HEALTH & HOPE INSTITUTE

Allow Nature and your Heart to guide your Healing Journey

MEDICAL RECORD - NEW PATIENT INTAKE FORM

Date _____ **Last Name** _____ **First Name** _____ **Middle** _____

Birthday _____ Place of Birth _____ Age _____ SS# _____
Sex M – F . Ht _____ Wt _____ Marital Status M-S-W-D-Other. Age(s) of Children _____
Address _____ City _____ State _____Zip Code _____
Telephone _____Cell _____ E-Mail: _____
Emergency Contact Name & Phone _____
_____How many Hrs/day: Working _____ Sleeping _____
Occupation _____ How did you hear from us/Referred by _____
Primary Physician _____ Specialty _____ Phys. Phone _____
Doctor's Diagnosis _____ Prognosis _____ Last visit _____

Please list the (3) three main Health complaints/concerns in order of their importance:

_____
_____
_____
Treatments received _____
Other symptoms _____
Does this condition interfere with your daily activities (work, exercise, sleep, sex, etc.)? How? _____
_____

Past Medical History (Significant Illnesses): Cancer ___ Diabetes ___ High Blood Pressure ___ Hepatitis ___ Heart Disease ___ Rheumatic Fever ___ Thyroid Disease ___ Epilepsy ___ Kidney Problem ___ Immune problems ___ Other _____Degenerative/Chronic Disease_____
Surgeries/When_____
_____ Exercise (type/how much) _____ Allergies _____
Occupational Stress (chemical, physical, psychological) _____ Birth History (prolonged labor, forceps delivery)_____ Significant Trauma (auto accidents, falls, etc.) _____

Diet/Life-Style: How many portions/cups of the following per day? Cigarettes_____ Coffee ___ Tea ___ Soda ___ Sweets/Candy ____ Salt _____ Green/Leafy Vegetables ____ Other Vegetables ____ Whole Grains/Nuts ____ Fruits ____ Cereal/Bread ____ Fried Foods ____ Microwave/Frozen Meals ____ Alcohol ____ Other _____

Drugs: a. Prescription _____
b. Over the counter _____ c. Recreational _____
d. Vitamins/Herbs_____

Cardiovascular: Blood Pressure: High _____ Low _____ Normal _____. Irregular Heart beat ___ Blood Clots ___ Fainting/Dizziness ___ Chest pain/Oppression ___ Difficulty breathing ___ Cold hands and feet ___ Phlebitis ___Varicosities ___ Swelling in hands and feet ___ Pacemaker _____
Other _____

Family Medical History (Diabetes, Cancer, Alcoholism, Drug Abuse, Heart Disease, ...) _____
_____
_____

Respiratory:
Cough ___ Coughing blood ___ Asthma ___ Bronchitis ___ Tight chest ___ Difficulty breathing when lying down ___ Pneumonia ___. **Phlegm:** ___ Thin ___ Thick ____ How much? ____What color? _____
Other lung problems _____

Gastrointestinal:
Nausea ___ Vomiting ___ Acid reflux ___ Gas ___ Belching ___ Bad Breath ___ Bowels Movement/day ____
Diarrhea ___Constipation ___ Rectal pain ___ Hemorrhoids ___ Sensitive abdomen ___ Pain/cramps _____
Bloody stools ___ Black stools ___; How often? _____. Laxative use _____; How often? _____
Other _____
Bowel movement: Frequency ___ Color ___ Odor ___ Texture/form _____

Genito-Urinary:
Pain/burning on urination ___ Frequent urination ___ Urgency to urinate ___ Unable to hold urine ___
Blood in urine ____ Impotency ____ Premature ejaculation ____ STD/Venereal Dis._____
Wake up at night to urinate ___ time(s) what time _____. Other _____

Musculoskeletal:
Neck pain ___ Back pain ___ Fractures _____ Joint pain (where) _____
Muscle pain _____ Scars (accidents/surgeries) _____
Amputations _____ Malformations _____ Gait problems _____
Other bone, joint, muscle or ligament problem _____

Neuro-Psychological:
Seizures ___ Poor memory ___ TIA/Stroke ___ Herniated Disc (level) _____
Areas of numbness/tingling _____ Nerve pain (where) _____
Confusion ___ Concussion ___ Head Trauma ___ Spine Injury ___ Blurry vision ___ Migraine ___
Parkinson's Disease ___ Alzheimer's Disease ___ Coordination problems _____
Balance problems during: Gait ___ Standing ___ Changes in position _____
Stress (when) _____ Anxiety ___ Depression ___ Paranoia ___ Poor Self-Esteem _____
Irritability ___ Considered/attempted Suicide/When _____
Treated for emotional problems/When _____
Most predominant Feeling/Emotion _____ Other Emotion_____

Pregnancy and Gynecology:
# of Pregnancies ___ Number of births ___ Premature births ___ Miscarriages ___ Other _____
Age at first menses ____ Period cycle (days) ____ Period duration ____ Irregular periods _____
Flow (light, medium, heavy) _____ Clots ___ Last PAP _____ Last menses _____
Vaginal discharge (color/amount/odor) _____ Burning/itching _____
Vaginal sores ___ Breast Lumps ___ Fibrocystic Breast ___ Menopause (age) _____
Pre-Menstrual changes (physical/emotional) _____

