THE EMPEROR'S MEDICINE
AN INTEGRATIVE MEDICINE CLINIC

NEW PATIENT INTAKE FORM INSTRUCTIONS

PLEASE READ THE INSTRUCTIONS CAREFULLY

- **THE FORM MUST BE FILLED OUT BEFORE YOUR APPOINTMENT, PLEASE GIVE YOURSELF A COUPLE OF HOURS TO FILL THIS OUT PRIOR TO YOUR APPOINTMENT. NOT HAVING THE FORM FILLED OUT COMPLETELY MAY RESULT IN RESCHEDULING YOUR APPOINTMENT**
- **PLEASE BRING THIS FORM AND YOUR RECENT LAB WORK TO YOUR APPOINTMENT OR YOU CAN SEND IT TO US VIA FAX AT 630-428-9006 OR EMAIL AT info@foxvalleyacupuncture.com PRIOR TO YOUR SCHEDULED APPOINTMENT**
- **REMEMBER: THE MORE THAT WE KNOW, THE BETTER WE ARE ABLE TO WORK WITH YOU IN ADDRESSING THE ROOT CAUSES OF YOUR SYMPTOMS TO GET YOU BACK TO OPTIMAL HEALTH**

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NEW PATIENT INTAKE FORM

Today's Date:_____

PERSONAL INFORMATION

Name: _____Age: _____ Date of Birth:_____

Nickname or preferred name: _____

Marital Status: □S □M □D □W □Other _____

Home Address:_____ City:_____ State:_____ Zip_____

Home Phone: (_____) _____Cell Phone: (_____)_____

Email Address:

_____

Occupation: _____Employer:_____

In case of Emergency – Contact: _____Relationship:_____

Home Phone: (_____) _____ Cell Phone: (_____)_____

How did you hear about us?

_____

Primary Care

Physician:_____Phone:_____

HEALTH INFORMATION

Health Concerns: Please list your top health concerns or complaints that you would like to address (in order of priority):

1) _____

2) _____

3) _____

When did your conditions/symptoms/pain first appear?_____

Is this condition getting progressively worse? □ Yes □ No □ Constant □ Comes and Goes

Are these concerns affecting your quality of life? (Please check all applicable)

Work/School: □Y □N Recreation: □Y □N Sleep: □Y □N Exercise/Sports: □Y □N

Eating: □Y □N Walking: □Y □N Sitting: □Y □N Intimate/Personal Life: □Y □N

When was the last time that you really felt well? _____

Do you feel that something triggered a change in your health/symptoms? _____

What makes you feel worse? _____

What makes you feel better? _____

What physician or other provider have you seen for this condition? _____

What do you hope to achieve through our program? _____

Where do you see yourself in three years if your condition was to worsen?

_____

_____

MEDICAL HISTORY

Please check all that apply (**P** = Past / **C** = Current):

