Robyn Gordon, M.A., M.Ac., L.Ac.

NEW PATIENT INTAKE FORM

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.

All answers are confidential. Please print clearly in ink.

IIDENTIFICATION: Date: _____

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Date of Birth: _____ Age: _____ E-mail: _____

Height: _____ Weight: _____ Education: _____

Occupation: _____

_____ Single _____ Married _____ Partner _____ Widowed _____ Separated _____ Divorced

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: _____

I am a provider with Aetna, CareFirst, Cigna, & United Healthcare. If you have a policy with one of these companies, please provide the following information:

Name of Insurance Co: _____

Name of Policy Holder: _____

Member ID: _____

Group number: _____

Reason for visit: _____

_____

_____

FAMILY HISTORY Please complete for each family member as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	Self (date)	Mother	Father	Sibling	Partner	Child(ren)
Adopted						
Good Health						
Cancer or tumors						
Diabetes (indicate Type 1 or 2)						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/ anemia						
Seizures						
Allergies						
Alcohol or drug use						
Depression or mental illness						
Hepatitis/ other liver disease						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (indicate age)	N/A					

PERSONAL LIFESTYLE HABITS For each item, please indicate how many or how often. Please note if this is current or the date you quit.

Cigarettes (packs per day) _____ Alcohol (drinks per week) _____
Coffee/Tea (cups per day) _____ Soda (regular or diet) _____
Recreational drug use (what kind/often?) _____
Exercise (what kind/how often?) _____

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below (do not include normal pregnancies/labors):

YEAR **OPERATION/ILLNESS** **HOSPITAL**

_____
_____
_____
_____

MEDICINES Please list all medications, vitamins, herbs, and/or food supplements you are currently taking:

MEDICATION/SUPPLEMENT **DOSAGE** **FOR WHAT CONDITION**

_____
_____
_____
_____

CURRENT AND PAST CONDITIONS/ SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P. Mark "P-C" if you have experienced both past and currently.

General

____ Insomnia
_____ Dreams/ nightmares
_____ Fatigue
_____ Poor memory
_____ Strongly like cold drinks
_____ Strongly like hot drinks
_____ Recent weight loss/gain
_____ Cold hands & feet
_____ Chills
_____ Fever
_____Bad breath
Other (describe) _____

Head & Neck

_____ Headaches
_____ Migraines
_____ Stiff neck
_____ Dizziness
_____ Fainting
_____ Swollen glands
Other (describe)
_____

Ears

_____ Ringing
_____ Hearing loss
_____ Hearing aids
_____ Infections
_____ Earache
_____ Vertigo
Other (describe)
_____

Eyes

_____ Glasses/contact lenses
_____ Blurred vision
_____ Poor night vision
_____ Spots or floaters
_____ Eye inflammation
_____ Double vision
_____ Glaucoma
_____ Lazy eye
Other (describe) _____
How often checked
_____

Nose, Throat & Mouth

Sinus Infection
_____ Hay fever/allergies
_____Frequent sore throat
_____ Difficulty swallowing
_____Mouth & tongue ulcers
_____ Frequent colds
_____ Nosebleed
_____ Dry nose
_____ Nasal congestion
_____ Loss of voice
_____ Thirst
_____ Excessive phlegm
_____ TMJ
_____ Facial pain
_____ Gum problems
_____ Dry mouth
_____ Dental problems?
Last dental visit _____
Other (describe) _____

Skin

_____ Hives
_____ Rashes
_____ Eczema/psoriasis
_____ Night sweating
_____ Excess sweating
_____ Dry skin
_____ Easily bruised
_____ Changes in moles, lumps
_____ Itching
Other (describe) _____

Respiratory

_____ Difficulty breathing
_____ Difficulty breathing when reclining
_____ Wheezing
_____ asthma
_____ Chronic cough
_____ Wet cough
_____ Dry cough
_____ Coughing up phlegm
_____ Coughing up blood
_____ Shortness of breath
_____ Tight chest
_____ Pneumonia
Other (describe) _____

