Layton Acupuncture

Patient Intake Form | Health History

IMPORTANT: Complete this document as thoroughly as possible.
Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

Name _____ Email _____ Date ____/____/_____

Address _____ City _____ State _____ Zip _____ Hom

Phone _____ Cell Phone _____ Date of Birth ____/____/_____ Place of Birth _____ How did you hear about our office _____

Medications _____

Supplements _____

Please tell me your physical and/or emotional ailment(s) _____

_____

How is your sleep _____ How is your digestion _____

Energy on a scale of 1 to 10 (1 being lowest) _____ Difficult symptoms/irregularities with your menstrual cycle? Y or N

Please explain _____

_____

Experiencing depression, anxiety, stress, easy agitation? Y or N Please Explain _____

_____

Check any you have had in the past:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Jaundice
- ☐ Other _____
- ☐ Syphilis
- ☐ Paralysis
- ☐ Allergies
- ☐ CVA (Stroke)
- ☐ Pneumonia
- ☐ Gonorrhea
- ☐ Measles
- ☐ HIV
- ☐ High Fever
- ☐ Cancer
- ☐ Glaucoma
- ☐ Vein Condition
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Polio
- ☐ Hepatitis
- ☐ Migraines
- ☐ Rheumatic Fever
- ☐ Thyroid Disorder
- ☐ Emphysema
- ☐ Bleeding Disorder
- ☐ Nervous Disorder
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ High Blood Pressure

☐ Surgeries _____

Overall Temperature (Kidney Function)

- ☐ Cold hands
- ☐ Sweaty hands
- ☐ Hot body temperature (sensation)
- ☐ Afternoon flushes
- ☐ Heat in the hands, feet & chest
- ☐ Thirsty
- ☐ Lack of perspiration
- ☐ Difficulty keeping eyes open in the daytime
- ☐ Cold feet
- ☐ Sweaty feet
- ☐ Cold body temperature (sensation)
- ☐ Night sweats
- ☐ Hot flashes any time of the day
- ☐ Perspire easily
- ☐ Take water to bed

Overall Energy (Lung, Kidney Function)

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise

Heart Function

- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Drink coffee

cups/day _____

Lung Function

- ☐ Nasal discharge
  Color _____
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Allergies
  To what _____
- ☐ Alternating fever & chills
- ☐ Sneezing
- ☐ Headache
  Location _____
- ☐ Overall achy feeling in body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes
  # per day _____
- ☐ Sadness
- ☐ Melancholy

Blood (Liver, Spleen, Heart) Function

- ☐ Dizziness
- ☐ See floating black spots
- ☐ Difficulty calming mind before sleep

Eyes

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Blurry vision

Spleen Function
☐ Low appetite
☐ Abrupt weight gain
☐ Abrupt weight loss
☐ Abdominal gas
☐ Gurgling noise in the stomach
☐ Fatigue after eating
☐ Prolapsed organ, which _____
☐ Easily bruised
☐ Hemorrhoids
☐ Pensive
☐ Over thinking
☐ Worry

Stomach Function
☐ Burning sensation after eating
☐ Large appetite
☐ Bad breath
☐ Mouth (canker) sores
☐ Bleeding, swollen, or painful gums
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer (diagnosed)
☐ Belching
☐ Hiccoughs
☐ Stomach Pain
☐ Vomiting

Dampness Trapped in Body
☐ General sensation of heaviness in body
☐ Mental heaviness
☐ Mental sluggishness
☐ Mental fogginess
☐ Swollen hands
☐ Swollen feet
☐ Swollen joints
☐ Chest Congestion
☐ Nausea
☐ Snoring
☐ Discharge

Liver/Gall Bladder Function
☐ Chest pain
☐ Tight sensation
☐ Bitter taste in the mouth
☐ Anger easily
☐ Frustration
☐ Depression
☐ Irritability
☐ Unable to adapt to stress
☐ Skin rashes
☐ Headache top of the head
☐ Sexually transmitted disease which _____
☐ Numbness
☐ Muscle spasms
☐ Muscle twitching
☐ Muscle cramping
☐ Seizures
☐ Convulsions
☐ Lump in throat
☐ Neck tension
☐ Limited range of motion in neck
☐ Shoulder tension
☐ Limited range of motion in shoulder
☐ Drink alcohol
☐ Recreational drugs
☐ High pitched ringing in ears
☐ Gall stones

