



**AIMC**

ACUPUNCTURE &  
INTEGRATIVE  
MEDICAL CENTER

# New Patient Intake Form

Please print clearly and bring with you to the office for your first appointment. All records are confidential.

Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_

M F Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

City/State/ZIP Code

Occupation \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact (Name & Number) \_\_\_\_\_

Referred by \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Other Health Care Practitioners Treating You \_\_\_\_\_

Chief Complaint (reason for visit) \_\_\_\_\_

How important is this problem (medical issue/etc.) to you? (Ex. 10% - 100%) \_\_\_\_\_

List all previous treatments for this condition (including medication) \_\_\_\_\_

Other Medical Issues \_\_\_\_\_

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**MESQUITE:** 18601 LBJ #501 · Mesquite, TX 75150 **PLANO:** 4090 Mapleshade Ln. · Plano, TX 75093

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Current Medication/Supplements \_\_\_\_\_  
\_\_\_\_\_

Past Medical History: (check all that apply and include medication )

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV _____                | <input type="checkbox"/> Chest pain _____          | <input type="checkbox"/> Pneumonia _____               |
| <input type="checkbox"/> Diabetes Mellitus _____       | <input type="checkbox"/> Glaucoma _____            | <input type="checkbox"/> Seizures _____                |
| <input type="checkbox"/> Herpes (oral, genitals) _____ | <input type="checkbox"/> Cancer _____              | <input type="checkbox"/> Thyroid disorder (type) _____ |
| <input type="checkbox"/> Rheumatic Fever _____         | <input type="checkbox"/> Asthma _____              | <input type="checkbox"/> Ulcers _____                  |
| <input type="checkbox"/> Stroke _____                  | <input type="checkbox"/> Hepatitis (type) _____    | <input type="checkbox"/> Depression _____              |
| <input type="checkbox"/> Tuberculosis _____            | <input type="checkbox"/> High blood pressure _____ |  |

List any previous surgery / major trauma (include dates) \_\_\_\_\_  
\_\_\_\_\_

Family History: (list major medical conditions)

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

**LIFE STYLE**

Do/did you smoke? Yes No Cigarettes \_\_\_\_ Pipe \_\_\_\_ Cigars \_\_\_\_ Vaping \_\_\_\_

# of Years \_\_\_\_\_ How much? \_\_\_\_\_ Year quit \_\_\_\_\_

Do/did you drink alcohol? Yes No Do/did you use recreational drugs? Yes No

What type/how often? \_\_\_\_\_ What type/how often? \_\_\_\_\_

Do you regularly drink coffee/soda/diet/energy drinks? No Yes How many cups/cans per day? \_\_\_\_\_

How stressed are you? 1 (not stressed) - 10 (extremely stressed) 1 2 2 4 5 6 7 8 9 10

Why? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ Type \_\_\_\_\_ # hours of sleep \_\_\_\_ bed time \_\_\_\_\_ awaken \_\_\_\_\_

Describe your typical diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Food allergies \_\_\_\_\_ Food cravings \_\_\_\_\_

