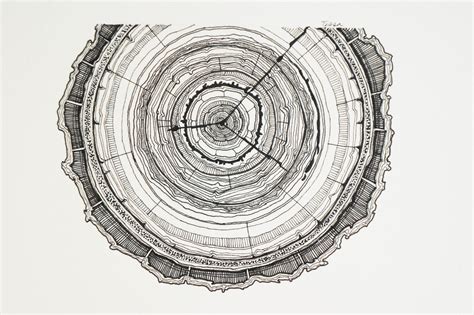
Lisa Hadley, R.Acu **INTAKE FORM** 

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M / F Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear of us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your primary reason(s) for treatment today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Current Meds/Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was your general health as a child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a contagious disease at this time? (ie. hepatitis, T.B, the Flu, HIV etc.) Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

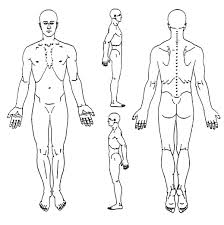
How much do you consume per day of? *Water \_\_\_\_ Coffee \_\_\_\_ Tea \_\_\_\_ Soda \_\_\_\_ Alcohol \_\_\_\_ Cigarettes \_\_\_\_*

Are you? Always Thirsty ( ) Never ( ) Thirsty for sips Later in the Day ( ) Do you like: Cold Drinks ( ) Warm Drinks ( )

What are your typical eating habits?  *Skip Breakfast ( ) Eat in a Rush ( ) Eat When Not Hungry ( ) Eat too Fast ( ) Eat Late at Night ( ) Cannot eat when Worried/Stressed ( ) Excess Hunger ( ) No Desire to Eat ( ) Food Allergies ( )* Do you have aversion to: *Cold ( ) Wind ( ) Dampness ( ) Heat ( ) Loud Noises ( ) Crowds ( )*  What is your approximate: Height \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_ Is there any possibility you may be pregnant? Y / N Are you receiving or seeking any other type of therapy for your current concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have:** Pacemaker ( ) Surgical Replacements ( ) Implants ( ) Hemophilia ( ) Sensitive Skin ( ) Fear of Needles ( )

**NATURE OF YOUR PAIN ( Circle for pain # 1 , X for pain # 2 )**

**1.** Constant ( ) Comes & Goes ( ) Fixed ( ) Moves ( ) One sided ( ) Dull ( ) Sharp ( ) Burning ( ) Aching ( ) Spastic ( ) Numb ( ) **Better:** Heat ( ) Cold ( ) Motion( ) Rest ( ) Pressure ( ) am / pm **Worse:** Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( ) am / pm

**SCALE** **0 1 2 3 4 5 6 7 8 9**  **2.** Constant ( ) Comes & Goes ( ) Fixed ( ) Moves ( ) Unilateral ( ) Dull ( ) Sharp ( ) Burning ( ) Aching ( ) Spastic ( ) Numb ( ) **Better:** Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( ) am / pm **Worse:** Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( ) am / pm

**SCALE 0 1 2 3 4 5 6 7 8 9**

**Please Place a check beside anything you currently have or have had in the past**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Anemia | O | Cataracts | O | Gout | O | Lyme Disease | O | Prostate Disorder | O |
| Appendicitis | O | Celiac | O | Heart Disease | O | Meningitis | O | Scarlet Fever | O |
| Arteriosclerosis | O | Chicken Pox | O | Hernia | O | Mononucleosis | O | Rheumatoid | O |
| Bladder Disease | O | Chronic Fatigue | O | Herpes | O | Multiple Sclerosis | O | Stomach Disorder | O |
| Blood Disorder | O | Chronic Pain | O | High Cholesterol | O | Mumps | O | Stroke | O |
| Bronchitis | O | Diabetes | O | Intestinal Disorder | O | Osteoarthritis | O | Thyroid Disorder | O |
| Broken Bones | O | Emphysema | O | Impotence | O | Osteoporosis | O | Tonsillitis | O |
| Bulimia | O | Epilepsy | O | Kidney Disease | O | Parkinson's | O | Tuberculosis | O |
| Cancer | O | Measles | O | Liver Disease | O | Pneumonia | O | Ulcers | O |
| Candidiasis | O | Goiter | O | Lupus | O | Polio | O | Other: | O |

**Is There Family History of:**

Alcoholism ( ) Allergies ( ) Asthma ( ) Bleeding Disorders ( ) Cancer ( ) Depression ( ) Diabetes ( ) Heart Disease ( ) High Blood Pressure ( ) Kidney Disease ( ) Mental Illness ( ) Seizures ( ) Stroke ( )

**Do you Frequently Experience Any of these Emotional Behaviors in *Excess*:**

Anger ( ) Anxiety ( ) Bitterness ( ) Depression ( ) Stress ( ) Fear ( ) Impatience ( ) Impulsiveness ( ) Irritability ( ) Jealousy ( ) Mood Swings ( ) OCD ( ) Over Excitement ( ) Worry / Over-Thinking ( ) Sadness ( )

**GENERAL SYMPTOMS:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Fatigue | O | Can’t fall asleep | O | Can’t stay asleep | O | Excess Dreaming | O | Night Sweats | O |

