3929 Center Road • Brunswick, OH 44212 • 330.460.5155

Acupuncture Intake Form

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender ○ Male ○ Female

Highest Education Level ○ High School ○ Undergraduate ○ Post-Graduate

Job Title

Nature of Business

Primary Address *Number, Street* *Apt. #*

City *State* *Zip*

Home Phone

Work Phone

Cell Phone

Email

Emergency Contact *Name* *Phone Number*

Number, Street *Apt. #*

City *State* *Zip*

Physician *Name* *Phone Number*

Fax

Referred by:
○ Provider ○ Website
○ Friend or Family Member ○ Other ______________________________

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Good	Fair
Example: Post Nasal Drip		X		*Antibiotics*	X		

How do these conditions impair your daily activities: ____________________

Other treatments you have used: ____________________

How long have you had these symptoms? ____________________

What makes these symptoms better? ____________________

What makes these symptoms worse? ____________________

Have you received a medical diagnosis? ○ Yes ○ No If yes, what is it? ____________________

Allergies

Medications	Reaction

Supplements/Foods	Reaction

Please check all that apply: ☐ Pregnant ☐ Pacemaker ☐ Lymphedema ☐ Infection of skin; location: ____________

Patient Medical History

How was your childhood health? ____________________

Hospital visits/stays: ____________________

Immunizations: ____________________

Surgeries: ____________________

Accidents/Injuries? ____________________

Emotions and Sleep

How do you feel emotionally? ____

Are you: ☐ Married/Stable Relationship ☐ Single ☐ Widowed How do you feel about your relationship? _________

____

How do you hold your stress? ____

How do you relax? ____

How would you rate your stress level? (0 little or no stress to 10 high stress): ______________________

How long do you normally sleep? ________ Hours a night Do you feel rested upon waking? ○ Yes ○ No

Do you have any of the following (please check all that apply)

Please check all current symptoms occurring or present in the past 6 months

Overall Temperature (KI FXN)

- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Hot Body Temperature (sensation)
- ☐ Cold Body Temperature (sensation)
- ☐ Afternoon Flushes
- ☐ Night Sweats
- ☐ Heat in the hands, feet and chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire Easily
- ☐ Lack of Perspiration
- ☐ Take water to bed
- ☐ Difficulty keeping eyes open in the daytime

SP Fxn

- ☐ Low Appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas
- ☐ Gurgling Noise in the Stomach
- ☐ Fatigue After Eating
- ☐ Prolapsed Organs (organ: ________)
- ☐ Easily Bruised
- ☐ Hemorrhoids
- ☐ Pensive/Reflective/Daydreaming
- ☐ Overthinking
- ☐ Worry

LU Fxn

- ☐ Nasal Discharge (Color: ________)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Nose
- ☐ Dry Throat
- ☐ Dry Skin
- ☐ Allergies (to what? ____________)
- ☐ Alternating Fevers and Chills
- ☐ Sneezing
- ☐ Headache (location: ____________)
- ☐ Overall achy feeling in the body
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Sore Throat
- ☐ Difficulty Breathing
- ☐ Smoke Cigarettes (# per day: ____)
- ☐ Sadness
- ☐ Melancholy

Overall Energy

- ☐ Shortness of Breath
- ☐ Difficulty keeping eyes open in the daytime
- ☐ General Weakness
- ☐ Easily Catch Colds
- ☐ Feel worse after exercise

Blood (Liv, SP, HT Fxn)

- ☐ Dizziness
- ☐ See Floating Black Spots

SP, ST, LI, SI Fxn

- ☐ Loose Stool
- ☐ Constipation
- ☐ Incomplete Bowel Movements
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Mucous in Stool
- ☐ Undigested Food in Stool
- ☐ General sensation of heaviness in the body
- ☐ Mental Sluggishness
- ☐ Mental Fogginess
- ☐ Swollen Hands
- ☐ Swollen Feet
- ☐ Swollen Joints
- ☐ Chest Congestion
- ☐ Stiff Shoulders
- ☐ Nausea
- ☐ Snoring

ST Fxn

- ☐ Burning sensation after eating
- ☐ Large Appetite
- ☐ Bad Breath
- ☐ Mouth (canker) sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer (diagnosed)
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach Pain
- ☐ Vomiting

