Golden Oak Acupuncture
Kade Stotler
P.O. Box 318
Firestone, CO 80520

Phone: 206-218-6298
www.GoldenOakAcu.com
GoldenOakAcupuncture@gmail.com

Golden Oak Acupuncture & Herbal Medicine

"Root, Revive & Thrive"

New Patient Intake Forms

Patient Legal Name (+ "Preferred Name"):_____

Preferred Pronouns:_____ Gender:_____ Age:_____

Date of Birth (00/00/00):_____ Height:_____ Weight:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Preferred Phone Number:_____ Is this a cell phone? **YES / NO**

Email Address:_____
May we contact you and send informational, medical, and financially related emails to this address? **YES / NO**
Do you wish to receive a Claim Form to be reimbursed by your Health Care insurance? **YES / NO**
If YES, please fill out **HEALTH INSURANCE CLAIM INFORMATION** Document (see supplemental forms)
Is this treatment for an injury or accident that you will be making a claim on? **YES / NO**
If YES, please fill out **INJURY CLAIM INFORMATION** Document (see supplemental forms)
Primary Care Physician (Name, phone number, address): _____

_____
Other Regular Health Care Providers (Name, phone number: reason for visit)

1._____

2+_____
Have you ever received an Acupuncture or Oriental Medicine treatment before? **YES / NO**

Reason For Initial Visit: 1._____

2._____

3+_____
Referred By: _____
Emergency Contact (Name, Phone Number): _____

I understand that I am responsible for the cost of my treatment and products purchased at time of service. While Golden Oak Acupuncture does not directly bill my insurance for their services, if I wish to be reimbursed by my insurance, Golden OakAcupuncture will print me a Claim Form that I can submit to my insurance for them to reimburse to me directly according to their policies and procedures. I understand that I am financially responsible for all charges incurred as a result of my treatment contract with Golden Oak Acupuncture-including late and declined check fees-and I agree to pay for all services and herbal products prior to or at the time of service.

_____/_____ _____
Patient's or Guardian's Printed Name / Signature Date

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Patient Medical History

Name _____ DOB _____ Today's date _____
Address _____ City _____ State _____Zip _____
Telephone: (home) _____ (cell) _____ (work) _____
Email _____ Preferred means of contact: PHONE / TEXT / EMAIL
Occupation/Work Activities:_____
Preferred Leisure Activities:_____
Chief Complaint: Main problems you would like help with:
_____
When did your issue(s) begin? _____ Did anything initiate symptoms? _____
Does anything make it worse or better? (such as heat, cold, massage, rest, fatigue, use, exercise, weather, etc.)
_____
Have you been given a diagnosis for this problem? If so, what? _____

Past Medical History:

AIDs/HIV Alcoholism Allergies Antibiotic use Asthma Bleeding Issues Cancer Chicken pox Diabetes Epilepsy Glaucoma Heart disease Hepatitis High BP High fevers Jaundice Kidney Disease Measles Meningitis Mental Disorder MS Mumps Pacemaker Polio Pneumonia Rheumatic fever Scarlet fever Stroke Thyroid DO Tuberculosis Typhoid Ulcers Vascular Disease Venereal Disease

Other (please list)

Have you recently/are you currently?:

Fallen:Y/N Had a head injury:Y/N Pregnant:Y/N Running a fever:Y/N On Blood Thinning Medications: Y/N

ROS (Circle all that apply)