P/C	P/C	P/C	P/C
□□ Irritable Bowel Syndrome	□□ Arrythmia	□□ Breast Cancer	□□ Infertility
□□ Inflammatory Bowel Disease	□□ Hypertension	□□ Colon Cancer	□□ Weight Gain
□□ Lupus	□□ Crohn's Disease	□□ Rheumatic Fever	□□ Ovarian Cancer
□□ Weight Loss	□□ Immune Deficiency	□□ Ulcerative Colitis	□□ Mitral Valve Prolapse
□□ Prostate Cancer	□□ Freq. Weight Fluctuations	□□ Genital Herpes	□□ Gastritis/ Peptic Ulcer
□□ Other Heart Murmurs	□□ Type 1 Diabetes	□□ Bulimia	□□ Frequent Infections
□□ GERD/Heartburn/Acid Reflux	□□ Kidney Stones	□□ Type 2 Diabetes	□□ Anorexia
□□ Food Allergies	□□ Celiac Disease	□□ Gout	□□ Hypoglycemia
□□ Binge Eating Disorder	□□ Environmental Allergies	□□ Gallstones	□□ Interstitial Cystitis
□□ Pre-Diabetes	□□ Night Eating Disorder	□□ Chemical Sensitivity	□□ Heart Attack
□□ Frequent UTIs	□□ Hypothyroidism (Low)	□□ Eating Disorder	□□ Latex Allergy
□□ Heart Disease	□□ Frequent Yeast Infections	□□ Hyperthyroidism	□□ Pituitary Adenoma
□□ Hepatitis	□□ Stroke	□□ Asthma	□□ PCOS
□□ Autoimmune Disease	□□ Lung Cancer	□□ Elevated Cholesterol	□□ Erectile/Sexual Dysfunction
	□□ Endocrine/Hormone Problems	□□ Chronic Fatigue Syndrome	
□□ Chronic Sinusitis	□□ Bronchitis	□□ Emphysema/COPD	□□ Pneumonia
□□ Tuberculosis	□□ Sleep Apnea	□□ Osteoarthritis	□□ Fibromyalgia
□□ Chronic Pain	□□ Eczema	□□ Psoriasis	□□ Acne
□□ Melanoma	□□ Skin Cancer	□□ Anemia	□□ Chicken Pox
□□ German Measles	□□ Measles	□□ Mononucleosis- EBV	□□ Mumps
□□ Sleep Apnea	□□ Whopping Cough	□□ Depression	□□ Anxiety
□□ Bipolar Disorder	□□ Schizophrenia	□□ Headaches	□□ Migraines
□□ ADD/ADHD	□□ Autism	□□ Memory Problems	□□ Parkinson's
□□ Multiple Sclerosis	□□ ALS	□□ Seizures	□□ Alzheimer's
□□ Concussion	□□ Mild Cognitive Impairment	Other:_____	

Are you currently under the care of any other provider (s)? (MD, Dentist, Psychologist, please list condition or general care, etc.)_____

PAST MEDICAL TESTS: Provide to the best of your knowledge the last date of each test performed.

Last Physical Exam: _____Bone Density Scan: _____ Colonoscopy: _____

Cardiac Stress Test: _____ EKG: _____ MRI: _____

CT Scan: _____ Upper Endoscopy: _____ Upper GI Series: _____

Ultrasound: _____ Mammogram: _____ X-Ray: _____

Other:_____

WOMEN ONLY Is there any chance you might be pregnant? □Y □N Date of last menstrual cycle: _____

Are you experiencing perimenopause? □Y □N Reached menopause? □Y □N Are you experiencing symptoms? □Y □N

Do you currently or have you used any of the following? (please circle all that apply) Birth Control Pills Hormone Replacement Therapy / Hormone IUD / Copper IUD / Contraceptive Shot (ex. Depo) / Vaginal Ring Contraceptive Patch / Emergency Contraceptive

Reason for contraceptive or hormones? _____

Length of use of each type:

_____

Have you ever had an abnormal PAP? □Y □N

Age of menarche (periods began): _____ Age you gave birth (if applicable): _____

Number of pregnancies (if any): _____ Number of C-Sections (if any): _____

Did you develop any problems or symptoms in or after pregnancy, for example: diabetes, pre-eclampsia, post partum depression, etc? _____

Number of Children (if any):_____ Number of abortions (if any):_____ Number of miscarriages (if any):_____

Menstruation (check all that apply):

Blood Color: _____dark red _____ bright red _____pale/pink _____blackish _____purple _____brown

Clot: _____ no clots _____ some small clots _____some large clots _____ dark clots _____ red clots _____

dilute/watery Flow: _____ none _____1-3 days _____ 4-6 days _____ 7 or more days

Menstrual Pain: _____ before flow _____ first day _____during period, any day _____ after periods _____ on

ovulation Fertility: _____ I am trying to conceive _____Vaginal Discharge? If so, color:_____

