



# Health In Motion

Personalized Acutherapy by Kim Fong

Acupuncture Intake Form

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## New Patient Packet

*It is very important the information given is complete and accurate to assist you properly in your healing process.*

*Note: Information provided on this form is confidential.*

**Please Print Clearly**

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

### BACKGROUND INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ City/ State/ Zip \_\_\_\_\_

Phone # Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_ What is the best way to reach you? Home / Work / Mobile / Email

Occupation \_\_\_\_\_ Emergency Contact /Nearest Relative \_\_\_\_\_ Phone # \_\_\_\_\_

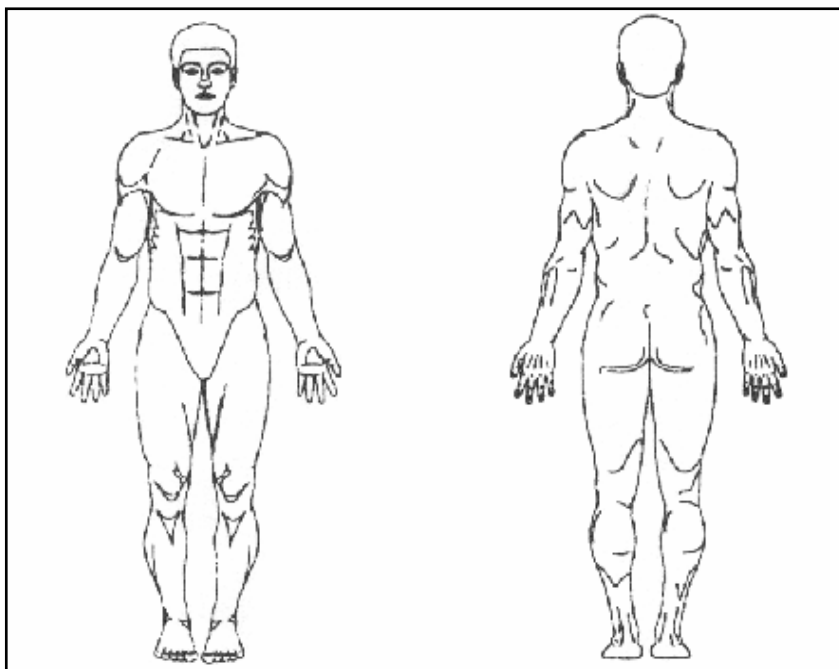
Physician \_\_\_\_\_ Physician's Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us? Friend  Relative  Website  UHC Network  Dr.: \_\_\_\_\_ Other \_\_\_\_\_

What health condition(s)/issue(s) would you like treated? Please list in order of priority.

Condition/Issue	Onset Sudden	Medical Diagnosis	What Treatment Methods Have you Received for the Condition/Issue Listed?	Symptoms Better by	Symptoms Worse by
	Y / N		<input type="checkbox"/> Chiro <input type="checkbox"/> ACU <input type="checkbox"/> PT <input type="checkbox"/> Injections <input type="checkbox"/> Counseling		
	Y / N		<input type="checkbox"/> Chiro <input type="checkbox"/> ACU <input type="checkbox"/> PT <input type="checkbox"/> Injections <input type="checkbox"/> Counseling		
	Y / N		<input type="checkbox"/> Chiro <input type="checkbox"/> ACU <input type="checkbox"/> PT <input type="checkbox"/> Injections <input type="checkbox"/> Counseling		
	Y / N		<input type="checkbox"/> Chiro <input type="checkbox"/> ACU <input type="checkbox"/> PT <input type="checkbox"/> Injections <input type="checkbox"/> Counseling		

**On the following drawings, shade in the areas where you feel should be addressed.**



**PAST MEDICAL HISTORY**

Have you had any of these condition(s)? Check all that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Allergies (food, latex) | <input type="checkbox"/> Hepatitis A/B/C       | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Birth Trauma            | <input type="checkbox"/> Joint Replacement(s)  | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Lyme Disease          | <input type="checkbox"/> Sinus Infections   |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lymph Node(s) Removed | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Drug Addictions         | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Operations _____   |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Other _____        |

