

# Eastern Shore Acupuncture and Healing Arts

Katherine Binder C.P., M.S., L.Ac.

## Confidential Intake Form

Today's Date \_\_\_\_\_

### Patient Information

Name \_\_\_\_\_ Gender: M F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Referred by \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of last physical \_\_\_\_\_

Physician's Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Have you had acupuncture before? Y N For what conditions? \_\_\_\_\_

What is the primary complaint you want treated with acupuncture today? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Was the onset: Sudden Gradual

Was there a significant event that lead to this condition? Y N If so, explain \_\_\_\_\_

Have you seen a doctor for this condition? Y N If so, when \_\_\_\_\_

List any medical diagnosis you received. \_\_\_\_\_

Are you currently being treated for this condition? Y N If so, what forms of treatment are you receiving. \_\_\_\_\_

Does this condition interfere with your:  
 Sleep  Work  Relationships  Emotional Well-Being  Other \_\_\_\_\_

Activities (please list) \_\_\_\_\_

Circle the intensity of your **physical discomfort**: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Circle the intensity of the **emotional distress** this creates: No distress 0 1 2 3 4 5 6 7 8 9 10 Extreme distress

Symptoms are relieved by \_\_\_\_\_ Symptoms are worsened by \_\_\_\_\_



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## Diet and Nutrition

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How is your appetite? \_\_\_\_\_ Any food cravings? \_\_\_\_\_

List any food intolerances or allergies. \_\_\_\_\_

Please check any dietary restrictions:

Vegetarian Vegan Low calorie Low fat Low carb Low sodium Low sugar Other \_\_\_\_\_

How many meals do you eat daily? \_\_\_\_\_ List your taste preferences 1 to 5 (1 = like the most to 5 = like the least)  
Sweet \_\_\_\_\_ Spicy \_\_\_\_\_ Salty \_\_\_\_\_ Sour \_\_\_\_\_ Bitter \_\_\_\_\_

How many glasses/cups do you have:

Water \_\_\_\_\_ daily Caffeinated beverages \_\_\_\_\_ daily or weekly Alcohol \_\_\_\_\_ daily or weekly  
(please circle) (please circle)

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## Gastrointestinal

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Please check all that you are currently experiencing or experience frequently:

- Belching / Gas  Nausea  Vomiting  Vomiting blood  Ulcers  Abdominal Pain / Bloating  
 Indigestion  Severe stomach pains  Trouble Digesting Fats  Hernia  Acid Reflux / Heart Burn  
 Constipation  Hard stool  Loose / soft stool  Diarrhea  Irregular bowel movements  
 Blood in Stool  Hemorrhoids  Undigested food in stool  Painful bowel movements  
 Other \_\_\_\_\_

How frequent are your bowel movements: \_\_\_\_\_ daily / weekly

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## Urogenital

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Please check all symptoms that you are currently experiencing or experience frequently:

- Frequent urination  Pain with urination  Burning urination  Urinary tract infections (UTIs)  
 Trouble holding urine  Incontinence  Trouble starting stream  Blood in the urine  
 Kidney stones  Waking in the night to urinate  Urine is usually pale/clear  Urine is usually dark/orange  
 Other \_\_\_\_\_

### **Sexual Function:**

What form of contraception do you use? \_\_\_\_\_

- Low sex drive  Excessive sex drive  Painful intercourse  Infertility  
 Other \_\_\_\_\_

**Men's Health:**

- Erectile dysfunction     Impotence     Premature ejaculation     Nocturnal emission  
 Prostate condition     Genital pain     Genital itching/burning     Genital discharge  
 Other \_\_\_\_\_

**Women's Health:**

Are you currently pregnant?   Y   N                      Are you currently trying to become pregnant?   Y   N  
Number of pregnancies? \_\_\_\_\_ Number of deliveries? \_\_\_\_\_ What age did you start menstruating? \_\_\_\_\_  
Number of days between cycles: \_\_\_\_\_ Number of days of flow: \_\_\_\_\_ Color: \_\_\_\_\_  
Are you currently taking oral contraceptives?   Y   N      If so, for how long? \_\_\_\_\_  
When was your last pelvic exam / pap smear? \_\_\_\_\_ List any unusual results: \_\_\_\_\_