____ Foul Smell? _____How often do you experience discharge? Spotting Between Periods? Yes or No

_____ Pelvic Pain?_____ Pelvic Pressure? _____Hysterectomy? If so, which type? :_____

_____ I am not trying to get pregnant, but could become pregnant during the course of treatment

If trying to conceive, please explain what you have done in the past and what you are doing currently to try to conceive a child:

_____

_____

_____

Past Gynecological Screenings/ Procedures: (if applicable, please date)

Last Pap Test: _____ □ Normal □ Abnormal

Last Mammogram: _____ □ Normal □ Abnormal

Last Bone Density Test: _____ □ Normal □ Abnormal

Additional

Comments:_____

MEN ONLY Please check the boxes if applicable:

□ Testicular Mass □ Testicular Pain □ Prostate Enlargement □ Changes In Sex Drive

□ Impotence □ Premature Ejaculation □ Difficulty Getting and Keeping an Erection

□ Loss of Control of Urine □ Urinary Urgency □ Weak Urine Stream

Are You Balding? Do you have male pattern baldness? □ Yes □ No Age Balding Started: _____

Do you wake up to urinate in the middle of the night? □ Yes □ No How Often? _____

Have you had your PSA Checked? □ Yes □ No

PSA Level: □ 0-2 □ 2-4 □ 4-10 □ Above 10

Additional Comments:

_____

HEAD & FACE

_____ Headaches _____ Migraines _____ Tension _____ Cluster _____ Hormonal _____ Sinus

Where do you feel the headaches?

_____ Front/Forehead _____ Top of Head _____ Side/Temples _____Back/Occipital/Neck _____Behind Eye(s)

How often do you get a headache?

_____ 1-2 a year _____ 3-11 a year _____1/month _____2-4 month _____1-2/week _____ more than 2 a week

How long does the headache last without medication?

_____

CHILDHOOD/EARLY LIFE

Any known pregnancy or birth complications? If yes, please explain:_____

You were born: □ Term □ Premature □ Unknown

You were: □ Breastfed/How long?: _____ □ Bottle Fed/Type of Formula:_____

□ Unknown

Did you eat a lot of sugar/candy as a child? □ Yes □ No

Were there any food that you avoided as a child because they gave you symptoms? □ Yes □ No

If yes, which foods and symptoms?

_____

Did you follow the current vaccination schedule as a child? □ Yes □ No □ Not Vaccinated

Please indicate which of the following conditions you experienced as a child (birth to 12 years) and the approximate age of onset:

ADD (Attention Deficit Disorder) □ Yes Age: _____ Bronchitis: □ Yes Age:_____

Asthma □ Yes Age: _____ Chicken Pox: □ Yes Age: _____ Colic: □ Yes Age: _____

Congenital Problems: □ Yes Age: _____ Ear Infections: □ Yes Age: _____Fever Blisters: □ Yes Age: _____

Frequent Colds or Flu: □ Yes Age: _____ Frequent Headaches: □ Yes Age: _____

Hyperactivity: □ Yes Age: _____ Jaundice: □ Yes Age: _____ Mumps: □ Yes Age: _____

Pneumonia: □ Yes Age: _____ Seasonal Allergies: □ Yes Age: _____ Skin Disorders: □ Yes Age: _____

Strep Infections: □ Yes Age: _____ Tonsillitis: □ Yes Age: _____ Measles: □ Yes Age: _____

Upset Stomach/Digestive Disorders: □ Yes Age: _____ Whooping Cough: □ Yes Age: _____

Other (describe):

_____

As a child, did you have frequent absences from school? □ Yes □ No

If yes, why?