Kidney/Urinary/Bladder
☐ Frequent cavities
☐ Easily broken bones
☐ Sore knees
☐ Weak knees
☐ Cold sensation in the knees
☐ Low back pain
☐ Memory problems
☐ Excessive hair loss
☐ Low pitched ringing in the ears
☐ Kidney stones
☐ Bladder infections
☐ Wake two or more times during the night to urinate
☐ Lack of bladder control
☐ Fear
☐ Easily startled

Urination
☐ Normal color
☐ Dark yellow
☐ Clear
☐ Reddish
☐ Cloudy
☐ Strong odor
☐ Burning
☐ Painful

Large Intestine Function
☐ Loose stool
☐ Constipated
☐ Incomplete
☐ Diarrhea
☐ Blood in stool
☐ Mucous in stool
☐ Undigested food in stool
☐ Alternating constipation and diarrhea

Libido
☐ Normal
☐ High
☐ Low

Women Only
Regular Menstrual Cycle: Y or N
# of children _____
Age of first menses _____ # Days cycle lasts _____
Pregnant: Y or N
# of Pregnancies _____ Age of menopause _____
☐ Vaginal discharge Color _____
☐ Bleeding between periods

Premenstrual Symptoms
☐ Nausea
☐ Depression
☐ Breast changes
☐ Pain
☐ Migraines
☐ Other

Men Only
☐ Swollen testes
☐ Testicular pain
☐ Impotence
☐ Premature ejaculation
☐ Feeling of coldness or numbness in genitalia

Family Member	Alive	Deceased	Present Health Or Cause Of Death
Father	☐	☐	
Paternal Grandfather	☐	☐	
Paternal Grandmother	☐	☐	
Mother	☐	☐	
Maternal Grandfather	☐	☐	
Maternal Grandmother	☐	☐	
Spouse	☐	☐	
Children	☐	☐	
Brother	☐	☐	
Brother	☐	☐	
Sister	☐	☐	
Sister	☐	☐	

Check any that have occurred in blood relatives:
☐ Diabetes
☐ Allergies
☐ Kidney Disease
☐ Stroke
☐ Cancer
☐ Tuberculosis
☐ Alcoholism
☐ Heart Disease
☐ Obesity
☐ Nervous Illness
☐ High Blood Pressure
☐ Bleeding Disorder
☐ Mental Illness

ACKNOWLEDGMENT OF LIABILITY AND ASSIGNMENT OF BENEFITS

The undersigned patient / or responsible party, hereby acknowledge personal responsibility for all the medical services which are provided by Layton Acupuncture. This personal obligation I not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continue personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician of facility name above the following rights, power and authority.

Consent of Treatment: The undersigned hereby consents to the provision of examination, fitness evaluations, treatments, therapies, medical and laboratory procedures, drugs and supplies to the patient as ordered by the patient's health care provider of **Layton** Acupuncture and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures, or examinations.

Released Information: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory report and the results of all tests of any type or character to such person(s) as the physician and or facility deems appropriate.

Assignment Of Rights: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable information needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

Demand For Payment: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy.

Third Party Liability: If patient(s) treatments for injuries are the result of the negligence of any third party, the patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

Statute Of Limitations: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above.

Terms And Attorney Fees: Net 30 days from date of invoice unless otherwise indicated. A finance charge of 1.5% per month (Annual Percentage Rate 18%) of the unpaid balance will be added monthly, both pre-judgment an post-judgment. Should collection become necessary, the patient(s) agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs for services rendered by the physician/facility named above.

Limited Power of Attorney: I hereby grant to the physician/facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility. I agree that any insurance payment representing an amount in excess of the charges for the treatment rendered will be credited to my/account or forwarded to my/our address upon request in writing to the physician/facility named above.

Cancellation/No Show Policy: Here at **Layton Acupuncture** we understand that things occur that may impede you from being able to keep your appointment, therefore the first and second missed appointments with be overlooked. The third missed appointment without a cancellation at least 24 hours prior will result in a $35 fee. Any missed appointments beyond the third will also yield a $35 fee each time.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of the Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL.

Signature of Patient and/or Responsible Party:

Signature _____ Date _____

Address _____ City _____ State _____ Zip _____