Please check all symptoms that you are currently experiencing or experience frequently:

- Cramping with / before menses     Mood fluctuation with menses     Intestinal distress during menses  
 Heavy menstrual bleeding             Light menstrual bleeding             Spotting between periods     Endometriosis  
 Clotting with menses                     Frequent vaginal infections             Ovarian cysts                     Uterine Fibroids  
 Vaginal itching / burning                 Pelvic Inflammatory Disease             Missed periods                     Prolapsed uterus  
 Frequent vaginal discharge (*please describe color & consistency*) \_\_\_\_\_  
 Menopausal symptoms (*please list*) \_\_\_\_\_  
 Hysterectomy     Breast tenderness     Breast swelling     Discharge from the breast     Breast lumps  
 No menses (*for how long*) \_\_\_\_\_     Other \_\_\_\_\_

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**Cardiovascular**

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When was the last time your blood pressure was checked? \_\_\_\_\_ What was it? \_\_\_\_\_

Please check all symptoms that you are currently experiencing or experience frequently:

- Chest pain     Palpitations     Rapid heart beat     Irregular heart beat     Poor circulation     Raynaud's Disease  
 High blood pressure     Low blood pressure     Face flushes easily     Cold hands / feet     Phlebitis  
 Other \_\_\_\_\_

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## Respiratory

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Do you smoke? Y N

If so, how many cigarettes do you have \_\_\_\_\_ daily / weekly How long have you been a smoker? \_\_\_\_\_

Please check all symptoms that you are currently experiencing or experience frequently:

- Chest congestion  Difficulty breathing  Shortness of breath  Chronic cough  Dry cough  Bronchitis
- Chest tightness  Painful inhalation  Painful exhalation  Coughing blood  Pneumonia  Catch colds easily
- Coughing up phlegm What color? \_\_\_\_\_ How frequent? \_\_\_\_\_ Worse in: A.M. P.M.
- Asthma (what triggers an attack) \_\_\_\_\_
- Other \_\_\_\_\_

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## Exercise, Energy & Sleep

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What kind of exercise do you do? \_\_\_\_\_

How frequently? \_\_\_\_\_ How many hours of sleep do you get a night? \_\_\_\_\_

Please check all symptoms that you are currently experiencing or experience frequently:

- Low energy  Fatigue easily  More energy in the morning  More energy in the evening
- Trouble falling asleep  Trouble staying asleep  Dream disturbed sleep  Frequent use of sleeping aids
- Wake not feeling rested  Night sweats  Feelings of heaviness (where) \_\_\_\_\_
- Other \_\_\_\_\_

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## Emotional Well Being

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What is most stressful to you in your life at the moment? \_\_\_\_\_

What aspect of your daily life is:

Most satisfying: \_\_\_\_\_ Most difficult: \_\_\_\_\_

Where do you hold your stress? \_\_\_\_\_

What do you do to relax? \_\_\_\_\_

Please check all symptoms that you are currently experiencing or experience frequently:

- Anxiety  Panic attacks  Depression  Frequent mood swings  Irritability  Outbursts of anger
- Nervousness  Poor memory  Feeling foggy headed  Difficulty concentrating  Feeling overwhelmed
- Other \_\_\_\_\_

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### Eyes, Ears, Nose, Throat & Mouth

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Please check all symptoms that you are currently experiencing or experience frequently:

- |   |   |   |   |   |                                    |
|---|---|---|---|---|------------------------------------|
| <input type="checkbox"/> Poor vision          | <input type="checkbox"/> Blurred vision   | <input type="checkbox"/> Floaters           | <input type="checkbox"/> Red, dry, itchy eyes | <input type="checkbox"/> Eye infections   |                                    |
| <input type="checkbox"/> Ringing in the ears  | <input type="checkbox"/> Ear pain         | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Vertigo / dizziness  | <input type="checkbox"/> Ear infections   |                                    |
| <input type="checkbox"/> Chronic runny nose   | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sinus headaches    | <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> Sinus infections |                                    |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Strep throat     | <input type="checkbox"/> Dry / itchy throat | <input type="checkbox"/> Always thirsty       | <input type="checkbox"/> Never thirsty    |                                    |
| <input type="checkbox"/> Cold sores           | <input type="checkbox"/> Oral herpes      | <input type="checkbox"/> Bleeding gums      | <input type="checkbox"/> Toothaches           | <input type="checkbox"/> TMJ problems     | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Other _____          |   |   |   |   |                                    |

