BRANDON ACUPUNCTURE CENTER AND WELLNESS
Merle J. Friedman AP, LD/N, PA
National Board Certified Acupuncture Physician, Licensed Dietitian/ Nutritionist
902 W. Lumsden Road Suite 101, Brandon, FL 33511

Tel: 813-381-3835 Fax: 813-324-9800 email: acupuncture@merlejfriedman.com www.brandonacupuncturecenter.com

PATIENT INTAKE FORM

Thank you for coming. Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All your information will be confidential. If you have questions do not hesitate to ask. Thank you.

Personal information: **Date** : _____

Last Name:_____ **First Name:** _____ **Middle:** _____

Date of Birth:___/___/___ **Age**_____ **Gender: F**___ **M** ___

Address:_____**City:**_____**State** _____**ZIP** _____

Telephone:_____ **Email:** _____ Allow email contact: Yes ___ No __

How did you hear about our clinic?_____Referred by: _____

Have you been treated by Acupuncture or Oriental Medicine before? _____

Name of your physician: _____ Tel: _____

Emergency contact name: _____ Tel: _____

Main Complaint/Reason for visit: _____

1. How long ago did this problem begin? _____
2. What diagnosis have you been given for this problem? _____
3. What kinds of treatment have you tried?_____
4. Are you currently receiving treatment for your problem? _____
   If so, please describe: _____
5. Does anything improve your problem? _____

PAST MEDICAL HISTORY (Please include the month/year when the event occurred)

Surgeries: _____

Auto Accident: _____

Other accident/trauma: _____

MEDICINE: (prescription and over-the-counter drugs, vitamins, herbs, supplements, etc. taken within the last three (3) months)

_____

_____

ALLERGIES (drugs, chemicals, foods, environmental): _____

FAMILY MEDICAL HISTORY:

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Anemia			Hepatitis			Thyroid disease		
Arthritis			Headaches			Tuberculosis		
Asthma			Heart Problems			Alcoholism		
Cancer			High Blood Pressure			Depression		
Diabetes			High Cholesterol			Emotional disorders		
Eye diseases			Obesity			Other:		

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Occupation: _____ Do you usually work ▪ indoors or □ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

Habits: Do you smoke?□Yes □No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes:_____

Exercise: □None □Light □Moderate □Active □Very Active □ Elite Athlete

Type of Exercise_____ How often?_____

Sleep: How many hours do you sleep in general? _____

Insomnia □Yes □No Difficulty Falling Asleep □Yes □No Difficulty Staying Asleep □Yes □No

Wakes Up Frequently □Yes □No Cannot Wake Up in Morning □Yes □No

Diet: How much coffee do you drink? _____cups/day Sodas _____number/day Tea _____ cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? □ Yes □ No □Yes, but not so strict Do you eat a lot of spicy food? □ Yes □ No

Remarks and additional information about your diet_____

Please describe your average daily diet:

Morning:_____

Afternoon:_____

Evening:_____

Snacks: _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

▪ Fevers	□ Tremors	□ Change in Appetite
□ Chills	□ Seizures	□ Peculiar tastes or smells
□ Fatigue	□ Night Sweats	□ Sudden energy drops? What time of day?
□ Poor Circulation	□ Day Sweating	□ Strong thirst
□ Dream Disturbed Sleep	□ Poor Balance	□ Headaches
□ Depression	□ Weight Loss	□ Localized Weakness
□ Mania	□ Weight Gain	□ Bleeding or Bruising
□ Emotional Changes	□ Poor Appetite	□ Joint Pain

CARDIOVASCULAR

□ High blood pressure	□ Dizziness	□ Swelling of Hands	□ Blood Clots
□ Irregular heartbeat	□ Fainting	□ Difficulty in Breathing	□ Palpitations
□ Low blood pressure	□ Cold Sweats	□ Cold Hands/Feet	

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□ Chest pain □ Swelling of Feet □ Phlebitis

RESPIRATORY

□ Cough □ Pain w/ Deep Breaths □ Difficulty in Breathing
□ Asthma □ Bronchitis □ Shortness of Breath
□ Easily Winded □ Coughing Blood
□ Production of phlegm What color?

GASTROINTESTINAL

□ Nausea □ Abdominal Pain/ Cramps □ Digestive Disorders
□ Vomiting □ Parasites □ Constipation
□ Indigestion □ Belching □ Diarrhea
□ Ulcers □ Bad Breath □ Blood in Stools
□ Hernia □ Hemorrhoids

GENITO-URINARY

□ Painful Urination □ Waking up to Urinate How often? _____
□ Blood in Urine □ Kidney stones
□ Urgent Urination □ Frequent Urination □ Unable to Hold Urine
□ Impotency/ Infertility □ Genital Sores

MUSCULOSKELETAL

□ Muscular Weakness □ Arthritis □ Recent Sprains
□ Muscle Cramps □ Spasms □ Recent broken/fractured bones
□ Injuries or Falls □ Muscular Atrophy
□ General Aches □ Joint Instability

