Eastern Shore Acupuncture and Healing Arts

Confidential Intake Form			
Patient Information			
Name:	Gender: M☐ F☐	Date of Birth:	Age:
Address:			
City:	State:	Zip:	
Daytime Phone	Evening Phone		
Mobile Phone	Fax		
Email			
Physician	Referred by		
Physician's Address			
City:	State:	Zip:	
Emergency Contact	Phone	Relationship	
Insurance Information			
Insurance Carrier:	Insurance Phone (for providers):		
Member ID:	Group Number:		
Workman's Compensation			
Insurance Carrier:	Insurance Phone (for providers):		
Adjuster's Name:	Adjuster's Phone:		
Member ID:	Group Number:		
Social Security Number:	Date of Injury		
Diagnosis:			
Personal Injury			
Date of Injury:	Other Person's Name		
Insurance Carrier:	Insurance Carrier:		
Adjuster's Name:	Adjuster's Name:		
Adjuster's Phone Number:	Adjuster's Phone Number:		
Policy Number:	Policy Number:		
Claim Number:	Claim Number:		
Social Security Number:	Diagnosis:		

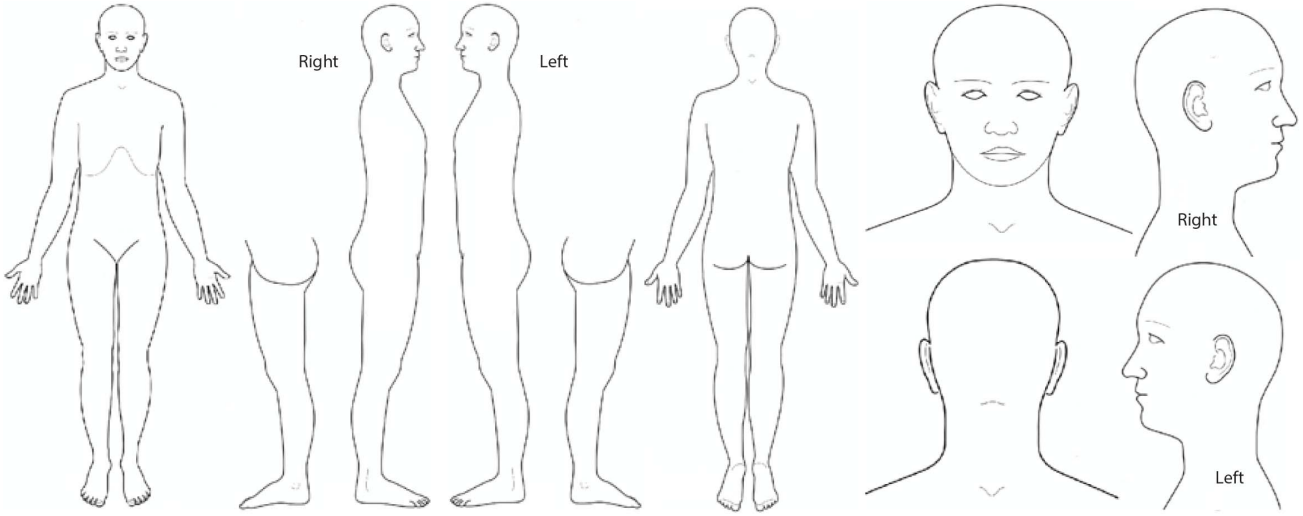
Official Use Only (below)

History of Present Condition(s):

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

Location:

Where are you experiencing symptoms:



Quality:

☐ Sharp	☐ Stiff	☐ Dull	☐ Achy	☐ Burning	☐ Tingling
☐ Numb	☐ Nagging	☐ Radiating/referral	☐ Local	☐ Other:	

Severity:

0 1 2 3 4 5 6 7 8 9 10

Completely able to Function — Mild — Moderate — Severe — Completely unable to Function

Duration:

How long have you had symptoms?

Is this the first time or a (re)exacerbation? (explain):

Progression of Symptoms:

Is the condition getting worse, better, remaining the same? If better or worse describe:

Timing/Frequency:

☐ Occasional – Up to 25% of time	☐ Intermittent – Up to 50% of time
☐ Frequent – Up to 75% of time	☐ Constant – up to 100% of time

Please describe if there is a pattern to the intensity of your symptoms:

Context:

Date of injury (day/month/year) if insidious onset please provide approximate time of initiation of symptoms:

How did the symptoms start?

