



Surfacing Wellness & Health

Lisa Reichert, L.Ac

Client Intake Form

Thank you for providing us with a complete account of your health and well-being. Please discuss any aspect of the questions or your responses with your acupuncturist.

I know this is a lengthy form, but what seems like inconsequential details are usually useful in a TCM diagnosis. Provide as much detail as you would like for all the following questions and lists. Thank You.

Name _____ Referred by _____

Address _____

City, State, Zip _____

Phone: Home _____ Work _____ Cell/Pager _____

Age _____ Ht _____ Wt _____ Occupation _____

Relationship Status Single, Live Alone Single, Shared Living

Partnered Married Divorced # of Children: _____

Emergency Contact _____ Phone: _____

Primary Care Practitioner/Physician: _____

Primary Complaint

Please include, briefly, complaint, time of onset, cause (if known), factors that aggravate symptoms, and any other pertinent information.

What outcome would you like from acupuncture services?

Have you received acupuncture before? Yes No When? Condition?

How would you rate your current level of health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Assistance on Your Path to Wellness & Health

Nutrition

Please indicate the use and/or frequency of the following:

	Never	Some-times	Often		Never	Some-times	Often
Coffee				Tobacco			
Tea				Alcohol			
Soda				Exercise			
Water				Recreation drugs			

Do you usually eat three meals a day? _____ If not, how many? _____

If you follow a diet or food plan? _____

What percentages of your diet is the following:

_____ Animal protein _____ Vegetables _____ Carbohydrates (breads, rice, pasta)

_____ Fruit _____ Sweets _____ Snacks

List any suspected or known allergies or sensitivities to foods, medications, or drugs:

Personal & Family History

Check those applicable:	Self	Parent	Grandparents		Self	Parent	Grandparents
Asthma	_____	_____	_____	Chicken Pox	_____	_____	_____
Alcoholism/Drug Abuse	_____	_____	_____	Chrohn's Disease	_____	_____	_____
Alzheimer's	_____	_____	_____	Diabetes	_____	_____	_____
Anemia	_____	_____	_____	Eating Disorders	_____	_____	_____
Anxiety/Depression	_____	_____	_____	Emphysema/COPD	_____	_____	_____
Arteriosclerosis	_____	_____	_____	Gout	_____	_____	_____
Arthritis (indicate type)	_____	_____	_____	Headache/Migraine	_____	_____	_____
Bleeding Disorder	_____	_____	_____	Heart condition (type)	_____	_____	_____
Bronchitis	_____	_____	_____	Hepatitis (A, B, C)	_____	_____	_____
Cancer (indicate type)	_____	_____	_____	HIV	_____	_____	_____
Celiac's Disease	_____	_____	_____	Hypertension	_____	_____	_____

Assistance on Your Path to Wellness & Health

	Self	Parent	Grandparents
Hypotension	_____	_____	_____
Hypoglycemia	_____	_____	_____
Intestinal parasites	_____	_____	_____
Irritable Bowel Syndrome	_____	_____	_____
Kidney Disease	_____	_____	_____
Liver Disease	_____	_____	_____
Mental Illness	_____	_____	_____
Multiple Sclerosis	_____	_____	_____
Mumps	_____	_____	_____
Numbness, Neuropathy	_____	_____	_____
Reproductive issues	_____	_____	_____
Seizures	_____	_____	_____
Sexually Transmitted Disease	_____	_____	_____
Sinus Infection	_____	_____	_____
Skin condition	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers	_____	_____	_____

Do you have a pacemaker or any other metal devices inside your body?

No Yes If yes, which one and where? _____

Review of Systems

Please check the following that pertain to you

Overall Temperature

- Hot body temperature or sensation
- Cold hands
- Sweaty hands
- After-noon flushes
- Cold body temperature of sensation
- Cold feet
- Sweaty feet
- Night sweats
- Heat in the hands, feet and chest
- Hot flashes any time of the day
- Lack of perspiration
- Perspire easily
- Thirsty: for hot or cold drinks

Overall Energy

- Difficulty keeping eyes open in the daytime
- Shortness of breath
- General weakness

Assistance on Your Path to Wellness & Health

Review of Systems

Please check the following that pertain to you

Overall Blood Function

- See floaters or floating black spots in the eyes
- Recent moles, unusual moles
- Freckles
- Dizziness
- Pimples

Heart Function

- Cardiovascular disease
- High blood pressure
- Low blood pressure
- Chest pain
- Fainting
- Palpitations
- Sores on tip of tongue
- Chest pain traveling to shoulders or down arms

Sleep and Emotions

- Restlessness
- Anxiety
- Hard to fall asleep
- Wake unrefreshed
- Nightmares
- Restless sleep
- Mental Confusion
- Restless dreaming
- Waking during the night

Lung Function:

- Profuse nasal discharge: thin/clear/runny thick/white thick/yellow
- Cough: Wet or Dry
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry, itchy throat
- Sore throat
- Dry skin
- Allergies: to what?
- Sneezing
- Hives
- Stiff neck
- Stiff shoulders
- Bronchitis
- Rashes
- Itching
- Eczema
- Dandruff
- Sadness
- Melancholy
- Difficulty inhale or exhale
- Alternating fever and chills
- Achy feeling in the body

Eyes

- Itchy
- Red or Bloodshot
- Hot
- Dry
- Watery
- Gritty or sandy feeling
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted
- Cataracts
- Visual Disturbances

Assistance on Your Path to Wellness & Health

- Burning sensation after eating
- Large appetite
- Bad breath
- Vomiting
- Sores on lips, tongue or mouth
- Ulcer (if diagnosed)
- Belching
- Acid regurgitation
- Cold sensation in stomach
- Hiccoughs
- Stomach Pain
- Heartburn
- Bleeding, swollen or painful gums

Elimination Function:

- Constipation (less than 5 times weekly)
- Consistent use of laxatives: what type of laxative?
- Diarrhea or loose stools
- Incomplete Bowel Movements
- Alternating loose and constipation
- Blood in Stools
- Mucous in stools
- Undigested food in stools
- Black or tarry stools

How many times per day do you urinate?

