Intake form for Silvia Vidas, Dr. TCM

All information provided is confidential and will not be released unless authorized by you.

Date________________________ **Care card#**______________________

Name ____________________________ **DOB**_____________________________

Home Address ____

Email:____

Contact tel. number:____

Occupation: ____

Married: _______ **or** **Single:** _________ **Children:**________________

Physician's Name/Phone ____

Emergency contact (name/phone # & relationship to you) ______________________________

Who referred you to this clinic? ____

Main reason(s) for being here today:____

How long have you had issue(s)?____
Is there anything that makes this condition better?_____________________________________
Is there anything which makes this condition worse?____________________________________

Have you ever seen an Acupuncturist/Dr. of TCM before? ____yes ____no

Medical history & general Information

How would you describe your level of energy (1- little energy; 10- lots of energy)_________
Do you get tired easily? ____yes ____no
Do you catch colds easily? ____yes ____no

Check if you have had or currently have any of the following:

____allergies ____asthma ____bleeding tendency
____cancer ____cirrhosis of liver ____diabetes
____epilepsy ____heart disease ____hepatitis
____HIV or AIDS ____migraines ____multiple sclerosis
____tuberculosis ____STDs ____seizures
____stroke ____thyroid disorder

Are you being treated for any medical conditions at the present time or have you been treated in the past year? ____**yes** ____**no**.
If yes, please list__________________________________

Please list any other significant diseases, injuries or diagnosis that you currently have or have had in the past:____

Have you ever had any surgeries? If so, list____

When was your last medical check-up? ____

Current Meds: Please list any medications you are taking (include dosage if known):______

____

List of vitamins/ supplements (include dosage if known) _________________________________

____

Do you have any allergies: __yes __no If yes, please list________________________________

Have you ever had any peculiar or adverse reaction to any medicines? __yes __no

If yes, please describe____

Do you have any heart or blood pressure problems? __yes __no

Please describe____

High blood pressure: __yes __no

Low blood pressure: __yes __no

Have you ever been told not to give blood? __yes __no

Have you ever had a blood transfusion? __yes __no

Do you bruise easily or bleed for prolonged period of time after a cut? __yes __no

General Health Information:

What exercise do you do & how often per week? ___________________________________

How would you describe your diet? ____

Please note amount of cigarettes, alcohol & caffeine, if applicable:

____cigarettes: number /day______________________

____coffee & tea number cups/day___________________

____alcohol: drinks/week________________________

____recreational drugs-if so please describe:__________________

Aches & pain: Do you have any body aches/pains? If so, please describe location of pain, how long you have had the pain: ____

____

Please note additional factors regarding aches & pain:

______pain better with heat ______pain improved with pressure on affected area ______pain worse with pressure ______pain worse with damp weather	____pain associated with bloating, fullness and o distention ____pain that moves from location to location ____dull pain that is worse with fatigue ____sharp pain

Body temperature:

Do you usually feel cold? ____yes ____no. Do you usually feel hot? ____yes ____no

If you feel cold, does your whole body feel cold or just your hands or/and feet?

____

Sweating: please mark if you are experiencing any of the following:

_____daytime sweating with no or little exertion

_____hot flashes

_____night sweats

_____sweating of whole body

_____sweating on palms, soles & chest

Head & face:

Do you have headaches? ____yes ____no

What triggers headache? ____

Please indicate words that best describe your headache: ____acute ____chronic

____Severe ____Dull pain ____Distend or throb pain ____Stabbing pain

____Worse with fatigue ____Frontal headache

____Posterior or occipital headache ____Worse during the day ____Worse in evening

____worse with wind or cold ____Feels heavy "like a damp towel around head"

Do you have dizziness? ____yes ____no. If yes, how often? ______________________

____Dizziness with loss of balance

____Dizziness with heavy feeling in head

____Dizziness worse with fatigue

____Dizziness comes on suddenly

____Dizziness with gradual onset

Do you have palpitations? ____yes ____no. If yes, how often? ____________________

Eyes:	Ears:
____eye pain, well and or redness ____blur vision or with floaters ____dry eyes ____yellow sclera ____abnormal eye movements	____sudden onset ringing in ears (tinnitus) ____chronic ringing in ears (tinnitus) ____Sudden onset deafness ____Gradual onset deafness

Digestion & water metabolism:

Thirst:	Appetite:
____lack of thirst ____desire for warm liquids ____strong thirst especially for cold drinks ____dry mouth with desire to sip liquids ____thirst but no desire to drink	____lack of appetite ____insatiable appetite ____fullness/bloating or distention after eating ____preference for warm/hot foods ____preference for cold/cool foods

Do you have any tastes in your mouth such as: ____bitter taste ____sweet taste

____sour taste____salty taste ____metallic taste ____lack of taste

Do you experience any of the following?

____nausea/vomiting ____heartburn

____excess gas ____bloating after meals

____indigestion ____other:____________________________________

Urination & stools:

Urination: Do you have any of following:	**Bowels:**
___lack of urine control ___urine retention ___incomplete urination ___pain with urination ___pale colored urine ___dark color urine ___copious amounts of urine ___scanty urination ___need to get up at night to urinate	___normal stools ___Constipation ___diarrhea/loose stools ___alternating diarrhea & constipation ___diarrhea in the early morning ___rectal bleeding ___hemorrhoids Average # of bowel movements per day:_______

Sleep quality & habits: Do you have any problems falling asleep or do you wake up often at night? ___yes ___ no

___difficulty falling asleep but sleeps well
___wakes up often
___nightmares a/or violent dreams
___restless sleep after eating late

Thorax & Abdomen: Do you have any of the following?
___Shortness of breath
___pain in chest area
___persistent cough
___pain in costal region or region below the ribs
___pain in the upper abdomen above belly button
___pain in lower abdomen below belly button

Emotions: Please mark emotions that seem to be affecting your life:

___anger	___often	___ sometimes	___never
___irritability	___often	___ sometimes	___never
___nervousness	___often	___ sometimes	___never
___depression	___often	___ sometimes	___never
___anxiety	___often	___ sometimes	___never
___panic attacks	___often	___ sometimes	___never
___stress	___often	___ sometimes	___never
___sadness	___often	___ sometimes	___never

Gynecology:
Age at first period:_______________________
Age at menopause (if applicable):__________________
How many days does your period last? ___________
Please indicate if applies:
__PMS
__Irregular period
__heavy period
__light period
__blood clots
__bleeding between periods

CONSENT FORM

I do hereby voluntarily consent to be treated with acupuncture and Chinese medicinal herbs by Silvia Vidas, Dr. TCM.

***Initial here*________** **Acupuncture:** I understand that acupuncture is performed by the insertion of sterile single use needles through the skin in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture is a typically safe method of treatment however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

***Initial here*________** **Pregnancy:** I will notify Silvia Vidas, Dr. TCM should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage.

Initial here*________** **Chinese Herbs:** I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. ***Should I experience any problems, which I associate with these substances, I should suspend taking them and call Silvia Vidas, Dr. TCM as soon as possible.

***Initial here*________** **Acupressure/Tui-Na Massage, Qi Gong:** I understand that I may also be given acupressure/tui-na massage and/or Qi Gong as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Initial here*________** **Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass or plastic cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perceptions and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and through unsightly are not normally painful. However, certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

***Initial here*________** I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I do not expect Silvia Vidas, Dr. TCM to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask Silvia Vidas, Dr. TCM for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Patient signature: _________________________________ Date: __________________________

Printed Name: ____________________________________ DOB: __________________________

Parent/legal guardian signature:_____________________ (if patient is under 18 years of age)
Printed Name:__________________________________