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### Skin & Hair

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Please check all symptoms that you are currently experiencing or experience frequently:

- |                                      |                                    |  |   |   |                                |                                     |
|--------------------------------------|------------------------------------|--|---|---|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Acne        | <input type="checkbox"/> Dry skin  | <input type="checkbox"/> Bruise easily     | <input type="checkbox"/> Eczema             | <input type="checkbox"/> Psoriasis        | <input type="checkbox"/> Hives | <input type="checkbox"/> Itchy skin |
| <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Premature graying | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Lack of sweating |                                |                                     |
| <input type="checkbox"/> Other _____ |                                    |  |   |   |                                |                                     |

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### Musculoskeletal & Neurological

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Are you currently experiencing any: *(check all that apply)*     Pain     Tension     Stiffness     Numbness

Where is it located? \_\_\_\_\_

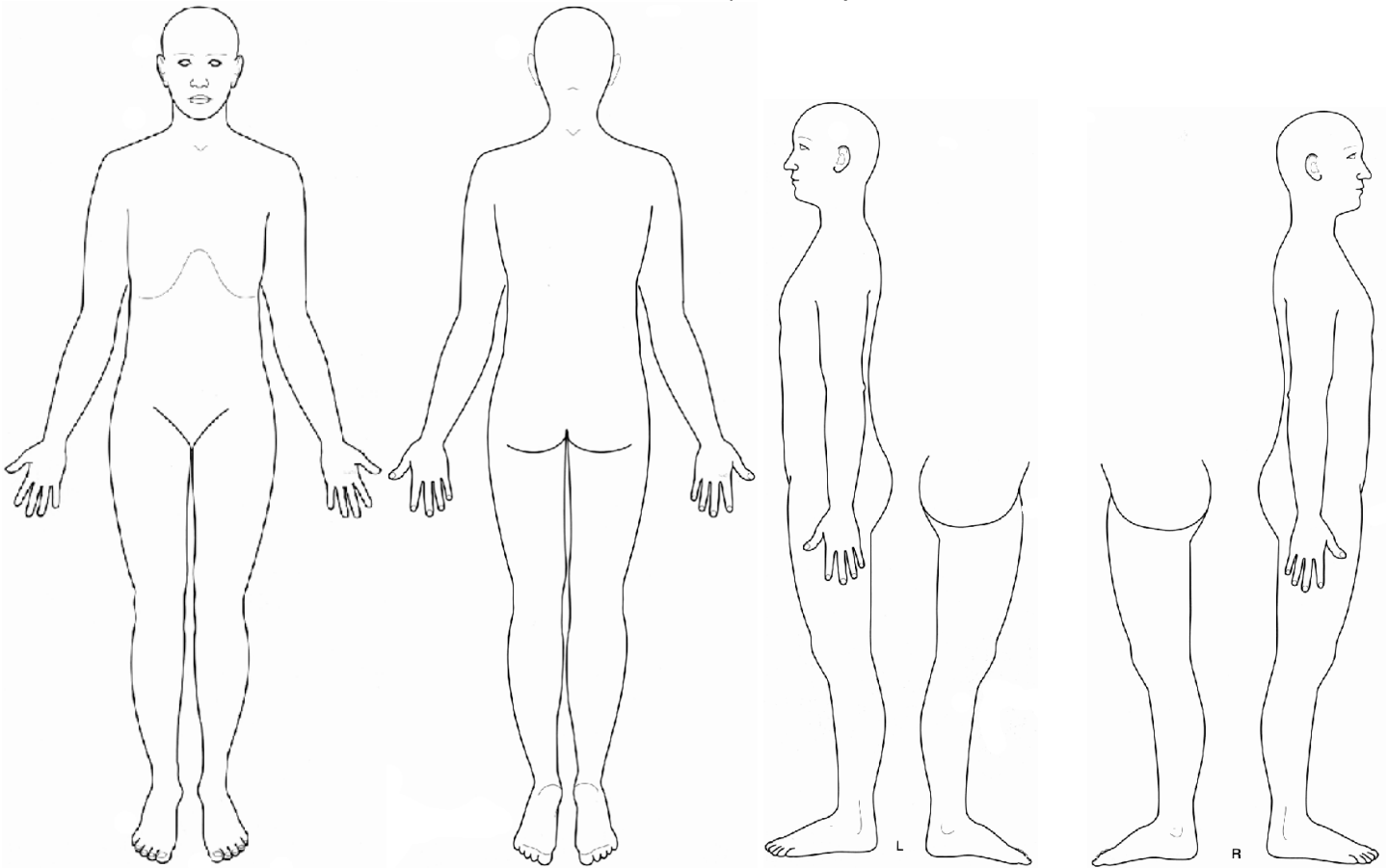
Describe your discomfort: *(check all that apply)*