Cardiovascular

_____ High blood pressure
_____ Low blood pressure
_____ Chest pain or tightness
_____ Palpitation
_____Rapid heart beat
_____Irregular heart beat
_____ Poor circulation
_____ Swollen ankles
_____ Phlebitis
_____ Anemia
_____ History of heart disease
_____ Heart murmur
_____ Night sweats
_____ Tendency to be cold
_____ Tendency to be warm
Other (describe) _____

Gastrointestinal

_____ Nausea
_____ Indigestion
_____ Stomach pain
_____ Diarrhea
_____Constipation
_____Poor appetite
_____Excessive hunger
_____ Vomiting
_____Gas
_____ Hiccups
_____Acid reflux/regurgitation
_____ Bloating
_____ Laxative use
____ Bloody stool
Other (describe) _____

Musculoskeletal

_____ Joint pain/swelling
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Pain (describe)
_____
_____ Limited range of motion

Neurological

_____ Seizures
_____ Tremors
_____ Numbness or tingling
_____ Paralysis
_____ Poor coordination
_____ Pain (describe)
_____
_____

Mental/Emotional
_____ Depression
_____ Mood swings
_____ Irritability
_____ Difficulty relaxing
_____ Loneliness
_____ Sensitive
_____ Shyness
_____ Frequent crying
_____ Frequent worrying
_____Compulsive behavior
_____ Difficulty focusing
_____ Hopeless outlook
_____ Suicidal thoughts
_____ Lose temper easily
_____ Frustration
Other (describe) _____
_____

Urinary
_____ Pain on urination
_____ Frequent urination
_____ Urgent urination
_____ Blood in urine
_____ Incontinence
_____ Incomplete
_____ Bedwetting
_____ Wake to urinate
_____ Kidney (specify)
_____
Other (describe) _____
_____
_____

Male Genital
_____ Impotence
_____ Premature ejaculation
_____ Nocturnal emission
_____ Pain/itching of genitalia
_____ Lumps in testicles
_____ Increased libido
_____ Decreased libido
Other (describe) _____
_____

Gynecological
_____ Currently pregnant
_____ # or pregnancies
_____ # of live births
_____ # of miscarriages
_____ # or abortions
_____ Menopause
_____ Irregular periods
_____Menstrual cramps
_____ Excessive blood flow
_____ Breast tenderness
_____ Abnormal Pap smear
_____ Vaginal infections
_____ Vaginal pain/itching
_____ Uterine fibroids
_____ Endometriosis
_____ Breast lumps/cysts
_____ Increased libido
_____ Decreased libido
Other _____

Infection Screening (Circle self and/or partner)
_____ HIV risks: self or partner
_____ TB: self or partner
_____ Hepatitis risk: self or partner
_____ History of sexually transmitted disease: self or partner (specify)
_____
_____
Other (describe)
_____
_____

Trauma (list)
_____
_____
_____
_____
_____

Other Information
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Patient Signature Date

Robyn Gordon, M.A., M.Ac., L.Ac.

Office Policies & Procedures

Welcome to the Acupuncture practice of Robyn Gordon, M.A., M.Ac., L.Ac. at Crossings Healing & Wellness. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies. Please read each policy statement below and provide your initials to signify your agreement and understanding of each.

FEES The fees charged in this office are comparable to those charged by other healthcare providers with similar qualifications in this area. Please ask to see our fee schedule if you have a question about rates. We accept cash, credit cards, and personal checks. Please note: there is a $35.00 charge for checks returned due to insufficient funds.

Initial _____

INSURANCE COVERAGE Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of the deductible and the percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

Initial _____

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial _____

CANCELATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least **24 hours in advance** if you need to cancel or reschedule your appointment. You will be charged a $90.00 fee for any missed appointment or cancellation giving less than 24 hours' notice for any non-emergency situations.

Initial _____

FINANCIAL AGREEMENT/ ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered or upon receiving my bill. If I choose to use my insurance I understand I will be responsible for all "non-covered" services and / or coinsurance/ co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Robyn Gordon, M.A., M.Ac., L.Ac.

By signing below, I agree to comply with the office policies stated above which I have read and understand. I also authorize the use of this signature on all insurance submissions.

Signed _____ **Date** _____