Water consumption / day \_\_\_\_\_

**GENERAL SYMPTOMS: Please check all that apply. (C = Current, P = Past)**

- |          |                          |          |                          |                                     |          |                          |          |                          |                              |          |                          |          |                          |  |
|----------|--------------------------|----------|--------------------------|-------------------------------------|----------|--------------------------|----------|--------------------------|------------------------------|----------|--------------------------|----------|--------------------------|--|
| <b>C</b> | <input type="checkbox"/> | <b>P</b> | <input type="checkbox"/> | poor / increased appetite           | <b>C</b> | <input type="checkbox"/> | <b>P</b> | <input type="checkbox"/> | swollen glands               | <b>C</b> | <input type="checkbox"/> | <b>P</b> | <input type="checkbox"/> | diarrhea                                     |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | weight loss / gain                  |          | <input type="checkbox"/> |          | <input type="checkbox"/> | sore throat                  |          | <input type="checkbox"/> |          | <input type="checkbox"/> | loose stools                                 |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | fatigue                             |          | <input type="checkbox"/> |          | <input type="checkbox"/> | difficulty swallowing        |          | <input type="checkbox"/> |          | <input type="checkbox"/> | constipation                                 |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | irritable / depressed/ anxious      |          | <input type="checkbox"/> |          | <input type="checkbox"/> | decreased hearing            |          | <input type="checkbox"/> |          | <input type="checkbox"/> | blood / mucous in stools                     |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | prefer hot / cold drinks            |          | <input type="checkbox"/> |          | <input type="checkbox"/> | ringing in ears              |          | <input type="checkbox"/> |          | <input type="checkbox"/> | intestinal cramping                          |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | sweat easily                        |          | <input type="checkbox"/> |          | <input type="checkbox"/> | gum / teeth problems         |          | <input type="checkbox"/> |          | <input type="checkbox"/> | hemorrhoids                                  |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | night sweating                      |          | <input type="checkbox"/> |          | <input type="checkbox"/> | hair loss                    |          | <input type="checkbox"/> |          | <input type="checkbox"/> | frequent urination                           |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | fever / chills                      |          | <input type="checkbox"/> |          | <input type="checkbox"/> | shortness of breath          |          | <input type="checkbox"/> |          | <input type="checkbox"/> | urgent urination                             |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | cold hands & feet                   |          | <input type="checkbox"/> |          | <input type="checkbox"/> | chest tightness              |          | <input type="checkbox"/> |          | <input type="checkbox"/> | blood in urine                               |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | poor circulation                    |          | <input type="checkbox"/> |          | <input type="checkbox"/> | asthma / wheezing            |          | <input type="checkbox"/> |          | <input type="checkbox"/> | pain / burning urination                     |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | numbness & tingling in hands / feet |          | <input type="checkbox"/> |          | <input type="checkbox"/> | dry / hacking cough          |          | <input type="checkbox"/> |          | <input type="checkbox"/> | cloudy urination                             |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | muscle cramps / weakness            |          | <input type="checkbox"/> |          | <input type="checkbox"/> | colored phlegm               |          | <input type="checkbox"/> |          | <input type="checkbox"/> | incontinence                                 |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | bruise easily / bleed               |          | <input type="checkbox"/> |          | <input type="checkbox"/> | copious/sticky/bloody phlegm |          | <input type="checkbox"/> |          | <input type="checkbox"/> | night urination                              |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | dry skin                            |          | <input type="checkbox"/> |          | <input type="checkbox"/> | environmental allergies      |          | <input type="checkbox"/> |          | <input type="checkbox"/> | urinary infections                           |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | itchy skin                          |          | <input type="checkbox"/> |          | <input type="checkbox"/> | palpitations                 |          | <input type="checkbox"/> |          | <input type="checkbox"/> | neck / shoulder pain                         |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | rashes / eczema / psoriasis / acne  |          | <input type="checkbox"/> |          | <input type="checkbox"/> | irregular heart beat         |          | <input type="checkbox"/> |          | <input type="checkbox"/> | upper back pain                              |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | headache / migraine                 |          | <input type="checkbox"/> |          | <input type="checkbox"/> | low blood pressure           |          | <input type="checkbox"/> |          | <input type="checkbox"/> | lower back pain                              |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | dizziness / vertigo                 |          | <input type="checkbox"/> |          | <input type="checkbox"/> | indigestion                  |          | <input type="checkbox"/> |          | <input type="checkbox"/> | rib pain                                     |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | blurred vision                      |          | <input type="checkbox"/> |          | <input type="checkbox"/> | gas / flatulence bloating    |          | <input type="checkbox"/> |          | <input type="checkbox"/> | difficulty falling asleep<br>time sleep_____ |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | eye pain / tear / red / itch        |          | <input type="checkbox"/> |          | <input type="checkbox"/> | belching / burping           |          | <input type="checkbox"/> |          | <input type="checkbox"/> | awake_____                                   |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | facial pain                         |          | <input type="checkbox"/> |          | <input type="checkbox"/> | acid regurgitation           |          | <input type="checkbox"/> |          | <input type="checkbox"/> | awaken at night                              |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | sinus disorder / pain / pressure    |          | <input type="checkbox"/> |          | <input type="checkbox"/> | nausea / vomiting            |          | <input type="checkbox"/> |          | <input type="checkbox"/> | nightmares                                   |
|          | <input type="checkbox"/> |          | <input type="checkbox"/> | runny nose                          |          | <input type="checkbox"/> |          | <input type="checkbox"/> | foul breath                  |          | <input type="checkbox"/> |          | <input type="checkbox"/> |  |

