## Patient Intake Form
## Jodi Knauer, L.Ac

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.

Today's Date ___/___/___
Name _____
Date of Birth ___/___/___ Age:_____ Sex: _____
Address_____
City/ State/ Zip _____
Email _____
Telephone: (home)_____ (work)_____ (cell) _____
Emergency Contact Person/Relationship_____
Phone #_____
Who is your Primary Care Physician? _____
Phone # of Primary Care Physician _____
Date of Last Visit to PCP _____
Referrals are the best compliments. Whom may I thank for your referral?_____

What are the concerns for which you are seeking care? (symptoms, diagnosis and date of onset)
1. _____
2. _____
3. _____

What other treatments have you received for any of these conditions? _____
What makes your condition better? (movement, rest, heat, cold, eating, sleeping, crying, screaming, etc)_____
What makes your condition worse? (fatigue, stress, certain foods or times of day, heat, cold, hunger, etc)_____

**Significant Trauma, Hospitalizations, Surgery, X-Rays, Special Studies**
Please include accidents, falls, illness as well as emotional along with month/year
_____
_____

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

**Medications and Supplements**
What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you currently taking?
_____
_____
_____

Circle each that you currently use:

| | | |
|---|---|---|
| Laxatives | Pain Relievers | Antacids |
| Cortisone | Antibiotics | Heart/Blood medication |
| Allergy Medication | Thyroid medication | Sleeping Pills |
| Anti-Depressants | Birth Control Pills | Hormones |

**Exercise, Energy and Dietary:**
How much exercise per week_____ Length of workout _____ Activities _____
How is your energy level?_____ When is it lowest?_____ Highest?_____

**Typical Diet**
Meals per day _____ # of Snacks per day _____
Caffeinated Drinks per week_____ Alcohol per week _____
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
What foods are your weakness?_____
Water intake per day _____Prefer warm or cold drinks _____
Excessively thirsty?_____ Special Diet:_____

**Personal History** Please circle any symptoms you have now or ever have had.

| | | |
|---|---|---|
| Cancer | Diabetes | Seizures |
| Heart Disease | High/Low Blood Pressure | Stroke |
| Anemia | Kidney Disease | Hepatitis |
| Thyroid Imbalance | Asthma | Eating Disorder |
| Arthritis | Ulcer | Alzheimers |
| Auto Immune | Alcohol/Drug Addiction | Chronic Fatigue |
| Blood Clotting Disorder | Prolapsed Organ | Chronic Pain |

Do you smoke? (Tobacco or Marijuana) For how long? _____How much a day?_____
Other serious Health Condition/s? _____

**Family Medical History** Please check any condition that applies to your immediate family: (M) Mother, (F) Father, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

| | | |
|---|---|---|
| High Blood Pressure _____ | Diabetes_____ | Heart Disease_____ |
| Cancer _____ | Stroke_____ | Asthma _____ |
| Seizures _____ | Genetic Disorder _____ | |
| Infertility_____ | Other Serious Condition _____ | |

**Have you had any of the following Childhood Illnesses (check if yes)**
Scarlet Fever ___ Diptheria ____ Rheumatic Fever ____ Mumps _____ Measles ____ German Measles _____ Have you had negative reactions to immunizations? Yes No _____

**General**
Height _____ Weight _____ lbs.
Weight one year ago _____ lbs. Maximum Weight _____ lbs. When _____
Blood Type _____ Most recent blood pressure reading? _____ /_____ Taken when?_____

## Mark any symptoms you currently experience with a (C) and mark ones with a (P) that you have had in the past

**GENERAL**

| | | |
|---|---|---|
| ____ Poor or Change in Appetite | ____ Poor Sleep | ____ Fevers |
| ____ Chills | ____ Cravings | ____ High Stress |
| ____ Bleed/Bruise Easily | ____ Night Sweats or Hot Flashes | ____ Sweat Easily |
| ____ Colder than those around you | ____ Warmer than those around you | ____ Weight loss or gain |
| ____ Libido Low, Med or High | ____ Fatigue / Low Energy | |

**NOSE AND SINUSES**

| | | |
|---|---|---|
| ____ Frequent Colds | ____ Nose Bleeds | ____ Sinus Congestion |
| ____ Frequent Runny Nose | ____ Hay Fever | ____ Sinus Problems |
| ____ Loss of Smell | | |

**IMMUNE**

| | | |
|---|---|---|
| ____ Chronic Fatigue Syndrome | ____ Chronic Infections | ____ Chronically Swollen Glands |
| | ____ Slow Wound Healing | |

