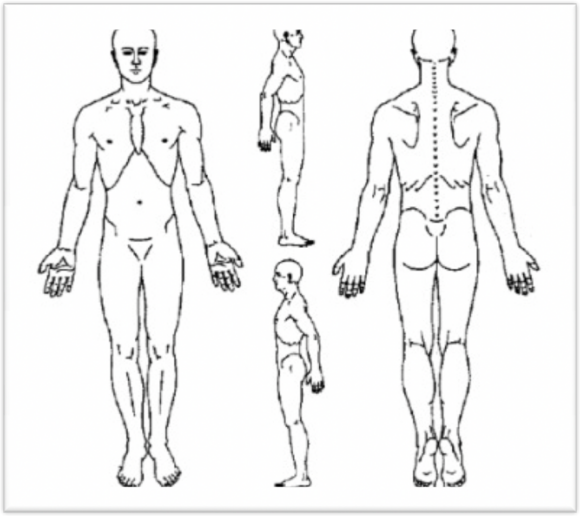
**MUSCLE / JOINT / BONES**

☐ General pain or tightness ☐ Recent injuries from an auto accident or work related ☐ Neck Pain ☐ Arm/Wrist Pain ☐ Back Pain: Low Middle Upper ☐ Jaw Pain ☐ Knee Pain ☐ Sciatica ☐ Muscle Weakness ☐ Shoulder Pain ☐ Muscle Pain/Tension ☐ Weak/Sore Lower Body ☐ Loss of Strength ☐ Heaviness of Limbs ☐ Muscle spasms / cramps ☐ Areas of Numbness ☐ Restless Leg Syndrome ☐ Tingling Sensations ☐ Swollen joints ☐ Arthritis/joint pain ☐ Tendonitis ☐ Bone pain

The pain is (check all that apply): ☐ Sharp ☐ Dull ☐ Aching ☐ Numb ☐ Superficial Pain ☐ Deep Pain ☐ Burning ☐ Tingling Shooting ☐ Pain worse/better with heat ☐ Pain worse/better with cold ☐ Pain worse/better with pressure ☐ Pain worse in am/pm ☐ Pain worse/better with movement Repetitive Strain Injury Fractured Bone(s) - Where?_____

Other_____

**Pain Diagram** (please mark all areas of pain on diagram below) A = aching B = burning N =numbness P = pins & needles S = stabbing pain O = other type of sensation



**MENTAL / EMOTIONAL/ SPIRITUAL**

☐ Mood Swings ☐ Poor Concentration ☐ Weepy ☐ Anxiety or Nervousness ☐ Poor Memory ☐ Sadness☐ Depression ☐ Angry Outbursts ☐ Seasonal Depression ☐ Treated for a psychological concern ☐ Sexual or physical abuse ☐ Considered or attempted suicide ☐ Treated for substance abuse? ☐ Stress level- Low Medium High

Are you currently working with a counselor? If so, who?_____

Most challenging emotion you experience?_____

When do you most often feel this emotion?_____

What experiences or activities bring you the most joy and nourishment?_____

_____

Do you have a spiritual practice?_____

**SLEEP**

How long do you normally sleep? ____ hours per night ☐ Trouble falling asleep ☐ Staying asleep ☐ Dream-disturbed sleep ☐ Waking up at about _____am/pm. ☐ Trouble falling fall back asleep ☐ Poor Sleep

**GENITO-URINARY**

☐ Pain/Burning when urinating ☐ Cloudy Urine ☐ Copious or Scanty Urination ☐ Urinary Tract Infections ☐ Frequent Urination ☐ Night Urination ☐ Inability to hold Urine ☐ Dark or Pale Yellow ☐ Kidney Stones ☐ Blood in Urine

**SEXUAL HISTORY**

Are you sexually active? _____ Do you practice Birth Control? _____ Type? _____

☐ Libido Low ☐ Libido Med ☐ Libido High

☐ Sexually Transmitted Disease ☐ Chlamydia ☐ Genital Warts ☐ Herpes ☐ Other

**FEMALE ONLY**

Age of first menses _____ What was it like for you? _____

Date of last menses _____ Recent menstrual changes If so, what? _____

How many days do you normally bleed? _____ How many days between periods? _____

How heavy is the bleeding? _____ How many pads/tampons per day? _____

What color is the blood? _____ What texture is the blood _____

Painful periods: ☐ If so, how many days does pain last? _____ What makes the pain better?_____

Heaviness or pressure in pelvis with periods ☐

Have you ever gone more than 2 months without getting your period? _____ When? _____

PMS What symptoms_____ When do they start?_____

Bleeding/Spotting between periods When in cycle _____

Do you ovulate regularly?_____ If so, on what day of your cycle?_____ Is ovulation painful?_____

Do you observe cervical mucus changes with ovulation?_____ Bleeding with ovulation?_____

Do any of your symptoms seem to change or worsen around you period? How?_____

Menopausal Symptoms Describe

_____

☐ Irregular Cycles ☐ Pain during Intercourse ☐ Painful Menses ☐ Endometriosis ☐ Pelvic/Tubal Infection ☐ Vaginal Itching/Burning ☐ Breast Lumps ☐ Ovarian Cysts ☐ Polycystic Ovarian Syndrome ☐ Uterine Fibroids/Polyps ☐ Pelvic Inflammatory Disease ☐ Clotting ☐ PMS ☐ Vaginal Odor ☐ Vaginal Dryness ☐ Nipple Discharge ☐ Pelvic Adhesions/Scarring ☐ Bleeding between Cycles ☐ Heavy or Excessive Flow ☐ Vaginal Discharge ☐ Menopausal Symptoms ☐ Breast Pain / Tenderness ☐ Have you ever taken the Pill? ☐ Current or past use of IUD? ☐ Routine Breast Self- Exams