**GYNECOLOGY (WOMEN):**

date of last pap smear \_\_\_\_\_ results \_\_\_\_\_ PMS \_\_\_\_\_  
 date of last menstrual period \_\_\_\_\_  
 length of cycle (regular / irregular) \_\_\_\_\_  
 duration of flow \_\_\_\_\_  
 do you have clots with menstrual flow \_\_\_\_\_  
 menstrual pain / cramping \_\_\_\_\_  
     location \_\_\_\_\_  
 method of contraception \_\_\_\_\_  
 uterine fibroids \_\_\_\_\_  
     type \_\_\_\_\_

breast tenderness  
 mood changes  
 bloating  
 headache  
 low back pain  
 food cravings  
 ovarian cysts \_\_\_\_\_  
 age of menopause \_\_\_\_\_  
 endometriosis \_\_\_\_\_  
 pregnancies \_\_\_\_\_ births \_\_\_\_\_

**UROLOGY (MEN):**

date of last prostate exam \_\_\_\_\_ results \_\_\_\_\_  
 poor stream flow  
 premature ejaculation  
 Night urination  
 Frequent urination

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# GENERAL PAIN INDEX QUESTIONNAIRE

Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.  
ex. 0= completely able to function 10= Totally unable to function

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL

1 2 3 4 5 6 7 8 9 10

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES

1 2 3 4 5 6 7 8 9 10

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS

1 2 3 4 5 6 7 8 9 10

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS

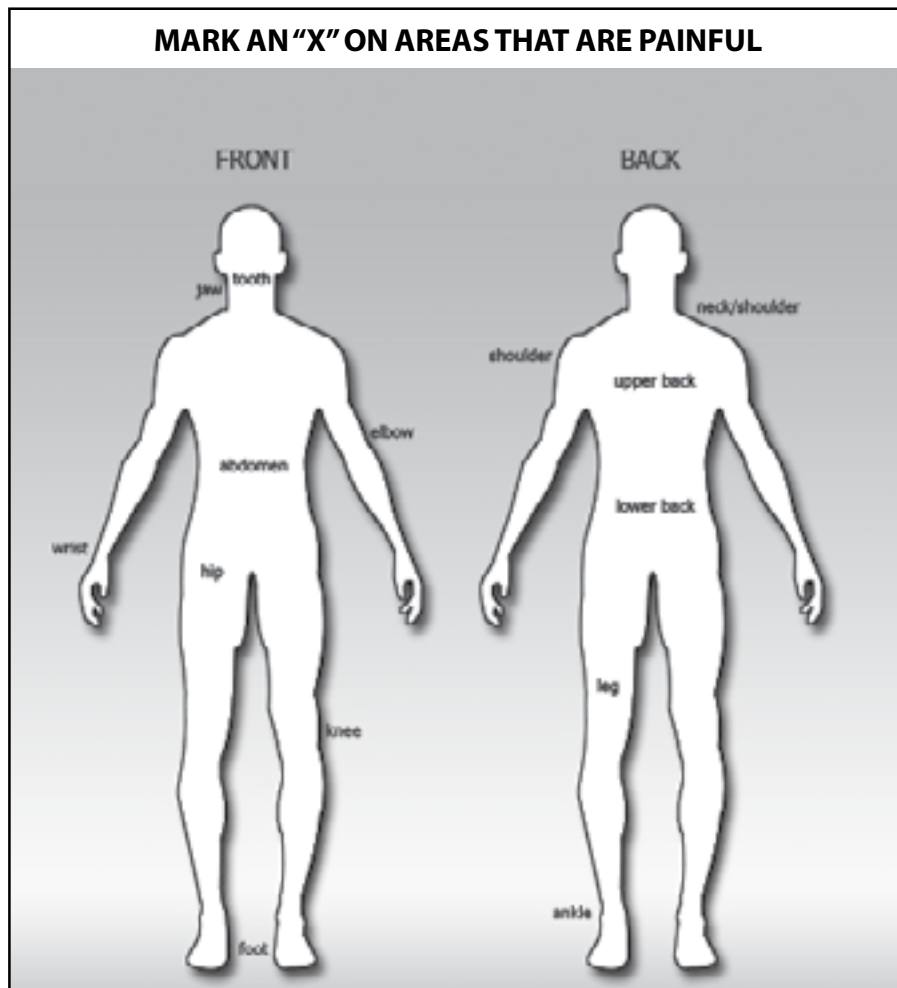
1 2 3 4 5 6 7 8 9 10

5. **SELF-CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED

1 2 3 4 5 6 7 8 9 10

6. **LIFE-SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING

1 2 3 4 5 6 7 8 9 10



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Rate each of the following symptoms based on your typical health profile for the past month:

**POINT SCALE**    0—Never or almost never have the symptom    1—Occasionally have it, effect is not severe    2—Occasionally have it, effect is severe  
 3—Frequently have it, effect is not severe    4—Frequently have it, effect is severe

<p><b>HEAD</b></p> <p>_____ Headaches</p> <p>_____ Faintness</p> <p>_____ Dizziness</p> <p>_____ Insomnia</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>EYES</b></p> <p>_____ Watery or itchy eyes</p> <p>_____ Swollen, reddened or sticky eyelids</p> <p>_____ Bags or dark circles under eyes</p> <p>_____ Blurred or tunnel vision</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>EARS</b></p> <p>_____ Itchy ears</p> <p>_____ Earaches, ear infections</p> <p>_____ Drainage from ear</p> <p>_____ Ringing in ears, hearing loss</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>NOSE</b></p> <p>_____ Stuffy nose</p> <p>_____ Sinus problems</p> <p>_____ Hay fever</p> <p>_____ Sneezing attacks</p> <p>_____ Excessive mucus formation</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>MOUTH/ THROAT</b></p> <p>_____ Chronic coughing</p> <p>_____ Gagging, frequent need to clear throat</p> <p>_____ Sore throat, hoarseness, loss of voice</p> <p>_____ Swollen or discolored tongue, gums, lips</p> <p>_____ Canker sores</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>SKIN</b></p> <p>_____ Acne</p> <p>_____ Hives, rashes, dry skin</p> <p>_____ Hair loss</p> <p>_____ Flushing, hot flashes</p> <p>_____ Excessive sweating</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>HEART</b></p> <p>_____ Chest pain</p> <p>_____ Irregular or skipped heartbeat</p> <p>_____ Rapid or pounding heartbeat</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>LUNGS</b></p> <p>_____ Chest congestion</p> <p>_____ Asthma, bronchitis</p> <p>_____ Shortness of breath</p> <p>_____ Difficulty breathing</p> <p style="text-align: right;"><b>TOTAL</b> _____</p>	<p><b>DIGESTIVE</b></p> <p>_____ Nausea, vomiting</p> <p><b>TRACT</b></p> <p>_____ Diarrhea</p> <p>_____ Constipation</p> <p>_____ Bloating feeling</p> <p>_____ Belching, passing gas</p> <p>_____ Heartburn</p> <p>_____ Intestinal/stomach pain</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>JOINTS/ MUSCLE</b></p> <p>_____ Pain or aches in joints</p> <p>_____ Arthritis</p> <p>_____ Stiffness or limitation of movement</p> <p>_____ Feeling of weakness or tiredness</p> <p>_____ Pain or aches in muscles</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>WEIGHT</b></p> <p>_____ Binge eating/drinking</p> <p>_____ Craving certain foods</p> <p>_____ Excessive weight</p> <p>_____ Water retention</p> <p>_____ Underweight</p> <p>_____ Compulsive eating</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>ENERGY/ ACTIVITY</b></p> <p>_____ Fatigue, sluggishness</p> <p>_____ Apathy, lethargy</p> <p>_____ Hyperactivity</p> <p>_____ Restlessness</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>MIND</b></p> <p>_____ Poor memory</p> <p>_____ Confusion, poor comprehension</p> <p>_____ Difficulty in making decisions</p> <p>_____ Stuttering or stammering</p> <p>_____ Slurred speech</p> <p>_____ Learning disabilities</p> <p>_____ Poor concentration</p> <p>_____ Poor physical coordination</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>EMOTIONS</b></p> <p>_____ Mood swings</p> <p>_____ Anxiety, fear, nervousness</p> <p>_____ Anger, irritability, aggressiveness</p> <p>_____ Depression</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>OTHER</b></p> <p>_____ Frequent illness</p> <p>_____ Frequent or urgent urination</p> <p>_____ Genital itch or discharge</p> <p style="text-align: right;"><b>TOTAL</b> _____</p> <hr/> <p><b>GRAND TOTAL</b> <span style="float: right;"><b>TOTAL</b> _____</span></p>
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How committed are you to getting better? (Ex. 10% - 100%) \_\_\_\_\_

