# Acupuncture Intake Form

## Client Information

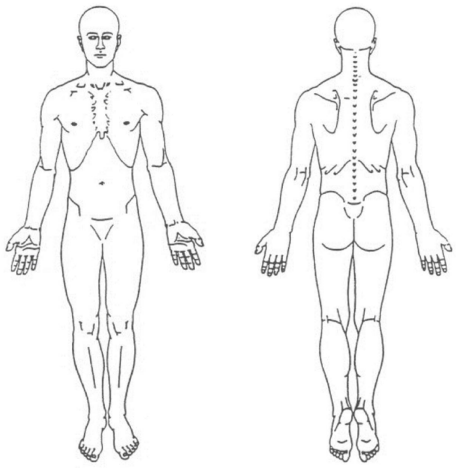
| First Name * | Last Name * | Date of Birth * | Patient Identifier (If known) | |
|---|---|---|---|---|
| Gender * | Preferred Pronouns | Email * | Preferred Phone Number * | |
| Address * | | City * | State * | Zip Code * |

## Emergency Contact

| Full Name | Relationship | Contact Number |
|---|---|---|
| Full Name | Relationship | Contact Number |

## Health Information

Spasm
Inflammation
Trigger Point
Elevation
Adhesion
Rotation
Pain
Tender Joint
Hypertonicity



Client Concerns *

Rate your current pain on a scale from 1 (least) to 10 (worst) *

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Indicate the type of pain you are facing *

☐ Sharp ☐ Piercing ☐ Aching ☐ Numbness ☐ Dull ☐ Shooting ☐ Tingling ☐ Stabbing

☐ Other, Please Specify: _____

| Current Medical Conditions * | Current Medication * |
|---|---|
| Past Medical Concerns * | Relevant Family History * |

| Current Injuries * | Past Injuries * | Allergies * |
|---|---|---|

| Signature * | Date * |
|---|---|

# Questionnaire

1. Do you like the feel of wind blowing on your body?

2. Do you feel chillness?

3. Do you feel alternatively hot and cold?

4. Do you have bitter taste in your mouth?

5. Do you get irritated easily?

6. Do you have dizziness?

7. Do you have a good appetite?

8. Do you feel bloated easily?

9. Do you feel nauseous?

10. Do you feel abnormal thirst?

11. Do you like to drink warm or cold water ?

12. Do you have good bowel movement everyday?

If the answer is yes, how many times a day? Firm or loose?

If the answer is no, how often do you have one ?
Firm or loose?

13. What is the color of urine?
(Light yellow, dark yellow or pale?)

14. How about urine stream? Strong or weak?

15. Are your hands warm or cold?

16. Are your feet warm or cold?

17. Do you sleep good?

18. Do you go to sleep late? (After 11:00pm)

19. If you always wake up in the night, what time is it?
(11:00pm-1:00am? 1:00am-3:00am? 3:00am-5:00am?)

20. Period（females only)

cycle:_____days, duration:_____days

Do you have blood clots?

Do you have cramping pain?

21. Do you have any phlegm? If yes, what is the color?

22. Reason for visit

23. Others?

**Yi Acupuncture & Traditional Chinese Medicine PLLC**
840 N State Rd 434, Suite 1010,
Altamonte Springs, FL 32714
Tel: 321-972-4636

YI ACUPUNCTURE &
Traditional Chinese Medicine PLLC

# PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signing by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Policies.
The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosure will then cease.
The Signature practice may condition treatment upon the execution of this Consent.

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**Patient or Representative:** _____ **Date** _____

**Relationship to Patient (if other than patient):** _____ **Date** _____

**Witness** _____ **Date** _____

(Printed Name Yi Acupuncture & Traditional Chinese Medicine PLLC Representative)

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YI ACUPUNCTURE &
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# Patient Consent to Treatment

I hereby consent to the following provisions by Yi Acupuncture & Traditional Chinese Medicine PLLC
Patient's Name (Please Print): _____

A. Treatment: Any and all health care and treatment, which may include acupuncture, herbal formulas, Tui Na (Chinese medical massage), Cupping therapy, moxibustion, therapeutic exercises and /or nutritional counseling.
I understand that needling and cupping therapy may cause bruising in some cases.

B. Financial Information: All professional fees are due in full at the time services are rendered. I hereby acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to Yi Acupuncture & Traditional Chinese Medicine PLLC for the amount due after services have been rendered.
Payment can be made by major credit cards, cash or check.

Patient or Representative Signature _____ Date _____

## CANCELLATION POLICY

I AGREE TO CANCEL OR RESCHEDULE APPOINTMENTS WITH A MINIMUM OF 24 HOURS NOTICE.

Patient Signature _____ Date _____