Client Intake Form *(long form)*

Name: _____ **Today's Date:** _____

Age _____ **Birth date**:_____

Location of Birth _____ of **Childhood**:_____

Please indicate birth gender: ❑ **M** ❑ **F** **Please indicate current gender identity**: ❑ **M** ❑ **F** ❑ **Other**

Current Height _____ **Weight**: _____ **Any recent significant changes to weight & when?**_____

Relationship Status: _____ **Number of Children:** _____

Occupation(s): _____

Phone: _____ **Email**: _____

Mailing Address: _____

Emergency contact name & phone number:_____

❑ **I give Vivian Linden, LAc. and her online scheduling software permission to email and/or text me appointment notifications and occasional announcements** *-Please note that our online scheduling software requires your phone and email in order to automatically confirm appointments and send reminders. You are responsible for providing that information and changing it if/when necessary.*

Primary Health Concerns:

PRIMARY CONCERNS: *List by order of importance to you. Please note when the condition/symptoms started and to what degree they interfere with your activities of daily living*
1.
2.
3.
4.

MEDICAL HISTORY

Have you had acupuncture before? ❑ Yes ❑ No
Do you have a **bleeding disorder** that affects clotting & bleeding time? ❑ Yes ❑ No
Are you currently on **anti-coagulant drugs** (warfarin, heparin, etc)? ❑ Yes ❑ No
Is there any possibility that you are currently **pregnant**? ❑ Yes ❑ No
Are you trying to become **pregnant**? ❑ Yes ❑ No
Are you currently **breastfeeding**? ❑ Yes ❑ No
Do you have any **implanted medical devices** (ex: pacemaker)? ❑ Yes ❑ No
Do you have a history of **needle shock** (**fainting** with needles)? ❑ Yes ❑ No
Do you experience **seizures**? ❑ Yes ❑ No
Have you been under the care of a licensed health care professional in the past year? ❑Yes ❑No
If so, for what reasons/conditions?

Please List All:

1. **Notable and/or serious illnesses, trauma, injuries, mental health challenges**:

2. **Hospitalizations** & **Operations:**

3. **Allergies**:

4. **List any other pertinent past & present conditions**
(Please include chronic infections –Hepatitis B/C, MRSA, HIV/AIDS, etc):

Medications, Herbs and Supplements taken regularly, dose, what they are for: *(please include birth control pills & allergy medications. Please note long-term or frequent use of antibiotics)*:

Item	What for	Dose & time taken

FAMILY HISTORY Please check the appropriate boxes and indicate family member.

Condition	Self	Family Member	Condition	Self	Family Member
Cancer (type)			Diabetes (type)		
High Blood pressure			Heart Attack // heart disease		
Stroke (type)			High Cholesterol		
Tuberculosis			Depression // Anxiety		
Thyroid disease (type)			Other mental health issues		
Hepatitis			Suicide/Suicide attempts		
Anemia			Alcohol or Substance abuse		

Caffeine? Source, amount/day:

Smoking? What, how much/day:

History of smoking cigarettes (include quit date if applicable):

Alcohol consumption (what type, amount, frequency):

Drug use (what type, amount, and frequency. *If there is a significant history of drug use, please note this and the substance used*):

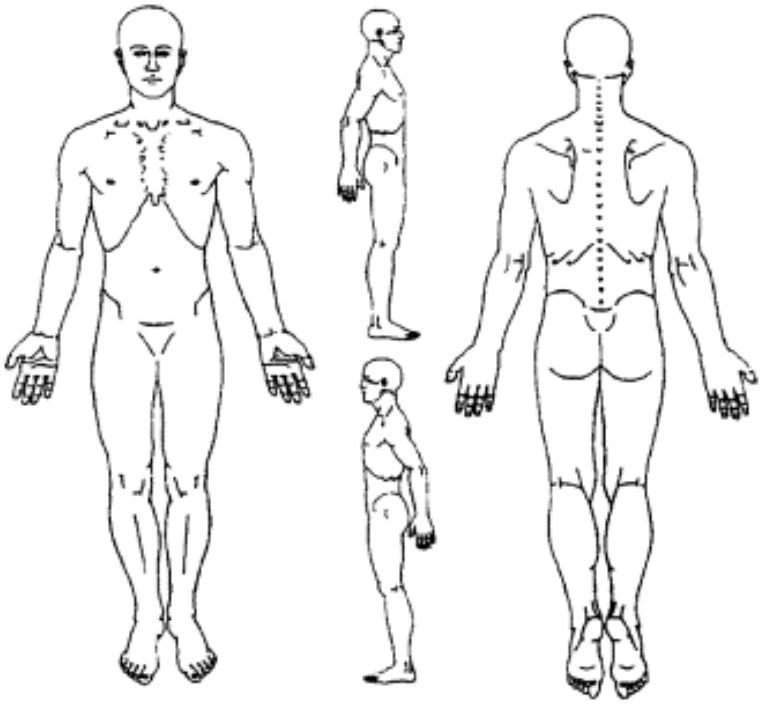
What type(s) of exercise do you engage in and how often?

