New Client Intake Form

Name: ....Date: ....

Address:...City:......................... State: .... Zip:...........

Primary Phone:... Date of Birth: ....

Emergency Contact & Phone: ....

Occupation: .... Have you received acupuncture before? ❑ Yes ❑ No

Who are your current health care providers? ....

Insurance Info

Insurance Carrier: ....

Member Number:....................................... Provider Phone Number:...............................

Insurance Billing Policy
I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that the provider will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

Cancellation Policy
I understand that Radiant Wellness will change the full session fee when a session is broken either by not providing 24 hours notice of cancellation, not showing, or showing up 20 minutes after my appointment time.

Signature: .... Date: ....

Please list your top three concerns/goals in order of importance to you.	**Mark an X on the scale to indicate the severity of the condition.**	**When did this start?**	**What makes it better?**	**What makes it worse?**
Primary Concerns or Goals				
1.	|__________|________| 1 10			
2.	|__________|________| 1 10			
3.	|__________|________| 1 10			

Health History — Check the "Self " box if you have or had the condition and the year it began and the "Family" box if there is a family history.

Condition	Self /Year	Family	Condition	Self /Year	Family
Cancer (specify:..........)	❏..................	❏	Diabetes	❏......................	❏
Hepatitis	❏......................	❏	High blood pressure	❏......................	❏
Stroke	❏......................	❏	Seizure disorder	❏......................	❏
Thyroid disease	❏......................	❏	Asthma	❏......................	❏
Eating disorder	❏......................	❏	Rheumatic fever	❏......................	❏
Osteoporosis	❏......................	❏	Allergies	❏......................	❏
STD (specify: ....)	❏......................	❏	Kidney disease	❏......................	❏
Substance dependency	❏......................	❏	Psychological	❏......................	❏
Anemia	❏......................	❏	History of Trauma	❏......................	❏

Medications — Please list any medications, herbs or supplements that you take regularly.

What taken	For what condition
....	....
....	....
....	....

Injuries & Surgeries (including dental) — Please list what happened to what body area and when it occurred.

Date	Issue
....	....
....	....
....	....
....	....

Mark an X on the scales and check any boxes of symptoms or conditions you have had in the past month, in any applicable sections.

Digestion

- ❑ Indigestion
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Poor appetite
- ❑ Nausea
- ❑ Vomiting
- ❑ Bad breath
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Excessive hunger
- ❑ Dry stools
- ❑ Difficult to pass
- ❑ Tired after BM
- ❑ Pain with BM
- ❑ Foul-smelling stools
- ❑ Alternating diarrhea & constipation / IBS

BM: How often?................ x every .... days

Stools keep shape? ❑ Yes ❑

|____|____|

DIARRHEA **CONSTIPATION**

Women

Age at first menses: ....
Average length of full cycle: .... days (i.e. 28)
Average length of menses: .... days (i.e. 3-4)
Last menses start date: ....
# of pregnancies: .... # of births: ....
 # premature: .... # of abortions:........
# of miscarriages: ....
Do you take hormonal birth control? ❑ Yes ❑ No
What assisted interventions have you tried?
(e.g., IUI, IVF, etc) ....

Periods

❑ Heavy ❑ Light ❑ Painful ❑ Irregular ❑ Clots

Cramps

❑ before bleeding ❑ first day ❑ during period

Menopause

Age at last menses: ..... Year changes began: ....
Vaginal dryness ❑ Loss of sex drive

During cycle

❑ Changes in body/psyche prior to menstruation
❑ Fatigue ❑ Breast tenderness ❑ Mood changes
❑ Digestive changes ❑ Mid-cycle spotting
❑ Hot flashes: .... x per day
❑ Night sweats: .... x per week

Energy

|____|____|

LOW **HIGH**

- ❑ Sudden energy drop time of day:.................
- ❑ Energy drop after eating
- ❑ Dependence on caffeine/stimulants
- ❑ Wired or ungrounded feeling
- ❑ Body or limbs feel heavy
- ❑ Body or limbs feel weak
- ❑ Shortness of breath
- ❑ Heart palpitations
- ❑ Blood pressure high / low
- ❑ Bleed / bruise easily
- ❑ Difficulty concentrating
- ❑ Poor memory
- ❑ Dizziness / lightheadedness
- ❑ Headaches: .... x per week

Emotions — What emotions are troubling to you or dominate your experience?

- ❑ Anger
- ❑ Irritability
- ❑ Anxiety
- ❑ Worry
- ❑ Obsessive Thinking
- ❑ Sadness
- ❑ Grief
- ❑ Depression
- ❑ Joy
- ❑ Fear
- ❑ Indecisiveness
- ❑ Timidness / Shyness

Sleep

- ❑ ....# hours per night
- ❑ Difficulty falling asleep
- ❑ Disturbing dreams
- ❑ Restless sleep
- ❑ Not rested upon waking
- ❑ Wake .... x per night at .... am / pm
- ❑ Wake to urinate: how often: :.....................

Temperature — How warm or cold you feel relative to other people?

|______________________________|______________________________|

COLD **HOT**

- ❑ Cold hands or feet
- ❑ Chills
- ❑ Cold "in the bones"
- ❑ Numbness
- ❑ Hot flashes
- ❑ Hot at night
- ❑ Night sweats
- ❑ Unusual sweats

Consent to Treatment

Patient Informed Consent

I agree to receive acupuncture treatment by the licensed acupuncturists of Radiant Wellness. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. On rare occasion current symptoms may worsen before they find relief. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment.

If I am pregnant or become pregnant, I will notify my practitioners immediately.

I understand that the acupuncturists of Radiant Wellness use only sterile, disposable, single-use needles, practice safe needling techniques, and maintain a clean and safe environment.

I understand that the Radiant Wellness practice may reach out to medical providers to introduce our services. No confidential information will be released. I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

I have read this form and have also had an opportunity to ask questions about its content. 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.

I agree:

Signature.. Date..

Print name ....

How Did You Hear About Us?

- ❑ Friend or family:..
  (we want to thank them!)
- ❑ Google or internet search
- ❑ Health Practitioner: ....
  (we want to thank them!)
- ❑ Yelp
- ❑ Picked up Postcard, Coupon or Misc Print Material
- ❑ Facebook/Twitter/Instagram

- ❏ **Walked-By or Live in the Neighborhood**
- ❏ **Other……………………………………………**