**HEAD / NECK**

____ Headaches
____ Migraines
____ Jaw Pain
____ Teeth Grinding
____ Swollen Glands
____ Goiter
____ Recurrent Sore Throats/Colds

**SKIN**

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

**MOUTH AND THROAT**

____ Sore Throat
____ Copious Saliva
____ Teeth Grinding
____ Sore Tongue/Lips
____ Gum Problems
____ Hoarseness

**RESPIRATORY**

____ Chest Congestion
____ Chest Tightness
____ Asthma
____ Difficulty inhale/exhale
____ Phlegm...what color ?
____ Pneumonia
____ Cough ___ Wet or ___ Dry
____ Coughing Blood
____ Bronchitis

**NEUROLOGIC**

____ Seizures or Tremors
____ Paralysis
____ Muscle Weakness
____ Numbness or tingling
____ Easily Stressed
____ Vertigo or Dizziness
____ Loss of Balance

**CARDIOVASCULAR**

____ Chest Pain or Pressure
____ Shortness of Breath
____ Irregular Heart Beat
____ Palpitations at Rest
____ Blood Clots
____ Irregular Heart Beat
____ Palpitations/ Fluttering
____ Swelling of Hands or Feet

**EYES AND EARS**

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

**DIGESTION**

____ Abdominal Pain/Cramps
____ Trouble Swallowing
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Pain or Cramps
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Food in Stools
____ IBS
____ Crohns

Bowel Movements: How Often a Day? ___
Stools ___ Hard ___ Firm ___ Soft ___ Loose ___Undigested Food ___Small Pebbles

**CIRCULATION**

____ Faintness
____ Dizziness
_____ Varicose Veins
____ Easy Bleeding or Bruising
____ Anemia
_____ Deep Leg Pain
_____ Cold hands/feet
_____ Spontaneous Sweating

**ENDOCRINE**

_____ Hypothyroid
_____ Heat or Cold Intolerance
_____ Hypoglycemia
_____ Diabetes
_____ Excessive Thirst
_____ Excessive Hunger
_____ Seasonal Depression

**MUSCLE / JOINT / BONES**

____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Loss of Strength
____ Back Pain: Low Middle Upper
____ Sciatica
____ Heaviness of Limbs

____ Muscle Pain/Tension
____ Weak/Sore Lower Body
____ Muscle spasms / cramps
____ Areas of Numbness
____ Restless Leg Syndrome
____ Tingling Sensations

**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

**MENTAL / EMOTIONAL**

____ Mood Swings
____ Poor Concentration
____ Weepy
____ Anxiety or Nervousness
____ Poor Memory
____ Sadness
____ Depression
____ Angry Outbursts

**FEMALE ONLY**

____ Irregular Cycles
____ Pain during Intercourse
____ Painful Menses
____ Vaginal Itching/Burning
____ Sexually Transmitted Disease
____ Breast Lumps
____ Bleeding between Cycles
____ Heavy or Excessive Flow
____ Vaginal Discharge ? Color ?
____ Menopausal Symptoms
____ Breast Pain / Tenderness
____ Clotting
____ PMS
____ Vaginal Odor
____ Vaginal Dryness
____ Nipple Discharge

Are you sexually active? Yes No
Do you practice Birth Control? Type? _____
Have you ever taken the Pill? _____
Used an IUD?_____
Number of Pregnancies _____
Number of Miscarriages _____
Number of Ectopic Pregnancies ____
Difficult or Premature Births _____
Number of Live Births _____
Number of Abortions _____
Difficulty Conceiving _____
Do you do Breast Self Exams?_____
Date of last PAP/Pelvic _____
Abnormal PAP?_____ When?_____

_____ Ovarian Cysts
_____ Polycystic Ovarian Syndrome
_____ Pelvic Adhesions/Scarring
_____ Bacterial Vaginosis
_____ Endometriosis
_____ Pelvic/Tubal Infection
_____ Chlamydia
_____ Genital Warts
_____ Uterine Fibroids/Polyps
_____ Pelvic Inflammatory Disease
_____ Herpes

**MALES ONLY**

_____ Hernias
_____ Varicoceles
_____ Prostate Disease
_____ Sexual Dysfunction
_____ Testicular Masses
_____ STD
_____ Sexually Transmitted Disease
_____ Testicular Pain
_____ Premature Ejaculation
_____ Discharge or Sores

Are you sexually active? Yes No
Birth Control? Type?
_____ Infertility
_____ Semen Analysis Results?