**HEAD, EYES, EARS, NOSE, THROAT:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Bitter Taste | O | Eye Pain / Strain | O | Cataracts | O | Ear Aches | O | Frequent Colds | O |
| Dry Mouth/ Nose | O | Blurred Vision | O | Spots in Eyes | O | Hearing Aid(s) | O | Allergies | O |
| Excess Phlegm | O | Dry / Itchy Eyes | O | Nose Bleeds | O | Poor Hearing | O | Dizziness | O |
| Gum Problems | O | Watery Eyes | O | Sinus Issues | O | Ringing in Ears:  High /Low Pitch | O | Headaches | O |
| Grinding of Teeth | O | Glasses/ Contacts | O | Facial Pain / TMJ | O | Migraines | O |
| Teeth Issues | O | Glaucoma | O | Trig. Neuralgia | O | Swollen Glands | O | Concussions | O |

**RESPIRATORY:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Asthma/Wheezing | O | Cough | O | Cough + Phlegm | O | Heavy Chest | O | Pneumonia | O |
| COPD | O | Cough + Blood | O | Difficult Breathing | O | Tight Chest | O | Short of Breath | O |

**CARDIOVASCULAR:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Blood Clots | O | Low BP / High BP | O | High Cholesterol | O | Fainting | O | Palpitations | O |
| Chest Pain | O | Poor Circulation | O | Bruise Easily | O | Pace Maker | O | Phlebitis | O |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Belly Pain |  | O | Bloating | O | Constipation | O | Gas | O | Bloody Stool | O | Nausea/Vomiting | O |
| Bad Breath |  | O | Rectal Pain | O | Diarrhea | O | Refulx | O | Mucus in Stool | O | Hemorrhoids | O |

**GASTROINTESTINAL:**

**MUSCULOSKELETAL:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Arthritis | O | Limited Motion | O | Neck Pain | O | Scoliosis | O | Other\_\_\_\_\_\_\_\_\_\_ |  |
| Atrophy | O | Weight Gain | O | Upper Back Pain | O | Rib Pain | O | Muscle Cramps | O |
| Joint Pain | O | Weight Loss | O | Low Back Pain | O | Knee Pain | O | BodyHeaviness | O |

**GENITO-URINARY:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Bed Wetting | O | Impotence | O | Nocturnal Emissions | O | Cloudy Urine | O | Pale Urine | O |
| Frequent/Urgent Urination | O | Incomplete Urination | O | Premature Ejaculation | O | Wake to Urinate | O | Dark Urine | O |
| Bloody Urine | O | Kidney Stones | O | Painful Urination | O | Time: | |  |  |
| Bladder Infections | O | Libido Issues | O | Unable to Hold Urine | O | Yeast Infections | O |

**GYNECOLOGICAL**:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Infertility | O | Heavy Periods | O | PMS | O | Menopause | O | Genital Burning | O |
| # Pregnancies | O | Light Periods | O | Blood Clots | O | Hysterectomy | O | Discharge | O |
| # Miscarriages | O | Irregular Periods | O | Painful Periods | O | Genital Itching | O | Color: |  |

**NEURO-PSYCHOLOGICAL**:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Addiction | O | Depression | O | ADD / ADHD | O | Brain Fog | O | Poor Memory | **O** |
| Anxiety | O | Easily Stressed | O | Mental Illness | O | Clumsy | O | Seizures | **O** |

**SKIN & HAIR**:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Acne | O | Dermatitis | O | Fungus | O | Hives | O | Rashes | O |
| Burning Skin | O | Discolorations | O | Hair Loss | O | Itchy / Dry Skin | O | Shingles | O |
| Dandruff | O | Eczema | O | Hot Flashes | O | Psoriasis | O | Warts | O |

**CONSENT TO ACUPUNCTURE TREATMENT**

I, the undersigned, do hereby give my consent for the administration of Traditional Chinese Medicine, which includes Acupuncture and its related modalities. (Cupping, Guasha, Electro-Acupuncture, Auricular Acupuncture and Seeding, Tuina and Acupressure Massage, Herbal Medicine, Dietary and lifestyle counselling).

I have been made aware of the possibility of complications that may result from these procedures. For Acupuncture, these include infection (very rarely), bruising (more commonly), bleeding, pain, discomfort, weakness, tiredness, fainting, nausea, short term aggravation of existing symptoms, as well as risk of organ puncture. For herbal medicine, I understand that I must follow the practitioner’s directions for treatment to prevent risks such as toxicity, reduce the side effects and optimize the therapeutic effect which may include dietary changes. I understand there may be some reactivity to certain medicines including nausea, stomach ache, diarrhea and numbness of the tongue. For physical manipulations and all procedures, I understand that I have full control of the treatment in relation to my complete comfort, safety, privacy and dignity.

I state that I will make my practitioner aware if I am pregnant, if I have a bleeding disorder, a pacemaker, a local infection, a contagious disease or if I am taking anti-coagulants. If any of these pertain to me I will list them now: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby certify that I understood the above authorization and the risks involved. The practitioner has explained the procedures involved in my treatment and all relevant questions have been answered to my satisfaction. I understand that my medical file is confidential and protected by law***. I also understand that I will be charged $25 for all missed appointments if an effort is not made to inform my practitioner within the 24-hour cancellation period.***

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

PLEASE PROVIDE IF YOU WOULD LIKE YOUR PRACTITIONER TO DIRECT BILL YOUR INSURANCE COMPANY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insurance Provider | Policy Holder | Holders Phone # | Relationship to holder | Patient Birthdate |
| Policy # | Group # | Co Pay Amount $ | Primary Holders Address | |
| Secondary Insurance | Subscribers Name | Policy # | Group # | Co Pay Amount $ |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to my practitioner. I understand that I am financially responsible for any balance. I also authorize Lisa Hadley, R.Acu or my insurance company to release any information required to process my claims.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent\Guardian for Youth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY**

Name of local relative or friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_