_____ Date of last PAP/Pelvic ☐ Abnormal PAP? When?_____

**PREGNANCY, DELIVERY AND POST-PARTUM**

_____Number of Pregnancies _____ Number of Live Births _____ Number of Abortions

☐ Miscarriage ☐ Ectopic Pregnancy ☐ Difficult or Premature Births ☐ Difficulty Conceiving

Attempting Pregnancy currently? If so, for how long? _____ Currently Pregnant If so, how far along _____

Currently breastfeeding If so, how long? _____ Difficult scanty or painful lactation _____

Post-partum difficulties_____Premature deliveries _____

Difficult deliveries _____ Difficulties in Pregnancy _____

Your birth weight, Full term? Full size? Vaginal or C-Section? Any trauma?

_____

**FERTILITY TREATMENT HISTORY**

Fertility Clinic _____Physician _____

**Western Medical Diagnosis (if any)**_____

**Western Diagnostic Tests & Hormone Panels** (include dates, menstrual cycle date & results)

Hysterosalpingogram (HSG)_____Endometrial Biopsy _____

Clomid Challenge test _____ Follicle Stim. Horm. (FSH)_____

Leutinizing Horm. (LH)_____ Estradiol (estrogen)_____

Progesterone_____ Prolactin_____

Doppler ultrasound (blood flow)_____Hysteroscopy/Saline Infused Sonogram_____

Any additional tests

_____

_____

_____

**GYN related surgeries (dates & outcome)**

_____

_____

_____

**A.R.T. History Intrauterine Insemination (IUI)** Please list each cycle with date, meds used, egg/sperm quality, any complications/side effects, outcome, etc.

_____

_____

_____

**In Vitro Fertilization (IVF)** Please list each cycle with date, type of cycle (fresh, frozen, donor, etc.), meds used, # of eggs retrieved and # fertilized, type of fertilization (ICSI, etc), egg/sperm donor or gestational carrier use, PGD/PGS use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.

_____

_____

_____

**MALE ONLY**

☐ Hernias ☐ Varicoceles ☐ Prostate Disease ☐ Sexual Dysfunction ☐ Testicular Masses ☐ Testicular Pain ☐ Premature Ejaculation ☐ Discharge/Sores ☐ Infertility ☐ Semen Analysis Results?

**MALE FACTOR FERTILITY**

(please include dates, results and any applicable treatment)

Sperm Count (#/cc)_____ Sperm Motility (% moving)_____

Sperm Morphology_____ Sperm Rise ("swim up test")_____

Anti-sperm Antibodies_____ Varicocele (including surgery)_____

Sperm penetration assay (SPA)_____

Any Additional Male Factor Fertility Information:

_____

_____

_____

**HIPPA Notice Privacy Disclosure and Policies:** As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

***Safeguards in place include:*** Limited access to facilities where information is stored. Policies and procedures for handling information. Requirements for third parties to contractually comply with privacy laws. All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

**Public Interaction:** Should I see you socially, by coincidence or intent, I will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is my preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

**Consultations:** I consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, I may gather and maintain information that may include these examples of non-public personal information: From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners. From health care providers, insurance companies, workman's comp and your employer, and other third-party administrators (e.g. requests for medical records, claim payment information)

**Records Release:** Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

**Definition and Penalties to Comply:** Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

***I have read and understand my right to privacy, as stated above, and agree to have Dr. Jodi Knauer, D.Ac. maintain my records confidentially in accordance with the law. I agree to inform Dr. Jodi Knauer, D.Ac. if I need any special arrangements pertaining to this issue.***

Signature_____ Date_____

Print Name_____

**Informed Consent to Receive Treatment**

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above 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 above or any other office or clinic, whether signatories to this form or not. I understand that acupuncturists practicing in the state of Virginia and the District of Columbia are not primary care providers and that regular primary care by a licensed physician is recommended by this clinic's practitioners. I understand that methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, Gua Sha, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated. Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pacemaker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage. I understand the clinical and administrative staff may review my

patient records and lab records 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 conditions and for any future condition(s) for which I seek treatment.

**Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.**

**I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Dr. Jodi Knauer, D.Ac., L.Ac is not a primary care physician.**

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature_____ Date_____

Print Name_____

**FINANCIAL POLICIES**

I request payment for your treatment at the time of service. I take VISA, MasterCard Cash or Check. Payment in full is expected at each visit. It is understood that if you provide a check and it does not clear your bank you will be charged an additional $50 fee on top of your service fee. I can provide a superbill with the proper codes for you to submit for reimbursement by your insurance carrier who may have acupuncture benefits. Initial_____

Missed Appointments. If you miss your appointment or cancel with less than 48 hours notice, you will be charged for the full appointment as I do not double book patients and often have a waitlist. Initial_____

I have read and understand the policies and agree to abide by the guidelines.

Signature of patient or responsible party_____

Date_____

***Thank you for understanding my policies. Please let me know if you have any questions.***