**Family Medical History:** (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

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

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

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

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

**CURRENT MEDICAL HISTORY**

Is this your first experience in Oriental Medicine? Yes / No How do you feel about Acupuncture? \_\_\_\_\_

**Exercise & Energy:** How is your energy? \_\_\_\_\_

What time of day is your energy: Highest? \_\_\_\_\_ Lowest? \_\_\_\_\_

Do you fatigue easily? Y / N What kind of exercise do you do? \_\_\_\_\_ How often do you exercise? \_\_\_\_\_

**Emotions & Sleep:** How do you feel emotionally? \_\_\_\_\_

Do you have (check all that apply):  Panic Attacks  Depression  Anxiety  Bad Temper  Nervousness  
 Fear Attacks  Poor Memory  Difficult Concentration

Are you in a relationship? Yes / No How do you feel about your relationship? \_\_\_\_\_

How do you hold stress? \_\_\_\_\_ How do you relax? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_ How long do you normally sleep? \_\_\_\_\_ hrs./night

I have difficulties with (check all that apply):  Falling Asleep  Staying Asleep  Dream-disturbed Sleep

Waking up at about \_\_\_\_\_ AM/PM and not being able to fall asleep again  Other \_\_\_\_\_

**Gastrointestinal:** I have (check all that apply):  Belching  Nausea  Vomiting  Vomiting of Blood

Ulcers  Bloating  Acid Regurgitation  Heartburn  Hernia  Indigestion  Severe Stomach Pain

Bowel Movements: How often? \_\_\_\_\_ time(s)/day \_\_\_\_\_ days/wk.

I have (check all that apply):  Irregularity  Constipation  Diarrhea  Gas  Burning Sensation

Hemorrhoids  Undigested Food in Stool  Loose Stool  Hard Stool  Blood in Stool  Itchiness

Painful Bowel Movements  Other \_\_\_\_\_

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**Urinary:** Urination: How often? \_\_\_\_\_time(s)/day Color:  Pale Yellow  Dark Yellow/Orange

I have or had (check all that apply):  Trouble Starting Stream  Frequent Urination  Incontinence  Pain  
 Burning  Dribbling when Sneezing  Blood in Urine  Kidney Stone(s)  Urinary Tract Infection(s)  
Other \_\_\_\_\_

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**Women:**

Are you currently pregnant? Yes / No Are you presently trying to get pregnant? Yes / No  
At what age did you start menstruating? \_\_\_\_\_ Number of days between cycles \_\_\_\_\_  
Number of days of flow \_\_\_\_\_ Color \_\_\_\_\_  
I have or had (check all that apply):  Irregular Menstruation  Heavy Flow  Light Flow  No Flow  Clots  
 Vaginal Itching/Burning  Spotting Between Periods  Discomfort/Pain Before Period  Discomfort/Pain  
During Period  Other \_\_\_\_\_ Any Vaginal Discharge? Yes / No Color \_\_\_\_\_

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**Men:**

I have (check all that apply):  Prostatitis  Impotence  Penis Blood/Mucous Discharge  
 Other \_\_\_\_\_

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**Muscles, Joints & Bones:**

Do you have pain or tightness? Yes / No Where? \_\_\_\_\_ The pain is (check all that apply):  
 Sharp  Dull  Aching  Numb  Superficial  Deep  Burning  Tingling  Shooting  
 Pain Worse/Better with Heat  Pain Worse/Better with Cold  Pain Worse/Better with Pressure  
 Pain Worse in AM/PM  
I have (check all that apply):  Swollen Joints  Arthritis/Joint Pain  Tendonitis  Bone Pain  
 Muscle Cramping  Muscle Pain  Repetitive Strain Injury  Fractured Bone(s) Where? \_\_\_\_\_  
Other \_\_\_\_\_

