EAST MEETS WEST Preventative Medicine

Dr. Aaron Nickamin
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NEW PATIENT INTAKE FORM Date: _____

Name	Marital Status:	Birthdate / / Age _____
Address_____		Male Female
		Ht_____ Wt
Email		Occupation
Home Phone	Work	Cell
Referred by		
Reason for visit today		Have you had acupuncture before? Chinese herbal medicine?
How long have you had this condition?		
Is it getting worse?	Does it bother your □sleep □work □other (specify)?	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now? □ Yes □ No if yes, for what? Physician's name:		Physician's phone:
Other concurrent therapies:		

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
	☐ Asthma		☐ Heart Disease	☐ Stroke
_____	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	
_____				

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Your Past Medical History:

☐ AIDs/HIV
☐ Alcoholism (Date:)
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma (your own birth)
☐ Chicken Pox
☐ Diabetes (Type:)
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis (Type:)
☐ Herpes (Type:)
☐ High Blood Pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Seizures
☐ Stroke
☐ Thyroid disorders
☐ Cancer type:
treatment: _____
☐ Surgery (list)
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough
☐ Other
☐ Major trauma (car,fall, pls list) _____

Your Diet:

Appetite ☐ Low ☐ High
☐ Coffee/Tea ☐ Soft Drinks/ day: Fruit Juices
☐ Artificial ☐ Sugar Sweeteners ☐ Salty foods
Protein Intake ☐ Low ☐ High
Thirst for water: # glasses per

Pharmaceuticals (name and dosage):

Vitamins/ Supplements (name and dosage):

Your Lifestyle:

☐ Alcohol
☐ Tobacco
☐ Marijuana
☐ Drugs
☐ Stress
☐ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

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General Symptoms:

☐ Poor appetite
☐ Heavy appetite
☐ Like cold drinks
☐ Like hot drinks
☐ Weight loss/gain
☐ Poor sleep
☐ Heavy sleep
☐ Dream-disturbed sleep
☐ Fatigue
☐ Lack of strength
☐ Bodily heaviness
☐ Cold hands or feet
☐ Poor circulation
☐ Shortness of breath
☐ Fever
☐ Chills
☐ Night sweats
☐ Sweat easily
☐ Muscle cramps
☐ Vertigo/dizziness
☐ Bleed or bruise easily
☐ Peculiar taste (Describe)
_____
_____
_____

Head, Eyes, Ears, Nose, Throat

☐ Glasses (age?)
☐ Eye strain
☐ Eye pain
☐ Red eyes
☐ Itchy eyes
☐ Spots in eyes
☐ Poor vision
☐ Blurred vision
☐ Night blindness
☐ Myopia/Presbyopia
☐ Glaucoma
☐ Cataracts
☐ Teeth problems
☐ Grinding teeth
☐ TMJ
☐ Facial pain
☐ Gum problems
☐ Sores on lips/tongue
☐ Dry mouth
☐ Excessive saliva
☐ Sinus problems
☐ Excessive phlegm Color:
☐ Recurrent sore throat
☐ Swollen glands
☐ Lumps in throat
☐ Enlarged thyroid
☐ Nosebleeds
☐ Ringing in ears
☐ Poor hearing
☐ Earaches
☐ Headaches
☐ Migraines
☐ Concussions
Other head or neck problems
_____
_____
_____

Respiratory

☐ Difficulty breathing wh lying down
☐ Shortness of Breath
☐ Tight chest
☐ Asthma/wheezing
□ Difficult inhale? Exhale?
☐ Cough
Wet or Dry? _____
Thick or thin? _____
☐ Color of phlegm: _____
☐ Coughing up blood
☐ Pneumonia

Cardiovascular

☐ High blood pressure
☐ Blood clots
☐ Low blood pressure
☐ Fainting
☐ Chest pain
☐ Difficulty breathing
☐ Tachycardia
☐ Heart palpitations
☐ Phlebitis
☐ Irregular heartbeat/ Afib

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating
☐ Bad breath
☐ Diarrhea
☐ Constipation
☐ Black stools
☐ Bloody stools
☐ Mucous in stools
☐ Hemorrhoid
☐ Itchy anus
☐ Intestinal pain/ cramps
☐ Burning anus
☐ Rectal pain
☐ Anal fissures
☐ Laxative use
What kind?
How often?

Bowel movements:

Frequency_____Texture/form_____

Color_____Odor_____

Musculoskeletal

☐ Neck/shoulder pain
☐ Muscle pain
☐ Upper back pain
☐ Low back pain
☐ Joint pain
☐ Rib pain
☐ Limited range of motion
☐ Limited use
☐ Other
_____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations
☐ Eczema
☐ Psoriasis
☐ Acne
☐ Dandruff
☐ Itching
☐ Hair Loss
☐ Change in hair/skin texture
☐ Fungal infections
Other (Specify)
_____
_____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics
☐ Poor memory
☐ Depression
☐ Anxiety
☐ Irritability
☐ Easily sressed
☐ Abuse survivor
☐ Considered/attempted suicide
☐ Seeing a therapist
Other (Specify)
_____
_____

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CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

1. May our Patient Care Coordinator contact you: At home? Yes No
   If yes, may we leave the following information on your home voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

   At work? Yes No
   If yes, may we leave the following information on your work voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

2. Please indicate the number you wish us to use to contact you:
   Home:_____ Work: _____ Cell: _____

Please print the names of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and heath care operation):

o NONE
Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

3. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:
   Name _____ Phone _____

4. Please print the address where you wish billing statements and/or correspondence from our office to be sent.
   o Use my home address
   o Use this one: _____

5. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? Yes No

6. May we send you email messages, such as newsletters and East meets West Preventative Medicine of Sarasota updates, events and specials? Yes, at this email _____ No

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of East meets West Preventative Medicine of Sarasota and give my permission to share the information as indicated with the person(s) named above.

PATIENT SIGNATURE _____ DATE _____

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INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and 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 indicated above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tuina (Chinese massage), Chinese herbal medicine, nutritional counseling, botanical medicine, cosmetic acupuncture, applied kinesiology/clearing, homeopathy, gua sha, reiki, Tai Qi Chuan/Tai Chi, Qi Gong, KST (Koren Specific Technique), Jin Shin Jyutsu (like Japanese Acupressure) and acupuncture injection therapy/ acupoint injection therapy/AIT. (incl. prp [incl. phlebotom], prolotherapy, neural therapy, perineural,Chinese herbal and nerve hydrodissection injections and biopuncture). I will immediately notify a member of theclinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or anynutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods 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 lamps. Bruising is a common side effect of cupping and injection therapy. Unusual risks of acupuncture and AIT. 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, at all times.

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 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE _____ DATE _____

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FINANCIAL RESPONSIBILITY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we required you to read and sign prior to any treatment.
All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS.

Regarding Insurance: We can provide you with a Super Bill, that you can send to your insurance company for reimbursement, at your request. You are responsible for full payment at time of service.
Usual and Customary Rates (UCR): Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Should a punch pass be in force upon missing an appointment without 24 hours' notice, one visit from said package shall be forfeited. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with FHC incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay a reasonable collection expense, all court costs and a reasonable attorney's fee incurred thereby.

I have read the Financial Policy. I understand and agree to this Financial Policy. A photocopy of this form shall be considered as effective as the original.

_____ _____

Patient/Authorized Person/Responsible Party Date