HT Fxn

- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on the tip of the tongue
- ☐ Restlessness
- ☐ Mental Confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent Dreams
- ☐ Wake Unrefreshed
- ☐ Drink Coffee (# of cups per day)

LIV, GB Fxn

- ☐ Alternating loose and hard stool
- ☐ Chest Pain
- ☐ Tight sensation in chest
- ☐ Bitter taste in mouth
- ☐ Anger Easily
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Frequent inability to adapt to stress
- ☐ Skin rashes
- ☐ Headaches at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle Spasms
- ☐ Muscle Twitching
- ☐ Muscle Cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in throat
- ☐ Neck Tension
- ☐ Limited range of motion, neck
- ☐ Shoulder Tension
- ☐ Limited range of motion, shoulder
- ☐ Drink Alcohol
- ☐ Recreational Drugs
- ☐ High pitched ringing in the ears
- ☐ Gall Stones
- ☐ Sexually transmitted disease

Eyes (LIV Fxn)

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurred Vision
- ☐ Decreased Night Vision
- ☐ Near-sighted
- ☐ Far-sighted

KI, UB Fxn

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low back pain
- ☐ Poor memory
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in the ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Frequent night time urination
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

Urination

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning
- ☐ Painful
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

Overall Temperature (KI Fxn)

- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Sweaty Hands
- ☐ Sweaty Feet
- ☐ Hot body temperature
- ☐ Cold body temperature
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet and chest

Libido

- ☐ Normal
- ☐ High
- ☐ Low

Women Only

- ☐ Regular Cycle ○ Yes ○ No
- ☐ Date of last period: __________
- ☐ Infertility? ○ Yes ○ No
- ☐ Number of children: ______
- ☐ Age of first menstruation: ______
- ☐ Average # of days of flow: ______
- ☐ Average # of days of cycle: _____
- ☐ Pregnant? ○ Yes ○ No
- ☐ Number of pregnancies: ______
- ☐ Number of miscarriages: ______
- ☐ Number of abortions: _______
- ☐ Age of menopause: _______

Vaginal discharge:

- ☐ Severe ☐ Moderate
- ☐ Slight ☐ Normal

Menstrual bleeing:

- ☐ Severe ☐ Moderate
- ☐ Slight ☐ Normal
- ☐ Clots ☐ Spotting

Color of menses: ______________

- ☐ Irregular menstruation
- ☐ Vaginal itching/burning
- ☐ Uterine fibroids
- ☐ Birth control use? What type?

____

Do you experience any of the following PMS symptoms?

- ☐ Nausea
- ☐ Headaches
- ☐ Migraines
- ☐ Anxiety
- ☐ Food cravings
- ☐ Irritability
- ☐ Breast swelling
- ☐ Breast tenderness
- ☐ Depression
- ☐ Bloating
- ☐ Vomiting
- ☐ Dull pain, where? __________
- ☐ Sharp pain, where? __________
- ☐ Pain before period
- ☐ Pain during period
- ☐ Pain after period

Men Only

- ☐ Swollen Testes ☐ Testicular Pain
- ☐ Impotence ☐ Premature ejaculation
- ☐ Feeling of cold or numb in testicles

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ○ Yes ○ No

Describe ____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin ○ Yes ○ No

Have you had prolonged or regular use of Tylenol? ○ Yes ○ No

Have you had prolonged or regular use of a Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? ○ Yes ○ No

Frequent antibiotics? >3 times/year ○ Yes ○ No

Long term antibiotics? ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ○ Yes ○ No

Use of oral contraceptives? ○ Yes ○ No

PLEASE COMPLETE IF YOU ARE SEEKING TREATMENT FOR PAIN:

☐ No pain

Please describe your pain level 0 no pain at all to 10 being the worst

0........1........2........3........4........5........6........7........8........9........10

Do any of the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other: _______________

Do any of the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other: _______________

Location of pain: ____

How long have you had pain? ______ years _____ months _____ days

How often are you experiencing pain?