How is your sleep? **How many hours per night?**_____

Do you often experience high stress? _____ **Current Stress Level** (on a scale of 0-10): _____

How & where do you experience the stress in your body (ex: shoulders, digestion)**?**

Please mark the areas where you are experiencing, or often experience, any kind of pain or discomfort:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General	☐ Poor appetite	☐ Poor sleep	☐ Fatigue	☐ Fevers	☐ Chills
☐ Night sweats	☐ Sweat easily	☐ Tremors	☐ Cravings	☐ Change in appetite	
☐ Poor balance	☐ Bleed or bruise easily	☐ Localized weakness	☐ Weight loss	☐ Weight gain	
☐ Peculiar tastes	☐ Desire hot food	☐ Desire cold food	☐ Strong thirst (cold or hot drinks)		
☐ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____					
Skin & hair	☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching	☐ Eczema
☐ Pimples	☐ Acne	☐ Dandruff	☐ Dry skin	☐ Recent moles	☐ Loss of hair
☐ Purpura	☐ Change in hair or skin texture		☐ Other?		
Musculoskeletal	☐ Joint disorders	☐ Muscle weakness	☐ Pain/soreness in the muscles		☐ Tremors
☐ Cold hands/feet	☐ Difficulty walking	☐ Swelling of hands/feet	☐ Spinal curvature	☐ Back pain	☐ Hernia
☐ Numbness	☐ Tingling	☐ Paralysis	☐ Neck tightness	☐ Neck pain	☐ Shoulder pain
☐ Hand/wrist pain	☐ Hip pain	☐ Knee pain	☐ Joint Sprain	☐ Other?	
Head, eyes, ears, nose, and throat		☐ Dizziness	☐ Concussions	☐ Migraines	☐ Glasses/lens
☐ Eye strain	☐ Eye pain	☐ Color blindness	☐ Night blindness	☐ Poor vision	☐ Cataracts
☐ Blurry vision	☐ Earaches	☐ Ringing in ears	☐ Poor hearing	☐ Spots in front of eyes	
☐ Sinus problems	☐ Nose bleeding	☐ Sore throat	☐ Grinding teeth	☐ Teeth problems	☐ Facial pain
☐ Jaw clicks	☐ Sores on lips/tongue	☐ Difficulty swallowing	☐ Other?		
Cardiovascular	☐ High blood pressure	☐ Low blood pressure	☐ Chest pain	☐ Palpitation	☐ Fainting
☐ Phlebitis	☐ Irregular heartbeat	☐ Rapid heartbeat	☐ Varicose veins	☐ Other?	

Respiratory	☐ Cough	☐ Coughing blood	☐ Wheezing	☐ Difficulty breathing
☐ Bronchitis	☐ Pneumonia	☐ Chest pain	☐ Production of phlegm – What color? _____	
Gastrointestinal	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation ☐ Gas
☐ Belching	☐ Black stools	☐ Blood in stools	☐ Indigestion	☐ Bad breath ☐ Rectal pain
☐ Hemorrhoids	☐ Abdominal pain/cramps	☐ Gallbladder problems	☐ Parasites	☐ Chronic laxative use
Bowel movements: Frequency _____		Color _____	Odor _____	Texture/ Form _____
Neuro-psychological		☐ Loss of balance	☐ Lack of coordination	☐ Concussion
☐ Depression	☐ Anxiety	☐ Stress	☐ Bad temper	☐ Bi-polar
Genital-urinary	☐ Painful urination	☐ Frequent urination	☐ Blood in urine	☐ Urgency to urinate
☐ Kidney stones	☐ Unable to hold urine	☐ Dribbling	☐ Pause of flow	☐ Frequent urinary tract infection
☐ Genital pain	☐ Genital itching	☐Genital rashes	☐ STD	☐ Other?