_____

Did you experience chronic exposure to secondhand smoke in your home? □ Yes □ No

Experience Abuse? □ Yes □ No

Have alcoholic parents? □ Yes □ No

REVIEW OF SYSTEMS

P/C **General**

□□ Fever
□□ Chills/Cold All Over
□□ Aches and Pains
□□ General Weakness
□□ Difficulty Sweating
□□ Excessive Sweating
□□ Swollen Glands
□□ Cold Hands & Feet
□□ Fatigue
□□ Difficulty Falling Asleep
□□ Sleepwalker
□□ Nightmares
□□ No Dream Recall
□□ Early Waking
□□ Daytime Sleepiness
□□ Decreased Appetite
□□ Increased Appetite
□□ Conjunctivitis

P/C **Head**

□□ Poor Concentration
□□ Confusion
□□ Headaches
□□ After Meals
□□ If Meals are Skipped
□□ Severe
□□ Migraine
□□ Frontal/Sinus
□□ Occipital
□□ Afternoon
□□ Daytime
□□ Relieved by Eating Sweets
□□ Concussion/mTBI
□□ Whiplash
□□ Mental Sluggishness
□□ Forgetfulness
□□ Facial Twitching

P/C **Eyes**

□□ Feeling of Sand in Eyes
□□ Double Vision
□□ Blurred Vision
□□ All the time
□□ When turning head
□□ When moving/driving
□□ Near Sighted
□□ Far Sighted
□□ Poor Night Vision
□□ See Bright Flashes
□□ Halo Around Eyes
□□ Eye Pains
□□ Dark Circles Under Eyes
□□ Sensitivity to Bright Light
□□ Cataracts
□□ Floaters in Eyes
□□ Visual Hallucinations
□□ White Spots/Lines on Nails
□□ Crawling Sensation
□□ Burning on Bottom of Feet
□□ Athletes Foot
□□ Cellulite
□□ Bugs Love to Bite You
□□ Hair Thinning/Hair Loss
□□ Sensitive Skin
□□ to Sun
□□ to Fabrics
□□ to Detergents
□□ to lotions/creams

P/C **Skin/Hair/Nails**

□□ Cuts Heal Slowly
□□ Bruise Easily
□□ Rashes
□□ Pigmentation
□□ Changing Moles
□□ Calluses
□□ Eczema
□□ Psoriasis
□□ Dryness/Cracking Skin
□□ Oiliness
□□ Itching
□□ Acne
□□ Hives
□□ Fungus on Nails
□□ Peeling Skin
□□ Shingles
□□ Splitting Nails

P/C **Ears**

□□ Aches
□□ Discharge
□□ Pains
□□ Ringing/Tinnitus
□□ Deafness/Hearing Loss
□□ Itching
□□ Pressure
□□ Required Hearing Aid
□□ Frequent Infections
□□ Itching
□□ Pressure
□□ Tubes in Ears
□□ Sensitive to Loud Noises
□□ Hearing Hallucinations
□□ Dizziness

P/C **Throat**

□□ Mucus
□□ Difficulty Swallowing
□□ Constant Clearing of Throat
□□ Tonsillitis
□□ Enlarged Glands
□□ Frequent Hoarseness
□□ Throat Closes Up

P/C **Neck**

□□ Stiffness
□□ Swelling
□□ Lumps
□□ Neck Gland Swell

P/C **Nose & Sinus**

□□ Stuffy
□□ Bleeding
□□ Running/Discharge
□□ Watery Nose
□□ Congested
□□ Infection
□□ Polyps
□□ Sensitive Smell
□□ Drainage
□□ Sneezing Spells
□□ Post Nasal Drip
□□ No Sense of Smell
□□ Seasonal Change of Symptoms
□□ from Fall
□□ from Winter
□□ from Spring
□□ from Summer

