PATIENT INTAKE FORM

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

BRITTANY PHILLIPS M.AC., L.AC.
CELL (443) 392 6044
EMAIL BPHILLIPS424@GMAIL.COM

IDENTIFICATION

Name ____ Sex o M o F Date ____________

Address ______________________ City__________ State _________ Zip ___________

Telephone: Home _______________ Work _________________ Cell __________________

Date of Birth __________________ Age _________ Email _________________________

o Single o Married o Partnered o Widowed oSeparated/Divorced

Height ________ Weight ________ Occupation ____________________________________

Emergency contact _____________________________ Relation _____________________

Emergency contact telephone: Home ________________ Cell __________________________

Primary Complaints or Symptoms ____

____

____

PERSONAL LIFESTYLE HABITS

For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Coffee/Tea (cups per day) _________ Soda (regular or diet) ____________________

Exercise o Yes o No How often? ___________ What kind of exercise? __________________

Cigarettes___________ (packs per day) ______________

Alcohol____________ (drinks per week) ____

Drug use (recreational) o Yes o No How often? ____________________________________

FAMILY HISTORY

Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an “X” or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/ partner	childr en
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/ stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)	N/A					

MEDICAL

If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

YEAR OPERATION/ ILLNESS HOSPITAL OR TREATMENT LOCATION

MEDICINES

Please list all medications, vitamins and/or food supplements you are currently taking:

Medication ________________________ Dosage ________ For what condition?__________________

Medication ________________________ Dosage ________ For what condition? __________________

Medication ________________________ Dosage ________ For what condition? __________________

Vitamin ____________________________ Dosage __________ For what condition? __________________

Vitamin ____________________________ Dosage __________ For what condition? __________________

Vitamin ____________________________ Dosage __________ For what condition? __________________

Food Supplements ____________________________ For what condition? ____________________________

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

General

_____ Insomnia
_____ Dreams/nightmares
_____ Fatigue
_____ Poor memory
_____ Strongly like cold drinks
_____ Strongly like hot drinks
_____ Recent weight gain/loss
_____ Cold hands/feet
_____ Chills
_____ Fever
_____ Bad breath
_____ Other (describe
____
____

Head & Neck

_____ Headaches
_____ Migraines
_____ Stiff neck
_____ Dizziness
_____ Fainting
_____ Swollen glands
_____ Other (describe)
____

Nose, Throat & Mouth

_____ Sinus Infection
_____ Hay fever/allergies
_____ Frequent sore throat
_____ Difficulty swallowing
_____ Mouth/tongue ulcers
_____ Frequent colds
_____ Nosebleeds
_____ Dry nose
_____ Nasal congestion
_____ Loss of voice
_____ Thirst
_____ Excessive phlegm
_____ TMJ
_____ Facial pain
_____ Gum problems
_____ Dental problems (last visit)
____
_____ Other (describe)
____

Ears

_____ Ringing
_____ Hearing Loss
_____ Infections
_____ Earache
_____ Vertigo
_____ Hearing Aids
_____ Other (describe)
____

Cardiovascular

_____ High blood pressure
_____ Low blood pressure
_____ Chest pain/tightness
_____ Palpitations
_____ Rapid heart beat
_____ Irregular heart beat
_____ Poor circulation
_____ Swollen ankles
_____ Phlebitis (vein inflammation)
_____ Anemia
_____ History of heart disease
_____ Heart murmur
_____ Night sweats
_____ Tendency to be cold
_____ Tendency to be warm
_____ Other (describe)
____

Musculoskeletal

_____ Joint pain/swelling
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Limited range of motion
_____ Pain (describe)
____
____
____

Eyes

_____ Glasses/contacts
_____ Blurred vision
_____ Poor night vision
_____ Spots or floaters
_____ Eye inflammation
_____ Double vision
_____ Glaucoma
_____ Cataracts
_____ "Lazy" eye
_____ Other (describe)
____

Neurological

_____ Seizures
_____ Tremors
_____ Numbness/tingling
_____ Pain (describe)
____
_____ Paralysis
_____ Poor coordination
_____ Other (describe)
____
____