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**Eyes, Ears, Nose, Throat, & Head:**

Do you smoke? Yes / No \_\_\_\_\_per day, for \_\_\_\_\_years  
I have (check all that apply):  Frequent Colds  Chronic Runny Nose  Frequent Sore Throats  Chronic  
Cough  Coughing Blood  Coughing Mucous  Pain Inhaling  Shortness of Breath on Exertion/at Rest  
 Asthma  Nose Bleeds  Painful/Red Eyes  Poor Vision  See Spots/Floaters  Dizziness  
 Cold Sores  Bleeding Gums  Dry Mouth  Ear Pain  Ringing in Ears  Clogged/Popping in  
Ears  Frequent Headaches/Migraines:  
Describe \_\_\_\_\_

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**Cardiovascular:**

I have (check all that apply):  Chest Pain  Palpitation  Varicose Veins  Phlebitis  
 Cold Hands and Feet  Irregular Heart Beat  Poor Circulation  Other \_\_\_\_\_

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**Skin & Hair:**

I have or often have (check all that apply):  Dry Skin  Skin Rashes  Itching  Acne  Eczema  
 Hives  Hair Loss  Premature Graying  Other \_\_\_\_\_

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## TREATMENT INFORMATION AND INFORMED CONSENT

Please take time to read this form, which will provide you with some basic knowledge about acupuncture and/or physical therapy treatment.

Acupuncture is performed by the insertion of pre-sterilized, disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to certain points on the body. Your acupuncture treatment may be combined with physical therapy. It may also be combined with tui-na/acupressure, Chinese herbs, moxibustion, cupping, electric stimulation, infrared heat lamp, and/or therapeutic exercises based on the fundamentals of Chinese Medicine. Your practitioner will explain the nature of each type of treatment as needed.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing.
- Maintain good personal hygiene.
- Avoid treatment when excessively fatigued, hungry, full, or emotionally upset.
- We are unable to treat patients who are intoxicated and /or are abusing substances.

**Acupuncture** is generally very safe. Although rare, certain side effects may result from acupuncture and each procedure or treatment has specific risks and benefits. While receiving acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness. Other potential risks from acupuncture are very rare. These risks include infection, bleeding, or pneumothorax (e.g. collapsed lung). We only use sterile needles one time, so the risk of infection is minimal and extremely rare. It is important that you advise the acupuncturist if you are on any blood thinning medication.

**Physical therapy** is performed by exercising, massaging, and/or applying heat to certain points of the body. Your physical therapy treatment may be combined with acupuncture. The Physical Therapist works to identify, prevent, improve, and/or restructure movement dysfunction. Holistic physical therapy treats the mind and the body. Rather than treating the conditions as dissected parts, the body is treated as a complete system – very much like the concepts of Oriental Medicine. We treat patients with deficits in range of motion, strength, endurance, and function due to musculoskeletal, cardiovascular or neurological involvement.

Please inform your practitioner if you have any of the following conditions:

- If you are pregnant and/or breastfeeding
- If you have ever experienced seizures, fainting or panic attacks
- If you have a pacemaker or any other electrical implants
- If you have HIV/AIDS, hepatitis or a sexually transmitted disease

Everyone responds to treatment differently therefore, we cannot guarantee the outcome. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visit(s), so that your treatment plan can be adjusted accordingly. Depending on your condition and your goal for treatment, we may require a physician referral in order for you to continue treatment in our clinic. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change, or if any new condition(s) arise.

The Notice of Privacy Practice, which describes how we may use and disclose your protected health information, is available upon request.

By signing this informed consent, you (the patient) acknowledge that you have read the information above carefully and are giving consent for treatment.

\_\_\_\_\_ Date \_\_\_\_\_  
*Signature of Patient or Guardian if patient is a minor.*  
I have read and understand the above statement.

\_\_\_\_\_ Date \_\_\_\_\_  
*Signature of Witness*