P/C **Circulation/Respiration**

□□ Swollen Ankles
□□ Sensitive to Heat
□□ Sensitive to Cold
□□ Extremities Cold/Clammy
□□ Numbness in Hands/Feet
□□ High Blood Pressure
□□ Low Blood Pressure
□□ Chest Pain
□□ Dizziness Upon Standing
□□ Fainting Spells
□□ Wheezing
□□ Irregular Heart Beat
□□ Palpitations
□□ Low Exercise Tolerance
□□ Frequent Coughs
□□ Breathing Heavily
□□ Frequent Sighing
□□ Shortness of Breath
□□ Night Sweats
□□ Varicose/Spider Veins
□□ Mitral Valve Prolapse
□□ Murmurs
□□ Skipped Heartbeat
□□ Heart Enlargement
□□ Bronchitis/Pneumonia
□□ Emphysema/COPD
□□ Croup
□□ Frequent Colds
□□ Heavy/Tight Chest
□□ Prior Heart Attack
When? : _____

P/C **Mouth**

□□ Coated Tongue
□□ Sore Tongue
□□ Dental Problems
□□ Bleeding Gums
□□ Canker Sores
□□ TMJ
□□ Cracked Lips/Corners
□□ Grinding Teeth in Sleep
□□ Chapped Lips
□□ Fever Blisters
□□ Wearing Dentures
□□ Bad Breath
□□ Dry Mouth

P/C **Gastrointestinal**

□□ Peptic/Duodenal Ulcers
□□ Gallstones
□□ Gallbladder Pain
□□ Nervous Stomach
□□ Feeling Full After Small Meal
□□ Indigestion
□□ Heartburn/GERD/Reflux
□□ Hiatal Hernia
□□ Nausea
□□ Vomiting
□□ Vomiting Blood
□□ Abdominal Pain/Cramps
□□ Gas/Bloating
□□ Diarrhea
□□ Constipation
□□ Use Laxatives
□□ Belch Frequently
□□ Anal Itching
□□ Blood in Stools

□□ Undigested Food in Stools
□□ Floating Stools

P/C **Joint/Muscles**

□□ Pain that Wakes You
□□ Weakness in Arms/Legs
□□ Balance Problems
□□ Muscle Cramping
□□ Head Injury
□□ Muscle Stiffness in AM
□□ Bothered by Damp Weather

P/C **Neck**

□□ Stiffness
□□ Swelling
□□ Lumps
□□ Neck Gland Swell

P/C **Kidney/Urinary Tract**

□□ Burning
□□ Frequent Urination
□□ Blood in Urine
□□ Nighttime Urination
□□ Problem Starting Urine
□□ Kidney Pain
□□ Kidney Stones
□□ Painful Urination
□□ Bladder Infections
□□ Kidney Infections
□□ Syphilis
□□ Bedwetting
□□ Trichomonas

P/C **Neurological/Emotional**

□□ Convulsions
□□ Dizziness
□□ Blackouts/Amnesia
□□ Had Prior Shock Therapy
□□ Frequently Jittery
□□ Startled by Sudden Noises
□□ Anxiety/Feeling of Panic
□□ Forgetful
□□ Groggy
□□ Withdrawn Feeling/Feeling Lost
□□ Had Nervous Breakdown
□□ Short Attention Span
□□ Unable to Reason
□□ Considered a Nervous Person
□□ Frustrations
□□ Emotional Numbness
□□ Often Break Out in Cold Sweats
□□ Often Awoken by Bad Dreams
□□ Previously Admitted in Psychiatric Care
□□ Use Tranquilizers
□□ Misunderstood by Others
□□ Irritable
□□ Feeling of hostility/volatile or aggressive
□□ Fatigue
□□ Hyperactive
□□ Restless Leg Syndrome
□□ Considered Clumsy
□□ Vision Changes
□□ Unable to Coordinate Muscles
□□ Daytime Sleepiness
□□ Workaholic
□□ Have Had Halucinations

DENTAL HISTORY

Check if you have had any of the following, and provide a number if applicable:

□ Silver Mercury Fillings _____ □ Root Canals _____ □ Bleeding Gums _____

□ Gingivitis _____ Have you had any fillings removed? □ Yes □ No

Do you brush regularly? □ Yes □ No Do you floss regularly? □ Yes □ No

ENVIORNMENTAL/DETOXIFICATION HISTORY

Do any of the following significantly affect you?