Any possibility of being Pregnant?_____ Birth control (Type/duration) _____
Other _____

General:
Sleep: # Hrs. ___ Quality: Heavy ___ Poor ___ Feeling rested and energized: Yes __ No __ Insomnia (from what time) _____ Difficulty Falling Asleep _____ Difficulty Staying Asleep _____
Appetite: Heavy ___ Poor ___ Fatigue ___ Tremors ___ Vertigo ___ Fever ___ Chills ___ Sweat easily ___
Night sweat (time) _____ Heat Sensation rushing to: Face ___ Chest ___ Hands ___ Feet ___
Relationships/Intimacy (level of satisfaction: low, medium, good) _____
Cold hands ___ Cold feet ___ Cold back ___ Cold abdomen ___ Sudden energy drop (time) _____
Localized weakness _____ Peculiar taste/smell _____
Strong thirst (cold/hot drinks) _____ Bleed/bruise easily (where) _____
Eye strain ___ Eye pain ___ Glasses ___ Night blindness ___ Color blindness ___ Cataracts ___
Poor hearing ___ Nose bleeds ___ Sinus problems ___ Ringing in ears (high/low pitch) _____
Teeth problems ___ Gum problems ___ Lip/tongue sores ___ Recurrent sore throats (month) _____
Dry mouth ___ Dry throat ___ Copious saliva ___ Blood transfusions ____
Rashes ___ Eczema ___ Ulcerations ___ Pimples ___ Hives ___ Itching ___ Change in hair/skin texture ___
Loss of Hair ___ Dandruff ___ Purpura ___ Jaundice ___ Other _____
Any Infectious Disease _____TB risk (self /partner) ____ Hepatitis (self/partner) ___ Other_____

Headaches: How long ago? _____ Why do they start? _____
Where? _____ How does it start? _____ How does it feel? _____ At What Time do they appear?_____ What makes it feel better? _____ Other _____

Classical:	Season	Taste	Color	Climate	Time of the day	Temperature
Most liked	_____	_____	_____	_____	_____	_____
Least liked	_____	_____	_____	_____	_____	_____

Additional Information/Concerns. What do you expect to achieve from receiving Treatments at Health & Hope Institute?_____
_____
_____
_____
_____

Signature _____ Printed Name _____ Date_____

***My initials confirm that I have read and/or that I could get a copy of the Privacy Policy observed by Health & Hope Institute, LLC.**

Patient's Initials _____

INFORMED CONSENT TO ACUPUNCTURE & ALTERNATIVE MEDICINE TREATMENT

I give consent to receive Acupuncture and Oriental Medicine treatments and/or any procedures associated with Natural Alternative Healing and Bio-Energetic Medicine that could be provided at Health & Hope Institute.

I understand that the methods of treatment may include, but are not limited to, **Acupuncture** (Chinese, Japanese, Toyohari), **Acupressure, Moxibustion** (burning of the herb Artemisa Vulgaris), **Cupping, Guasha, Cranio-Sacral Therapy, Electrical stimulation, Homotoxicology** (Homeopathic injections, drops, tablets), **Nutritional Counseling, Therapeutic Massage and Tui Na** (Chinese Massage).

Acupuncture provides a Safe and Effective Mode of Therapy with No Adverse Side effects. In few cases it may cause some bruising, numbness, tingling or dull sensation near needling sites, which may last for a few hours. Very few patients may experience dizziness and/or fainting (Usually happening if patient has not eaten prior to treatment or if is very ill and/or weak); however, in general treatments will strengthen the whole body and provide a sense of relaxation and wellbeing.

Very unusual complications due to Practitioner's lack of knowledge or experience may include nerve damage, puncture of a major artery or the lung (pneumo-thorax); **however, at Health & Hope Institute, only highly skilled Point Location and Needling techniques are applied.**

Infections are a remote risk; **however, at Health & Hope Institute we maintain a Safe and Clean Environment, and only Sterile, Single use, Disposable needles are used for insertion**. Local Burns and/or Minor Scarring are a potential risk of moxibustion; however, patient skin is protected at all times.

I will notify my Acupuncture Physician of any significant changes in my condition or concerns that I may have. ***Female Patient: I will notify my Acupuncture Physician if I become pregnant, because of the risk of spontaneous miscarriage with the strong stimulation of certain points.***

I do not expect my Acupuncture Physician to anticipate and explain all the possible risks and complications of treatment; I will rely on my practitioner to exercise judgment during the course treatment, which she may think necessary at the time, based upon the facts known to her, to be on my best interests.

By voluntarily signing below, I show that I have read, or have had read to me this consent to treatment; have been told about the risks and benefits of Acupuncture treatments and associated procedures, and have had an opportunity to ask questions regarding same.

My Acupuncture Physician may discontinue treatment at any time in the event that no significant improvement for my condition seems to be achieved.

I intend for this consent to cover the entire course of therapy for my present condition, and for any future condition(s) for which I may seek treatment.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date

_____

Acupuncture Physician's Signature – Date