What makes the pain worse? ____

Pain character: ☐ Dull ☐ Sharp ☐ Cramping ☐ Burning ☐ Radiating ☐ Ache

☐ Moves ☐ Numb ☐ Tingling

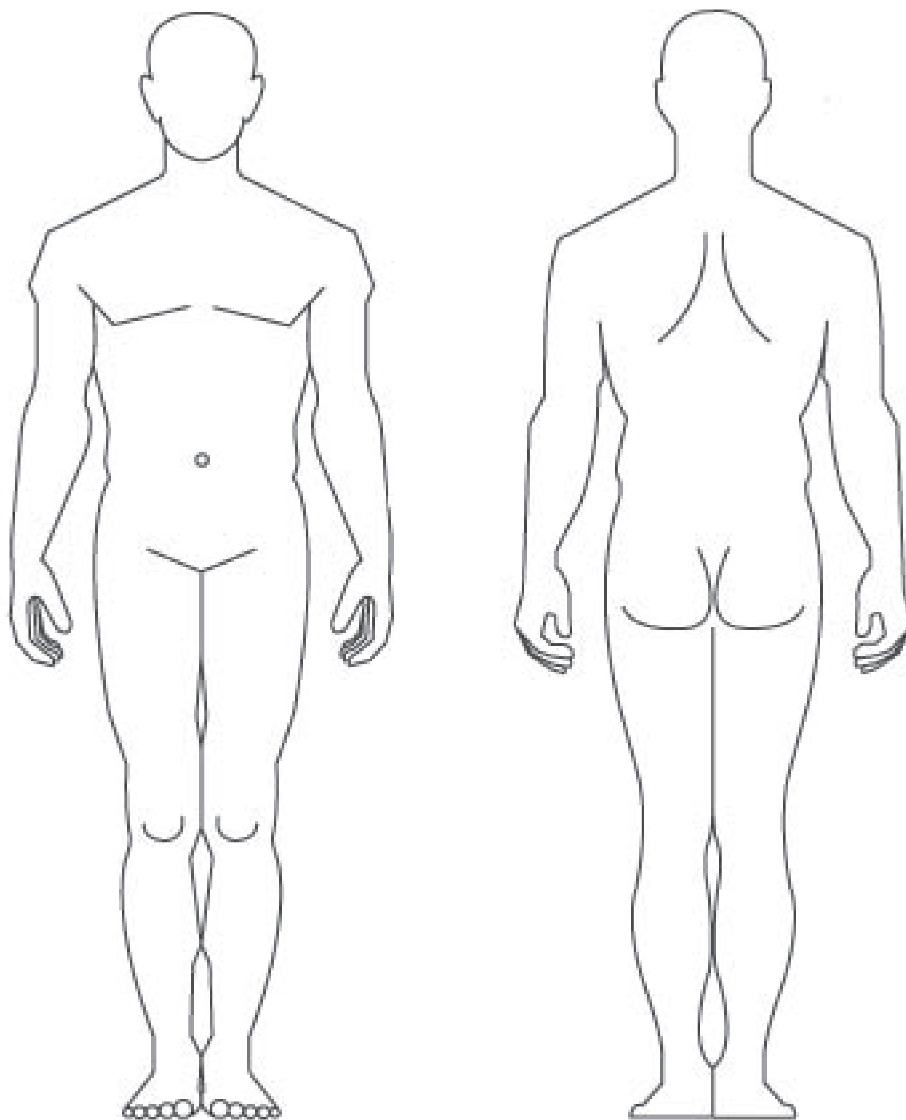
When did pain begin? ____

Was pain caused by an injury? ☐ Yes: _____________________________________ ☐ No

Prior treatment: ☐ Medication ☐ Blocks/Injections ☐ Surgery ☐ PT

☐ Chiropractor ☐ Massage ☐ Other

Using the letters at the bottom of the page to describe your pain, indicate on the figures the area(s) where you are experiencing pain.