□ Cigarette Smoke □ Auto Exhaust Fumes □ Perfumes/Colognes □

Other:_____

In your home or work environment, are you regularly exposed to: (Check all that apply)

□ Mold □ Renovations □ Chemicals □ Water Leaks □ Damp Environments □ Old Paint

□ Electromagnetic Radiation □ Stagnant or Stuffy Air □ Carpets or Rugs □ Pesticides □ Herbicides

□ Smokers □ Cleaning Chemicals □ Paints □ Airplane Travel □ Heavy Metals (mercury, lead,etc)

□ Harsh Chemicals (glue, solvents, gas, etc.)

□Other:_____

Have you had a significant exposure to any harmful chemicals? □ Yes □ No

Do you have any pets or farm animals? □ Yes □ No

If Yes, Do they live inside or outside? □ Inside □ Outside □ Both

ACCIDENTS: Have you been involved in any of the following types of accidents? (check all that apply)

□ Automobile □ Motorcycle □ Bicycle □ Sports □ Playground □ Abuse □ Other

Year *(approximate)* **Please describe *(injuries, treatment, outcome)***

INJURIES: Have you injured any of the following regions? (check all that apply)

□ Head □ Neck □ Rib/Chest □ Back □ Pelvis/Hip □ Arm/Hand □ Leg/Foot

Year *(approximate)* **Please describe *(injuries, treatment, outcome)***

SERIOUS ILLNESS/HOSPITALIZATIONS/SURGERIES: Please detail hospitalizations/serious illnesses/surgeries

□ Automobile □ Motorcycle □ Bicycle □ Sports □ Playground □ Abuse □ Other

Year *(approximate)*	**Reason**	**Outcome**

MEDICATIONS: Please list all medications you are currently or have recently taken (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Prescribed By**

NUTRITIONAL SUPPLEMENTS: List all Vitamins & Nutritional Supplements you are currently or have recently taken

Supplement	**Brand & Amount Consumed**	**Date Started**	**Prescribed By** (if applicable)

PREVIOUS MEDICATION HISTORY: Please list an approximate number of times you have taken antibiotics for illnesses, yeast infections, skin disorders (including acne), dental procedures, surgery etc. _____
Have you ever been on a long-term antibiotic (1 month or longer) or Intravenous (IV)? □Y □N
Have you ever taken probiotics? □Y □N

Has any medication or supplement ever caused unusual side effects or problems?

_____

_____

Have you had prolonged or regular use of NSAIDs (Aleve, Advil, etc.) Asprin or Motrin? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No
Have you had prolonged or regular use of PPIs, Acid Blocking Drugs or Anti-Acids? □ Yes □ No
Use of steroids (nasal inhalers, inhalers, prednisone) now or in the past? □ Yes □ No

ALLERGIES / SENSITIVITIES: Please check and list all allergies / sensitivities

□ **Food:** □ Gluten □ Dairy □ Soy □ Nuts □ Other

_____

□ **Medications:**

_____

□ **Seasonal/Latex/Other:**

_____

Have you taken oral steroids (Cortisone, Prednisone)? If yes, please list:

_____

As a child did you have a restricted diet, or were you allergic to any foods? If yes:

_____

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never	Amount
Alcohol	□	□	□	□	_____
Coffee	□	□	□	□	_____
Soda/Diet Soda	□	□	□	□	_____
Tobacco	□	□	□	□	_____
Rec. Drugs	□	□	□	□	_____

If you no longer consume the above, please note length of consumption and date stopped