**Muscles, Joints & Bones Continued:**

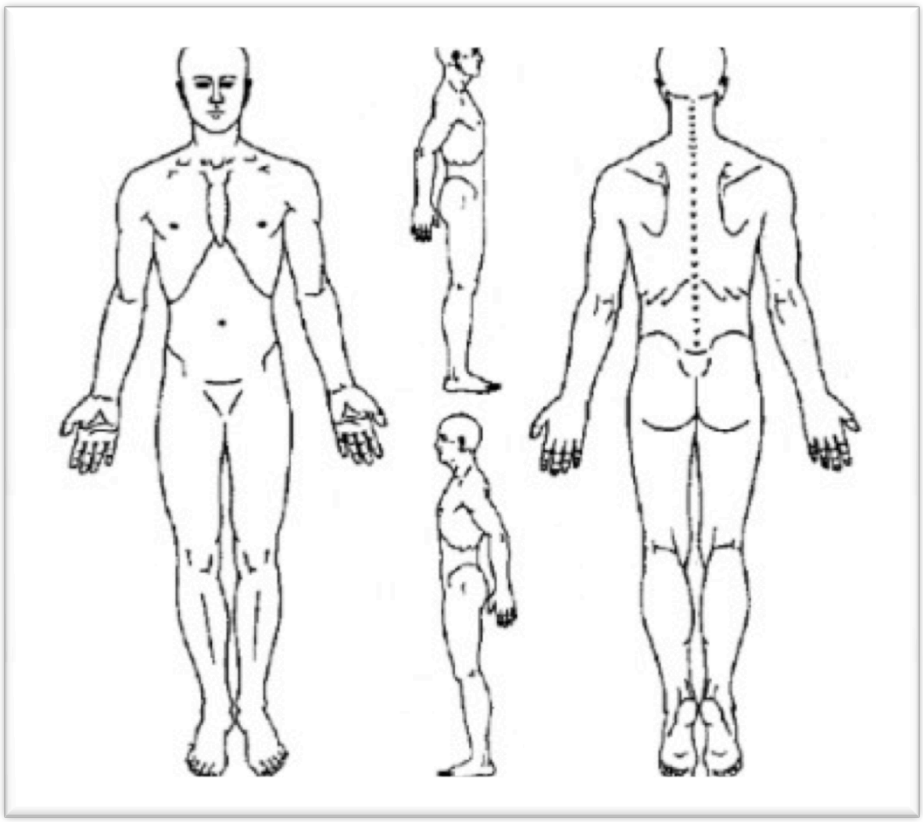
Do you have pain or tightness? Where?_____
Recent injuries ? _____
Was this from an auto accident or work related?_____

The pain is (circle 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

I have (circle all that apply): Swollen joints, Arthritis/joint pain, Tendonitis, Bone pain Muscle cramping, Muscle pain 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 and needles
S= stabbing pain
O= other type of sensation



**Sleep**
How long do you normally sleep? _____ hours per night
I have difficulties with (check all that apply): _____ Falling asleep_____ Staying asleep_____
Dream-disturbed sleep _____Waking up at about _____am/pm and not being able to fall back asleep

**Emotional Health**
Have you ever been treated for a psychological concern? Yes No
Have you experienced sexual or physical abuse? Yes No
Have you ever considered or attempted suicide? Yes No
Have you ever been treated for substance abuse? Yes No
Please rate your overall stress level. Low Medium High
Are you currently working with a counselor? If so, who?_____
If possible, please describe the 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? _____
What goals do you have for your acupuncture treatments?_____
_____
Comments Please describe anything else you would like to discuss. _____

**Gynecological/Reproductive, continued**
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_____
Describe_____
Premature deliveries _____
Difficult deliveries_____
Describe_____
Difficulties in Pregnancy
Describe_____
_____
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? Heavy Average Light How many pads/tampons per day?_____
What color is the blood? Pale red, pink, Red Dark, red, Purple, Brown, Black
Is the blood Watery, Clotted, Mucousy, Thick, Strong odor
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_____
_____

## Fertility Treatment History

We ask that you take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. The more information we have to work with, the better we can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to complete this form.

Name _____ Age_____
Date_____
Fertility Clinic _____
Physician _____
**Western Medical Diagnosis (if any)**_____
_____

**Western Diagnostic Tests & Hormone Panels** (include dates & 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 use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.
_____
_____

**Male Factor** (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) _____
Other male factor concerns _____

**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?**
_____
_____

**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 you 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 Jodi Knauer, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Jodi Knauer, Licensed Acupuncturist 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 Jodi Knauer, 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. Cash or check payments are preferred, but I also take VISA or MasterCard. Payment in full is expected at each visit. 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 24 hours notice, you will be charged for the full appointment as I do not double book patients. 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.

Referred by a Physician? Please provide a copy of the prescription or referral letter