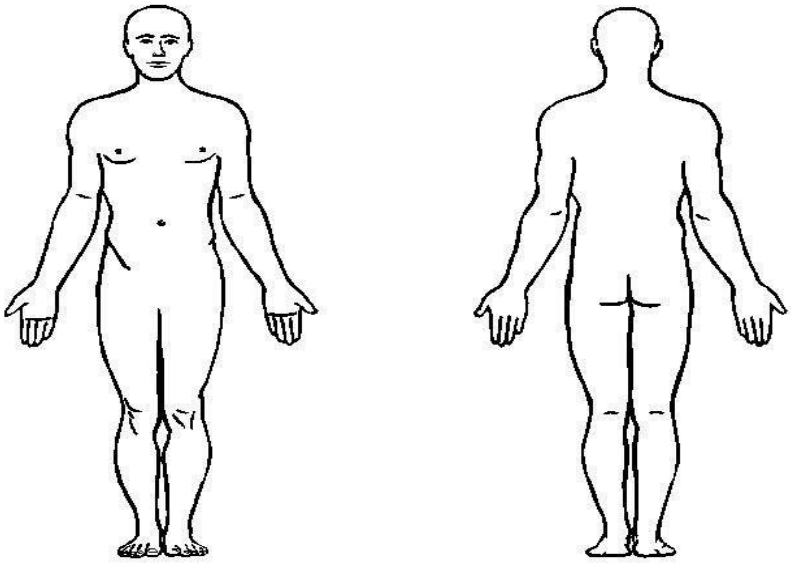
HH Naturopathic & Acupuncture Clinic

New patient intake form Date: _____/____/_____
Name: _____ DOB: ___/___/___
Birth Place & Birth time_____ □ M □ F
Address: _____
City_____Zip code: _____
Preferred contact phone: _____ Cell phone: _____
Emergency contact (Name & phone):_____
E-mail: _____ Occupation: _____
Whom should we thank for referral? _____

I (can) have □Asthma □Pacemaker □High blood pressure □Seizure Weight: Height:
What is your health concern?
1. _____
Circle severity: 0 1 2 3 4 5 6 7 8 9 10
For how long do you have it? _____ Is it getting worse □Y □N
It affects your: □Work □Sleep
2. _____
Circle severity: 0 1 2 3 4 5 6 7 8 9 10
For how long do you have it? _____ Is it getting worse □Y □N
It affects your: □Work □Sleep
3. _____
Circle severity: 0 1 2 3 4 5 6 7 8 9 10
For how long do you have it? _____ Is it getting worse □Y □N
It affects your: □Work □Sleep

MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS



Key: IIIII numbness
XX pain
00 tingling

List medication/s you're taking now: Name_____Reasons_____
List surgeries that you had: Year_____Reasons_____

(Circle/Answer at the best of your knowledge)
How is your energy? Normal/Low/Too high; The worst is Morning/Afternoon/Evening; Need a nap;
Extra info_____
How is your sleep? Good/Can't Fall asleep/Can't Stay asleep; Very light sleep
Extra info _____

How do you feel temperature wise? Neutral / Mostly Hot / Mostly Cold ; Hands/Feet are Hot / Cold; Chest is Hot/Cold
I have Spontaneous(day)/ Night sweats; I am often Thirsty; My mouth feels Dry; I like Room Temp to be Warm / Cold; Prefers Hot drinks/ Cold drinks
Extra info_____

How is your digestion? Appetite is Normal / Low /Excessive; I feel Bloated after eating; I feel Nauseous; I have Acid Reflux/Bad Breath
Extra info _____

How is your bowels? I'm regular; I have Constipation/Diarrhea ___times a week; I have hemorrhoids; The stool is Hard/Dry/Loose/Watery/Strong odor;
Extra info
_____

How is your urination? It's too frequent/ too short; It's Burning/Slow/Unsatisfactory. It's Cloudy/Too Dark/Bloody.
Extra info
_____

How is your Nose/Ears/Throat? I have frequent Allergies/Sinus Infections/Nosebleeds; Nose/Throat feels Dry; Too much Mucus
Extra info_____

Do you have Discomfort/Ache/Pain? Y N Where?
_____
How is your emotions? I feel Depressed/Sad/Constantly Worrying/Easily Irritated/Angry
Extra info _____

For women only.
When was the last period? _____; How long is the cycle? _____; Is it regular? Y N;
Is it painful? Y N
Do you have pre-menstrual syndrome? Y N
Extra info _____
The above information is true to the best of my knowledge. I understand that I will be responsible for payment at the time of service and I can request super-bill that I will submit the claim to my insurance on my own behalf.
Patient/Guardian Signature:_____

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405 Lake Cook Rd., Ste A211, Deerfield, IL 60015

ACUPUNCTURE INFORMED CONSENT TO TREAT

I, (first and last name) _____, hereby request and consent to the performance of Acupuncture Treatment by Sunhee Williams, Licensed Acupuncturist.

Acupuncture is a safe method of treatment, but on rare occasion it may induce minor bleeding, bruising, numbness or tingling near the needling sites, dizziness and fainting, which are not imposing any risks or danger to the patient's health or life.

By voluntary signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture, and have had an opportunity to ask questions.
I intend this consent form to cover the entire course of my present condition and for any future condition(s) for which I seek treatment.

Signature: _____ Date: ____/____/_____

ACUPUNCTURE PATIENTS IN-OFFICE POLICY

To maximize efficiency of your treatment and to maintain lower pricing for our services, please follow these rules:

1. Before you enter the clinic, please silence your cell phone to avoid disturbing other patients. If you need to make a phone call, do it before or after your treatment outside of the office.
2. Hang your coat/jacket on the hook at the front of the office. If you would like to bring it with you to the treatment area, put it on the chair next to your treatment chair (not on the floor, please!)
3. Please, use the "SIGN IN ROSTER" to make sure we know you are here.
4. Please, put your payment (cash or check only) into the blue box on the front desk before the treatment and let the practitioner know the amount. If you need change, there is some in the box – help yourself. Let us know if there is not enough. Handling money takes a lot of practitioner's time and energy that otherwise goes directly into your treatment. If you are using credit cards or debit cards, please let the practitioner know and there will be additional charge of $2.00 for processing fee.
5. Make sure your bladder is happy. Go to the restroom now, not when there are needles in your hands and feet.
6. If you don't like music in the office, or easily disturbed by snoring or noise, feel free to bring your own headphones and music player.
7. Go into the treatment area, pick any available reclining chair, take off shoes, socks and wrist watch, and put your bag and shoes under the arm chair. If you use pillows and blankets, do not forget to put them back on the table. We appreciate your efforts in keeping our clinic in healthy order.
8. Roll up pants to the knees and sleeves to the elbows, recline and RELAX.

NOW YOU ARE READY TO HEAL YOURSELF. THANK YOU.

I have read and understood the policy.

Sign:_____