	5-7x/wk	3-5x/wk	1-3x/wk	None
Exercise	□	□	□	□
	8+hrs	**7-8hrs**	**6-7hrs**	**5-6hrs**	**<5hrs**
Sleep	□	□	□	□	□
	5+	**4**	**3**	**2**	**1**
Meals/day	□	□	□	□	□
	8+ cups	**4-7 c**	**2-4 c**	**<8oz**
Water/day	□	□	□	□

Do you have problems falling asleep? □ Yes □ No
Do you have problems staying asleep? □ Yes □ No
Do you have problems with insomnia? □ Yes □ No
Do you feel rested upon awakening? □ Yes □ No
Do you use sleeping aids? □ Yes □ No
Do you wake up around 2-4 AM? □ Yes □ No
Do you snore? □ Yes □ No
Describe your current exercise program:

_____

_____

_____

Do you feel motivated to exercise? □ Yes □ No □ A Little
Are there any problems that limit exercise? □ Yes □ No If yes,explain:_____

WORK ACTIVITY: □ Heavy Labor □ Light Labor □ Sitting □ Standing □ Walking/Moving □ Driving

STRESS LEVEL: □ Very High □ High □ Medium □ Low

Do you use relaxation techniques? □ Yes □ No

Which techniques do you use?

_____

Have you ever sought counseling?

_____

NUTRITIONAL REVIEW

Do you currently follow any of the following special diets or nutritional programs? Check all that apply.

□ Vegetarian □ Vegan □ Elimination □ Low Carb □ Low Fat □ Allergy □ Gluten Free/Wheat Free

□ Low Sodium □ Paleo □ Blood Type □ No Dairy □ High Protein □ Other:_____

Do you have sensitivities to certain foods? □ Yes □ No

If so, please list the food and

symptoms:_____

Do you have an aversion to certain foods? □ Yes □ No

If yes, please

explain:_____

Do you adversely react to: (Check all that applies)

□ Chocolate □ Preservatives □ Alcohol □ Red Wine □ Food Coloring □ Monosodium Glutamate

(MSG) □ Garlic/Onion □ Citrus Foods □ Cheese □ Artificial Sweeteners □ Sulfite Containing

Foods (wine, dried fruit) □ Other foods:_____

Are you interested in the following services? □ Massage □ Nutrition □ Gluten Issues □ Thyroid

Dysfunction □ Weight-loss □ Cholesterol Issues □ Pain Management □ Other: _____

WILLINGNESS EVALUATION

Please grade yourself on a scale of 0 (not willing) to 3 (very willing)

In order to improve your health, how willing are you to:

	1	2	3
Take nutritional supplements everyday?	□	□	□
Keep a food diary of what you eat daily?	□	□	□
Engage in prescribed or regular exercise?	□	□	□

Make changes to or significantly modify your diet?	□	□	□
Make changes to your lifestyle (sleep habits, etc.)?	□	□	□
Practice relaxation techniques?	□	□	□

ADDITIONAL COMMENTS

Please use this section to provide information that you feel is pertinent in your history that was not provided by this form.

_____

_____

_____

_____

_____

_____

_____

_____

_____

We appreciate you for taking the time to complete this thorough health history intake form. You have provided us with invaluable information that will help us better understand you and identifying the root cause of your health concerns. We look forward to meeting with you and helping you reach your goals of optimal health. Signing below states that you have provided all information to the best of your truthful knowledge and provides consent for the providers and staff at The Emperor's Medicine, LLC. to use the information provided for treatment purposes.

_____ _____

Client Name (Printed) Client Signature Date

_____ _____

Parent and/or Guardian Printed Parent and/or Guardian Signature Date

ASSIGNMENT AND RELEASE (INSURED PATIENTS ONLY) I certify that I (or my dependent) have insurance coverage with_____ and **I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE ACUPUNCTURE OFFICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.** I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Policy Holder Name_____ Policy Holder DOB_____

Relationship to Patient_____ Insurance Company Name_____

ID Number_____ Group Number_____

Patient/Guardian Signature_____ Date_____