Why? \_\_\_\_\_

Are you willing to do whatever it takes to get better? \_\_\_\_\_

Are you ready to make any changes necessary to get better? \_\_\_\_\_

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## ACUPUNCTURE CENTER INFORMED CONSENT TO TREAT AND PAYMENT AGREEMENT

I hereby request and consent to the performance of acupuncture treatments and the other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist including those working at the clinic or office listed above or any other office or clinic.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamp. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 Chinese 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. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative 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 read 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 condition and for any future condition(s) for which I seek treatment.

Initial \_\_\_\_\_

### PAYMENTS

We request payment at the time of services rendered. Prepayment will be required for future visits that have previous unpaid balances. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Our office only accepts cash and all major credit cards.

Initial \_\_\_\_\_

I understand that any billing of my insurance company is a courtesy provided by my doctor and that I am ultimately responsible for 100% of my bill. Should I fail to pay in full, I will be responsible for collection costs. Cancellation Made With Less Than 24 hour notice will be charged \$25.00 for the first occurrence, and the full cost of the visit for additional occurrences. Our consultation fee is \$40 per 20 minutes.

Initial \_\_\_\_\_

### MAJOR MEDICAL INSURANCE

Although we cannot guarantee any reimbursement from your health insurance company, we are glad to answer any questions concerning the billing process. As a courtesy to you, we will bill your insurance company. Please provide a copy of your insurance card whenever your plan renews or changes. If your plan requires precertification it is your responsibility to inform us in writing when it is required. It is not

our responsibility for missing insurance company precertification requirements. If your plan changes due to COBRA or other policy changes it is your responsibility to inform us in writing of these changes. Your reimbursement may be affected because of these items ultimately it is your responsibility.

Initial \_\_\_\_\_

In signing below, I understand all these policies and agree to pay for treatments accordingly, and also agree that I am responsible for any unpaid balances. Additionally, I understand that this letter supersedes any previous telephone or other verbal communication about office policies and fees. I understand that AIMC may report me to a credit-reporting agency or take legal action as necessary to be paid for services rendered.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_