Do you wake during the night to urinate?

How many times per night?

- Normal color urine
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong Odor
- Burning
- Painful
- Difficult
- Urgent

Structural

- Tingling sensations
- Muscle Cramping
- Foot or ankle weakness or pain
- Numbness
- Muscle Spasms
- Muscle Twitching
- Neck tension
- Shoulder tension
- Hip pain/Sciatica
- Teeth Grinding
- Frequent cavities
- Easily Broken Bones
- Poor hearing
- Earaches
- Painful knees
- Weak knees
- Cold in knees
- Low back pain

General

- General sensation of heaviness in body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring
- Dizziness
- Snoring
- Phlegm production

Assistance on Your Path to Wellness & Health

Female Patients Please fill the following section

Pregnancy Are you presently pregnant? Y N Not sure

Number of pregnancies_____ Births_____ Abortions_____ Miscarriages_____

What form of birth control do you use?_____

What form of birth control have you used in the past?_____

Have you had difficulty conceiving?

- Hot flashes Dry vaginal fluids Copious vaginal discharge Nipple discharge

Date of last Pap exam and results

Approximate Date of last breast exam or mammogram and results

Approximate Date of last bone density scan and results

Have you ever had any gynecological surgeries or any abnormal findings on any tests?

Menstruation Age of first menses Age of menopause, if applicable

Date of Last Menstrual Period: Number of days of flow: General length of complete monthly cycle:

Are your periods:

- Short (Less than 28 days) Long (28+ days) Varied Regular

How many days do you bleed?_____

Painful? Before During After

Do you bleed Heavily Lightly Very little Between periods After intercourse

Do you have clots ? Early in the cycle Throughout

Relative to the blood color and consistency of a cut, is your menstrual blood:

- Same color Paler Purple Red Brown
 Same consistency Watery Thicker Contains cervical fluid

Do you have any of the following Pre-Menstrual Symptoms? When dos PMS begin?

- Irritability Depression Crying Rage Breast Tenderness
 Nausea Bloating/Water retention Cravings, and if so for what?_____
 Any other symptoms around the time of your period?_____

Are you experiencing any low or high sexual desires?

Office Policies and Treatment Guidelines

Your treatment

For the greatest benefit:

Prior to your treatment

- DO eat at least a large snack or a meal within a couple hours
- DO NOT exercise vigorously (at least 3 hours prior to treatment)
- DO NOT imbibe in coffee, alcohol, or recreational drugs

Following your treatment

- Drink a glass of water or eat a small snack if necessary
- Take it slow for the first hour
- Do not exercise vigorously

Appointment cancellations

I realize emergencies do arise. If you need to cancel, I do appreciate 24 hour notice. A \$50 charge for late cancellations could occur. Call my cell phone at any time: 773 805 1216. Thank You.

Payment due at the time of service

Payment for acupuncture or herbs is required at the time of service. Cash or check is acceptable. Credit card payments are accepted online through PayPal at my website surfacingwellness.com

Insurance Reimbursement

We do not bill directly to insurance companies. Itemized super-bills are available upon request for you to submit to your insurance company for reimbursement.

I look forward to addressing your medical concerns in an collaborative, empowering and creative way. Please feel free to offer feedback on any aspect of my service, so that I may provide the best care possible.

Surfacing Wellness & Health

Lisa Reichert, L.Ac

Patient Informed Consent

I consent to receiving acupuncture and/ or other Oriental medicine procedures (for the patient named below, for whom I am legally responsible) by Lisa Reichert, L.Ac. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, Tui-Na (Chinese massage), and Chinese herbal supplements. All modalities will be fully explained prior to application.

I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to benefit the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the *energetic* channels of the same name.

I acknowledge that Lisa Reichert L.Ac is not, and does not profess to be, a western-trained medical doctor and does not advise on the use of medically-prescribed pharmaceuticals or medical treatment; nor does she provide any substances by injection.

I acknowledge that Lisa Reichert L. Ac has completed a minimum of three years training in Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the state of Illinois.

Signature _____ Date _____
Patient or guardian

Witnessed by _____ Date _____
Practitioner

HIPAA - Health Insurance Portability and Accountability Act

These privacy rules impose significant responsibilities on acupuncturists and doctors of Oriental medicine, and will apply to all health care providers regarding the protection of patient health information.

The privacy of every patient's protected health information is mandatory. Since Surfacing Wellness & Health and Lisa Reichert, L.Ac maintain patient records; gather information from a patient; engage in oral communication; and possibly transmit records (whether electronic or not), I am a "covered entity" and need a patient's written authorization.

Without written authorization, I cannot use patient information for phoning or emailing or mailing information. I would not be able to confirm appointments, follow up a treatment, or update a patient with newsletters or flyers. If you are able to receive insurance reimbursement for acupuncture services, I cannot provide your information to assist in processing claims.

Surfacing Wellness & Health and Lisa Reichert, L. Ac may

- Contact me at the numbers provided on the intake sheet
- Contact me only at this number:
- Email updates or invoices may be sent to:
- Mail newsletters or flyers to the address provided on the intake sheet

Surfacing Wellness & Health and Lisa Reichert, L.Ac may release information regarding my care to

- Insurance Provider
- Other Practitioner

Patient Signature: _____ Date: _____