Modifying Factors:

☐ Better with Heat ☐ Worse with Heat	☐ Better with Cold ☐ Worse with Cold	☐ Worse in the morning ☐ Worse during the day	☐ Worse at night ☐ Worse with fatigue
☐ Better with Rest ☐ Better with Activity	☐ Better with Pressure/Massage ☐ Worse with Pressure/Massage	☐ Other Modifying Factors (explain):	

Associated Signs/Symptoms: (headaches, nausea, etc…)

Past Medical History

- ☐ Alcoholism/Drug Abuse
- ☐ Allergies
- ☐ Anemia/Blood Disorder
- ☐ Anxiety
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Bell's Palsy
- ☐ Blood Clots
- ☐ Cancer/Tumors
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis/Irritable Bowel
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Heart Surgery
- ☐ Headaches/Migraines
- ☐ Hepatitis A/B/C (circle one)
- ☐ Hernia
- ☐ Herpes Oral/Genital (circle one)
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Lupus
- ☐ Lyme's Disease
- ☐ Lymph Nodes Removed
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Singles
- ☐ Seizures
- ☐ Stroke/CVA/TIA
- ☐ Tuberculosis
- ☐ Other: _____

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

_____

_____

_____

_____

_____

_____

_____

Family History: (Please list any significant family illnesses.)

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Your Children: _____

Social History: ☐Married ☐Divorced ☐Single☐ Cohabitating ☐ Caretaker Child(ren)/Adult Explain_____

☐Non-Smoker (never smoked) ☐ Ex-Smoker ☐ Current Smoker ☐ How many packs per day? _____ ☐ How years?_____

Recreational Drug Consumption: ☐Never ☐Occasional ☐Frequent

How many glasses/cups do you have: Water_____daily Caffeinated beverages _____ daily/ weekly *(Circle One)* Alcohol _____ daily/week *(Circle One)*

Occupation:

Are you allergic to any medications: No ☐ Yes ☐ Please list any allergies and adverse reactions to medication or other substances:

_____

_____

_____

Current Medications, Supplements, Herbs	*For Treatment of:*

ROS	(-)	Please check all **CURRENT** positive findings
Constitutional		☐Weight Loss ☐ Weight Gain ☐ Fever ☐ Chills ☐ Poor Appetite ☐ Fatigue ☐ Insomnia ☐ Night Sweats
Eyes		☐Blurry vision ☐Eye pain ☐Eye redness ☐Decrease in vision ☐Dry eyes ☐Double vision
ENT		☐Sore Throat ☐Hoarseness ☐Ear pain ☐Hearing Loss ☐Ear Discharge ☐Nose Bleeds ☐Tinnitus ☐Sinus Problems
Cardiovascular		☐Chest Pain ☐Palpitations ☐Rapid Heart Rate ☐Heart Murmur ☐ Poor Circulations ☐Swelling in the Legs or Feet
Respiratory		☐Shortness of Breath ☐Chronic Cough ☐Coughing up Blood ☐History of Tuberculosis ☐Excess Sputum Production
Gastrointestinal		☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Blood in the Stool ☐Frequent Heartburn ☐Trouble Swallowing
Genitourinary		☐Increased Urinary Frequency ☐Blood in the Urine ☐Incontinence ☐Painful Urination ☐Urinary Retention ☐Frequent UTIs
Skin		☐Rash ☐Hives ☐Hair Loss ☐Skin Sores or Ulcers ☐Itching ☐Skin Thickening ☐Nail Changes ☐Mole Changes
Musculoskeletal		☐Joint Pain ☐Muscle Aches ☐Frequent Leg Cramps ☐Muscle Weakness ☐Bone Pain ☐Joint Swelling ☐Back Pain
Psychiatric		☐Anxiety ☐ Panic Attacks ☐Depression ☐Irritability ☐Outburst of Anger ☐Poor Memory ☐Difficulty Concentrating ☐Feeling Overwhelmed
Endocrine		☐Goiter ☐Heat Intolerance ☐Cold Intolerance ☐Increased Thirst ☐Change in Skin Pigment ☐Excess Sweating
Neurological		☐Seizure ☐Tremors ☐Migraines ☐Numbness ☐Dizziness/Vertigo ☐Loss of Balance ☐Slurred Speech ☐Stroke
Hem/Lymphatic		☐Low Blood Count ☐Easy Bruising ☐Swollen Lymph Nodes ☐Transfusions ☐Prolonged Bleeding ☐Blood Clots
Allergic/Immune		☐Allergic Reactions ☐Hay Fever ☐Frequent Infections ☐Hepatitis ☐HIV positive ☐Positive Tuberculin Skin Test (PPD)

Additional Information: Use this space to provide any additional information that may be important to your health care.

Signature of Patient Date

Katherine Elizabeth Binder CP, MS, LAc. Date
Signature of Reviewing Physician