Skin

_____ Hives
_____ Rashes
_____ Eczema/psoriasis
_____ Night sweating
_____ Excess sweating
_____ Dry skin
_____ Easily bruised
_____ Changes in moles/lumps
_____ Itching

Respiratory

_____ Difficulty breathing
_____ Wheezing
_____ Asthma
_____ Chronic cough
_____ Wet cough
_____ Dry cough
_____ Coughing up phlegm
_____ Coughing up blood
_____ Shortness of breath
_____ Tight chest
_____ Pneumonia
_____ Other_________________
____

Male Genital

_____ Impotence
_____ Premature ejaculation
_____ Nocturnal emission
_____ Pain/itching of genitalia
_____ Lumps in testicles
_____ Increased libido
_____ Decreased libido
_____ Breast checked
_____ Other (describe)
____

Gastrointestinal

_____ Indegestion
_____ Stomach Pain
_____ Diarrhea
_____ Constipation
_____ Poor Appetite
_____ Excessive Hunger
_____ Vomiting
_____ Gas
_____ Hiccups
_____ Acid Regurgitation
_____ Bloating
_____ Bloody Stool
_____ Other (describe)
____
____

Trauma (list)

____
____
____
____
____
____
____

Other Information

____
____
____
____
____
____
____
____
____
____

Mental/Emotional

____ Depression
____ Mood swings
____ Irritability
____ Difficulty relaxing
____ Loneliness
____ Sensitive
____ Shyness
____ Frequent crying
____ Worries frequently
____ Compulsive behaviors
____ Difficulty focusing
____ Hopeless outlook
____ Suicidal thoughts
____ Lose temper
____ Frustration
____ Other (describe
____

Gynecology (women only)

____ # of pregnancies
____ Currently pregnant
____ # of live births
____ # of miscarriages
____ # of abortions
____ Endometriosis
____ Menopause
____ Irregular periods
____ Menstrual cramps
____ Excessive blood flow
____ Menstrual blood clots
____ Breast tenderness
____ Abnormal pap smear
____ Vaginal infections
____ Vaginal pain/itching
____ Uterine fibroids
____ Breast lumps/cysts
____ Increased libido
____ Decreased libido
____ Other (describe)
____
____

Infection Screening

(Self or Significant Other)

____ History of STDs
____ HIV risk: self or partner
____ TB: self or household
____ Hepatitis risk
____ Other (describe)
____
____

Urinary

____ Pain on urination
____ Frequent urination
____ Urgent urination
____ Blood in urine
____ Incontinence
____ Incomplete urination
____ Bedwetting
____ Wake to urinate
____ History of UTI
____ Kidney (specify)
____
____

Other (describe)
____

I accept cash, checks, credit (Visa, MC, Discover, Amex). Please make checks payable to Arrowhead Acupuncture, LLC.

CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please give a 24 hour notice to ensure that you will not be charged. I am however flexible with personal and family emergencies.

If less then 24 hours notice is given and I am unable to fill your time slot or I am unable to reschedule you in the same week, you will be expected to pay for the missed appointment.

SIGN: ____ DATE:_____________

PRIVACY PRACTICES

Your health information will be routinely used for treatment, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

***** Treatment- Information obtained by you will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.

* Payment- Your record will be used to receive payment for services rendered by the Practice. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis and procedures performed.

In addition, the following disclosures are required by law and do not require your consent:

***** Food and Drug Administration- This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, product defects for surveillance to enable product recalls, repairs, or replacements.

* Public Health- This office is required by law to disclose health information to public health and/ or legal authorities charged with tracking reports or birth and morbidity. This office is further required by law to report communicable disease, injury or disability.

* Law Enforcement- (1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit and disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

Your personal health/medical/treatment information is confidential and will not be used in any form without your consent. It is my practice to consult colleagues on occasion and will disclose any pertinent information necessary for treatment planning, also in the event your well-being or whereabouts are in question- I may speak to a close friend or emergency contact (identified by you) in regards to this matter and will do so without consent.

SIGN: ____ DATE:______________