Dietary Restrictions: ((Vegan)) ((Vegetarian –eggs, dairy, etc)) ((Omnivore)) ((Gluten-free))

((Diet high in vegetables)) ((Favor Organic foods)) ((Favor non-organic foods))

**Are you regularly eating commercial/feedlot/factory-farmed animal products?*

**Do you regularly consume processed foods and/or a high sugar diet?*

**Are you aware of the health concerns associated with GMO (genetically modified) foods?*

Meals: *Please indicate the general time of day for each meal and the commonly eaten foods for each meal*

Breakfast:

Lunch:

Dinner:

Snack(s):

Appetite: ((high)) ((low)) ((variable))

Do you regularly experience cravings? What foods/flavors do you crave?

Thirst: ((High)) ((Low)) **How much water do you drink daily?**_____

Temperature preference of drinks: ((Icy)) ((Room Temperature)) ((Warm))

Digestion: ((Gas)) ((Bloating)) ((Heartburn)) ((Acid Reflux/GERD))

Bowel Movements: How often & what time of day, consistency/color, undigested food bits?
((Constipation)) ((Diarrhea)) ((IBS/IBD))

For women only:

Duration of typical cycle (from day 1 of menses onset until menses starts again):_____

Do you practice Birth Control? What type? _____

Do you experience PMS? *Please indicate symptoms such as bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.* _____

Do you experience and/or have a history of: *check all that apply*

Irregular periods		Polycystic Ovaries (PCOS)	
Fibroid Cysts on uterus		Endometriosis	
Vaginal Discharge		Fertility Challenges	
Painful breasts		Fibrocystic Breast changes	
Clotting with menses		Bleeding between periods	
Menstrual Cramps		Hot Flashes	
Pain with sex		Night Sweats	
(other)		(other)	

Age at first menses _____ # of pregnancies _____ # of births_____

# of miscarriages _____ # of abortions _____ # of C-Sections_____

Have you been through menopause? Age? _____

Have you had a hysterectomy (full or partial)? _____

Do you use Hormone Replacement Therapy (HRT)? *This question also applies to transgender clients* _____

For men only:

Prostate Issues?

Urinary hesitancy related to prostate issues?

Erectile dysfunction/impotence?

Fertility challenges?

Ejaculatory pain?

Do you or have you used medication to stop/slow balding?

Is there anything else you would like to tell us about that was not covered above?

What would you most like to get out of your work with us?

Cancellations, Financial Policy Agreement, and Electronic Communications Waiver

1. *We are in-network with several insurance companies and can attempt to bill out-of-network for other plans.* ***<u>This does not mean that your insurance company will cover acupuncture for your particular condition(s).</u>*** *Please check your benefits carefully! We are happy to work with you to make acupuncture affordable if you don't have insurance coverage -see below.*

2. ***Payments and Co-payments are expected in full at the time of the appointment.***

3. *Prices for goods and services may change or increase periodically to reflect changes in the cost of doing business. We will always strive to keep prices affordable and to honor the loyalty of our regular customers. Please let us know if we need to discuss a sliding scale fee in order to make a regular course of treatment possible.*

4. *We accept* ***credit cards****,* ***HSA/FSA credit cards****,* ***CashApp,*** *and* ***ApplePay,*** *as well as* ***checks*** *and* ***cash*** *for payment.*

5. *If you must miss or reschedule an appointment,* ***please make every attempt to notify us at least 24-48 hours in advance****. Repeated late cancellations will require pre-payment for future appointments.*

6. *If you choose* ***to communicate with us over regular email****, it is your responsibility to understand and accept the inherent privacy risks involved.*

7. *This practice and the appointment software it uses, utilize text and email for appointment reminders and notifications. By choosing to conduct business with this practice, you accept these communication formats.*

8. *We do not share your contact information. We rarely send out newsletters.*

I have read and understand the Financial and Cancellation policies

I understand and accept the risks of communicating over email (or will use another method)

I accept communication via text/email from the practitioner and the booking software.

I have completed this form correctly and to the best of my knowledge

_____ _____

Signature ☐ Adult patient ☐ Parent or Guardian ☐ Spouse Date