D - Dull	S - Sharp	C - Cramping	B - Burning
R - Radiating	M - Moves About	N - Numbness	T - Tingling
X - Scars from injury or surgery	A - Acne	O - Rashes, Skin Disorders	Other

For Patient Review Regarding Diagnostic Exam
Please sign one of the two options below:

Option 1

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

Patient Signature Date

Option 2

I have NOT received a diagnostic exam by a physician or a chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or a chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

Patient Signature Date

Licensed Acupuncturist Signature Date

cc: Patient file, Copy to patient

Informed Consent and Financial Policies

1. Consent for Healthcare: I, the undersigned, voluntarily seek healthcare services provided by Dr. Tamara Macdonald ND, LAc. I am, in good faith, exercising my free will and following the dictates of my own conscience, which allows me to contract for what I believe to be most beneficial for me. I am not obligated to continue utilizing the services of Dr. Macdonald, ND LAc, and may discontinue the use of these services at any time. The choice I make in contracting for these services is not to be overridden by any family member, court of law, medical facility or other physician, and I charge same to honor this contract.

2. I understand that Dr. Tamara Macdonald, ND, LAc, is not a Medical Doctor (MD), an Osteopathic Doctor (DO) or Chiropractor (DC). I also understand that Dr. Macdonald attended Bastyr University, a well-known Natural Medicine School in Kenmore, WA, completing all academic and clinical requirements as well as passing National Board exams. Dr. Macdonald holds and maintains her license as a primary care physician in the State of Washington. The State of Ohio does not currently license Naturopathic Physicians. I understand that the lack of licensure in the state of Ohio prevents her from diagnosing, treating or curing any specific disease I may have. I also understand that Dr. Macdonald can however, help me to improve my health in order to allow by body to heal itself. I agree to hold harmless and waive any claim of present or future liability or negligence against Tamara A Macdonald, and/or North Coast Natural Health for recommendations, services rendered or products purchased. I understand that the recommendations and serivces rendered by Dr. Macdonald may differ from those usually offered by a conventional medical doctor or other health care provider. I understand that like all medicine, Natural health care is not an exact science and understand that no guarantees have been made as to the results of services.

3. **Confidentiality:** All information provided on the health/questionnaire/intake form or during office visits is confidential. Information will only be released with the patient's written and signed request, or if requested by the proper legal authorities.

4. **Fees and Payment:** Fees for office visits and phone consultations are based on a rate of $165 per hour for Naturopathic Physician services and $125 per hour for Acupuncture services. Full payment is expected at time of service for office visits, supplements, lab fees and/or products sold. Cash, personal checks and major credit cards are accepted.

5. **Insurance:** Most insurance coverage is limited to those states that offer licensure to Naturopathic doctors. Currently, Ohio is not a licensed state and therefore, it is unlikely your insurance provider will cover services rendered by a Naturopathic doctor. Ohio does license Acupuncture, and, again, depending on your coverage, your visit may or may not be covered. Although Dr. Macdonald does not bill the insurance companies directly, we will be happy to supply you with the appropriate forms for you to submit to your insurance provider for reimbursement.

6. **Cancellation Policy:** Dr. Macdonald requires that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (M-F, 9am—5pm). We reserve the right to charge for missed or cancelled appointments that do not follow this policy. Fees are based on a rate of $145 per hour.

I fix my signature to certify that I, ______________________________ am voluntarily seeking the services of Dr. Tamara Macdonald, ND, LAc, and have read, understand and agree to the above statements and policies.

Signature: ____ Date: ____________________

Consent for Treatment, Payment, and Healthcare Operations

1. **Consent:** I consent to the use or disclosure of my protected health information by employees of Dr. Tamara Macdonald for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or conducting healthcare operations. I understand that diagnosis or treatment of me by Dr. Macdonald may be conditioned upon my consent as evidenced by my signature on this document.

2. **Rights:** I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Dr. Macdonald is not required to agree to the restrictions that I may request. However, if Dr. Macdonald agrees to a restriction that I request, the restriction is binding on Dr. Macdonald. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Macdonald has taken action in reliance on this consent.

3. **Protected Health Information:** My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

4. **Notice of Privacy Practices:** I understand I have a right to review the Notice of Privacy Practices of Advanced Medicine Clinic prior to signing this document. The Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations by Dr. Macdonald. The Notice of Privacy Practices is provided at Dr. Macdonald's place of business.

The Notice of Privacy Practices also describes my rights and the duties of Dr. Macdonald with respect to my protected health information. Dr. Macdonald reserves the right to change the practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy, or asking for one at the time of my next appointment.

______________________________	______________________________	______________
Name of Patient (Please print)	Signature (or parent/guardian of minor)	Date