Dr. Andrew J. Lee, DACM, Dipl. OM, L.Ac

Initital Patient Intake Form

Patient Name_____ **Birthdate**_____**Primary Language**_____ **Gender M / F**
Last First

Address_____ **City**_____ **State**____ **Zip**_____ **Primary Phone**_____

Reason for treatment:_____

Other Current Health Conditions:_____

Additional Comments:_____

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____ _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

Please check all of the following that apply to you and list any medication(s) you are taking:

- ☐ Alcohol/Drug Dependence
- ☐ Abnormal Menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast Lumps
- ☐ Cancer/Tumor
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ Hospitalizations/Surgical Procedures_____
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Palpitation/Arrhythmia
- ☐ Peptic Ulcer
- ☐ Pregnant, # Weeks_____
  If pregnant, are you under a medical doctor's care? ☐Y ☐ N
- ☐ Prostate Problems
- ☐ Weight Gain/Loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tobacco Use - Type_____ Frequency_____/Day
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ **Medications**_____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer_____
- ☐ Heart Disease_____
- ☐ Hypertension_____
- ☐ Lupus_____
- ☐ Other_____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co- managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature_____ **Date**_____

*There is a $35 No-show or Late Cancellation policy. Please let me know if you cannot make your appointment 24 hours ahead of time