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Sharp          | <input type="checkbox"/> Dull           | <input type="checkbox"/> Aching               | <input type="checkbox"/> Burning          | <input type="checkbox"/> Tingling             |
| <input type="checkbox"/> Numb           | <input type="checkbox"/> Deep           | <input type="checkbox"/> Superficial          | <input type="checkbox"/> Constant         | <input type="checkbox"/> Intermittent         |
| <input type="checkbox"/> Diffuse        | <input type="checkbox"/> Isolated       | <input type="checkbox"/> Better with Pressure | <input type="checkbox"/> Better with Heat | <input type="checkbox"/> Better with Activity |
| <input type="checkbox"/> Better in A.M. | <input type="checkbox"/> Better in P.M. | <input type="checkbox"/> Worse with Pressure  | <input type="checkbox"/> Better with Cold | <input type="checkbox"/> Better with Rest     |

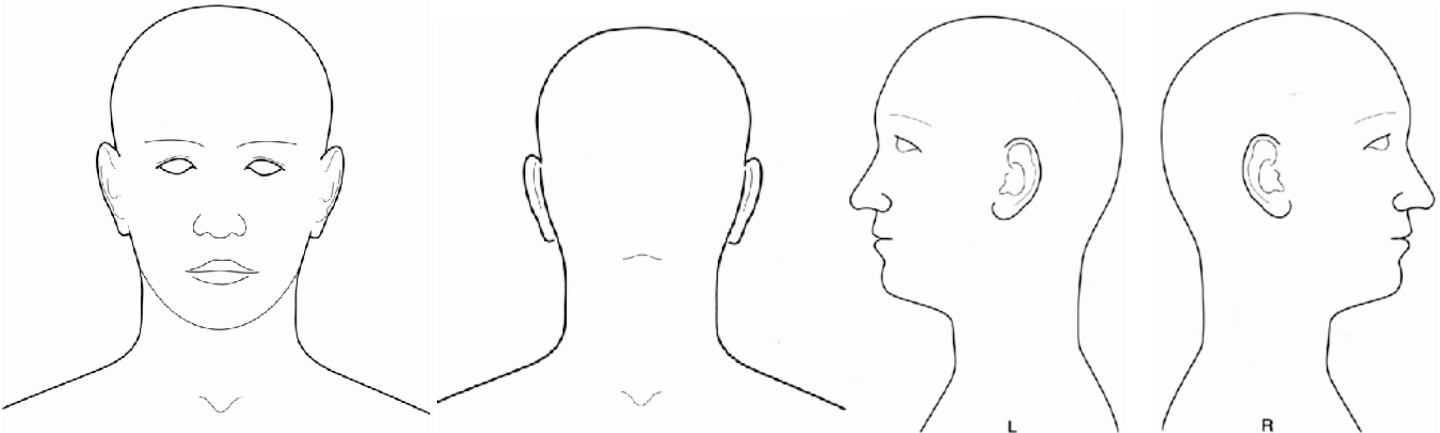
Please check all symptoms that you are currently experiencing or experience frequently:

- |  |   |   |  |  |                                    |                                     |
|--|---|---|--|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Muscle pain             | <input type="checkbox"/> Backache                 | <input type="checkbox"/> Herniated / bulging disc | <input type="checkbox"/> Sciatica              | <input type="checkbox"/> Hip pain      | <input type="checkbox"/> Bone pain |                                     |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Neck pain                | <input type="checkbox"/> Joint pain               | <input type="checkbox"/> Swollen joints        | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Repetitive strain injury | <input type="checkbox"/> Rheumatoid arthritis     | <input type="checkbox"/> Numb / tingling limbs |  |                                    |                                     |
| <input type="checkbox"/> Other _____             |   |   |  |  |                                    |                                     |
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Please shade in the areas where you feel pain or discomfort:



If you experience headaches, please shade in any areas where you feel pain or discomfort:



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### Headaches

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Please check all symptoms that you are currently experiencing or experience frequently with your headaches:

- Migraines     Tension headaches     Chronic     Severe     Sharp     Dull     Throbbing
- Pressure / pain behind the eyes     Worse with fatigue     Worse during the day     Worse at night
- Head feels thick / fuzzy     Accompanied with sensitivity to light     Accompanied with dizziness / vertigo
- Other \_\_\_\_\_

## Personal Health History

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Please check all conditions that you are currently experiencing or have experienced in the past.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Alcoholism/ Drug Abuse               | <input type="checkbox"/> Gallstones                                   | <input type="checkbox"/> Lymph nodes removed   |
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Genital warts                                | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Anemia/ Blood Disorder               | <input type="checkbox"/> Heart Disease                                | <input type="checkbox"/> Mononucleosis         |
| <input type="checkbox"/> Artificial joints                    | <input type="checkbox"/> Hepatitis A / B / C <i>(please circle)</i>   | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Hernia                                       | <input type="checkbox"/> Osteoarthritis        |
| <input type="checkbox"/> Birth trauma <i>(your own birth)</i> | <input type="checkbox"/> Herpes oral / genital <i>(please circle)</i> | <input type="checkbox"/> Osteoporosis          |
| <input type="checkbox"/> Bell's Palsy                         | <input type="checkbox"/> HIV/ AIDS                                    | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Cancer/ Tumors                       | <input type="checkbox"/> Hypoglycemia                                 | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Chronic Fatigue Syndrome             | <input type="checkbox"/> Hyperthyroidism                              | <input type="checkbox"/> Polio                 |
| <input type="checkbox"/> Colitis/ Irritable Bowel             | <input type="checkbox"/> Hypothyroidism                               | <input type="checkbox"/> Scarlet Fever         |
| <input type="checkbox"/> Crohn's Disease                      | <input type="checkbox"/> Kidney diseases                              | <input type="checkbox"/> Shingles              |
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Latex allergy                                | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Emphysema                            | <input type="checkbox"/> Lupus  | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Fibromyalgia                         | <input type="checkbox"/> Lyme's Disease                               | <input type="checkbox"/> Tuberculosis          |

Please describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not. Include approximate dates.

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Please list any significant family illnesses.

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

# The Fine Print

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## Advisory to Consult Physician

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While oriental Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any conditions for which you are seeking acupuncture treatment.

I, (PRINT NAME) \_\_\_\_\_

Have been advised by Katherine Binder, L.Ac., to consult a physician regarding the conditions, for which I seek acupuncture treatment.

Signature of Patient \_\_\_\_\_

(Parent's signature if patient is minor)

Date \_\_\_\_\_

Signature of Practitioner \_\_\_\_\_

Date \_\_\_\_\_

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## Financial Policy

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Eastern Shore Acupuncture and Healing Arts accepts many insurance plans as full or partial payment for professional services. Co-pays and deductibles may apply, and plan benefits will need to be verified by our practice manager

Full payment is expected at the time of service. We accept most forms of payment including major credit cards.

Most conditions require an average of 6-12 treatments, although some will respond well within 4-6 visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.

Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you may be responsible for payment in full. Insurance will not pay for a missed appointment.

Please indicate your understanding and acceptance of these policies by signing below.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Name of Patient (Signature)

\_\_\_\_\_  
Name of Patient's Representative (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date