Female

___ Number of Pregnancies ___ Number of Live Births ___ Miscarriages___Abortions □ Birth Control
___Age at First Menses ___Days between Menses ___Duration of Menses
□ Fertility Problems
□ Heavy or □ Light □ Difficult Births □ Vaginal Discharge
□ Irregular Periods □ Breast Lumps □ Vaginal Sores
□ Painful Periods □ Clots/Cramps

Date of Last Menstrual Cycle _____/_____/_____Date of Last Pap Smear _____/ _____/

Do you experience changes in Body and/or Psyche prior to menstruation ?_____

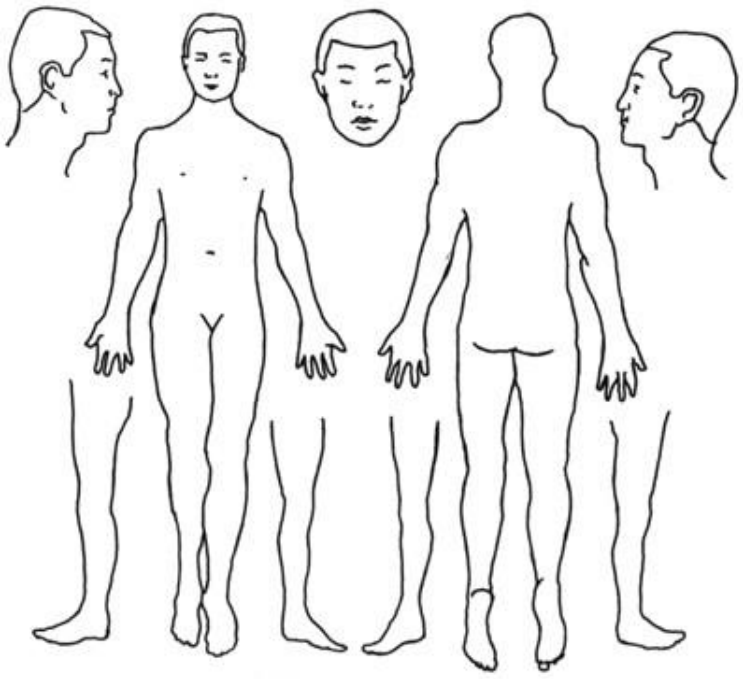
Any other issues? _____

Male

□ Prostate problems □Discharge □ Erectile dysfunction □ Ejaculation problems
□ Frequent seminal emission □ Low sperm count □ Painful/swollen testicles

Any other issues? _____

Please circle on the diagram any areas of any type of discomfort, pain or injury mark them using the codes **listed below:**



N=Numbness

T=Tingling

B=Burning

P=Pain

S=Soreness

A=Ache

SB=Stabbing

SF=Stiffness, X=Scars

List the frequency of your condition Frequency:

1 = 20% of the time
2 = 40% of the time
3 = 60% of the time
4 = 80% of the time
5 = 100% of the time

Please use the scale below to tell us how intense your pain is at its worst and circle the number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain the most intense pain

Are there any other internal organ or systemic dysfunctions that we should be aware of?_____

_____

Are there any other problems you would like to discuss? _____

_____

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture and traditional Chinese medicine on me (or a patient named below, for whom I am legally responsible) by the acupuncture practitioner named below and/or other licensed acupuncture practitioner serving as a back-up for practitioner, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to acupuncture, electrical stimulation, injection therapy, moxibustion, cupping, dietary and lifestyle counseling, Tui-Na (Oriental Massage), Oriental herbs and/or Western nutritional supplements to promote health and well-being. I understand that herbs may need to be prepared and teas consumed according to instructions provided orally and in writing. These herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist and/or member of clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but may have some side effects, including minor bruising, numbness or tingling near the sites that may last a few days, dizziness or fainting, a broken needle, or may produce a temporary flare-up of symptoms. Bruising is a common side effect of cupping. There is no risk of AIDS or hepatitis from the needles. Unusual risks of acupuncture are rare, but include pneumothorax (lung puncture), nerve damage and organ puncture, spontaneous miscarriage. 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 Oriental 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.

The acupuncture practitioner must be advised if the patient has a pacemaker, cardiac condition, bleeding disorder, history of seizures, is or may be pregnant. Patients who take blood thinners such as Coumadin (Warfarin) should probably not get acupuncture due to the increased risk of bleeding and should consider "needle-less" electrical stimulation of acupuncture points.

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which based on the facts then known is in my best interest. While there are several alternatives that exist, the prognosis for treatment depends on the patient's condition, the duration and frequency of treatment and the responsiveness of the patient to both the treatment and the treatment plan. I understand that the results are not guaranteed.

I understand that the practitioner is not responsible as my primary care provider, and that treatment is not intended to replace allopathic medical evaluation, diagnosis, or treatment.

I understand that the practitioner and/or clinical staff may review my patient records and lab reports, 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 filled out this form to the best of my knowledge and 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 to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

PRINTED NAME:_____ Relation to patient: _____

SIGNATURE:_____ Date:_____

Merle J. Friedman, A.P LD/N PA _____ Date: _____
FL License # AP 2449