Constitutional/ General	Weight loss – Fevers – Chills - Poor Appetite – Fatigue - Weight gain – Insomnia - Night Sweats - Chills Sweat easily - Localized weakness – Peculiar Tastes/Smells - Poor Sleeping - Cravings - Other_____
Eyes	Blurry vision - Eye pain - Eye discharge - Eye redness - Decrease in vision - Dry eyes - Double vision - Floaters – Glasses – Cataracts - Eye strain - Night blindness - Other_____
ENMT	Sore throat – Hoarseness - Ear pain - Hearing loss - Ear discharge - Nose bleeds - Tinnitus - Sinus problems Dizziness - Ringing in ears - Teeth problems - Concussions - Poor hearing - Facial pain - Jaw clicks – Migraine - Color blindness – Earaches - Grinding teeth - Lip/tongue sores - Headaches -Other_____
Cardiovascular	Chest pain – Palpitations - Rapid heart rate - Heart murmur - Poor circulation - Swelling in extremities - High blood pressure - Low blood pressure - Irregular heart beat - Cold hands or feet Blood clots – Dizziness Phlebitis – Fainting - Difficulty breathing - Other_____
Respiratory	Shortness of breath - Chronic cough - Coughing up blood - History of Tuberculosis - Phlegm – Bronchitis - Pain with deep breath – Pneumonia - Asthma - Other _____
Gastrointestinal	Nausea – Vomiting – Diarrhea – Constipation - Blood in stool - Frequent heartburn - Trouble swallowing - Black stools - Bad breath - Abdominal pain or cramps - Chronic laxative use – Gas - Rectal Pain – Belching Indigestion - Hemorrhoids - Other _____
Uro-genital	Frequent urination - Blood in urine – Incontinence - Painful urination - Urinary retention - Frequent UTIs Urgency to urinate - Decrease in flow - Unable to hold urine - Other_____ Do you wake up to urinate: ____ If yes, how often : _____ Any particular color to urine: _____
Reproductive	Number of pregnancies:____ Number of births: ____ Premature births ____ Miscarriages/Abortion_____ Age at first menses: ____ Birth Control: _____ # of days between menses: ____Duration of menses: ____ Date of last menses: ____ Heavy period - Light period - Painful periods - Clots with flow - Irregular periods Vaginal discharge - Breast lumps - PMS - PCOS - Difficulty climaxing - genital sores - STI - Premature Ejaculation - Erectile Dysfunction - Testicular Injury - Other _____
Skin	Rash – Hives - Hair loss - Skin sores or ulcers - Itching - Skin thickening - Nail changes - Mole changes – Dandruff – Ulcerations – Eczema - Pimples - Other _____

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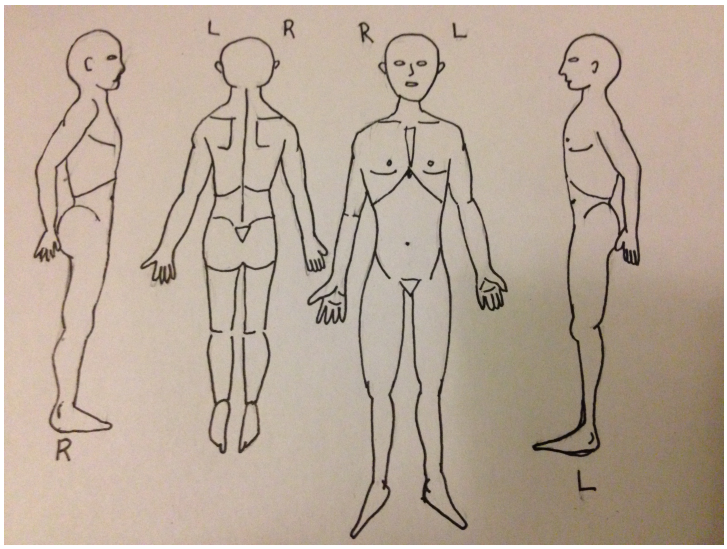
Patient Medical History (Continued)

Musculoskeletal	Joint pain - Muscle aches - Frequent leg cramps - Muscle weakness - Bone pain - Joint swelling - Back pain - Neck pain - Hand/ wrist pain - Shoulder pain - Knee pain - Foot /ankle pain - Hip pain - Other _____
Neuropsycho	Anxiety – Depression - Alcohol or drug dependence - Suicidal thoughts - Panic attacks - Seizures - Use of anti-depressants - Areas of numbness – Concussion - Bad temper - Dizziness - Lack of coordination - Easily susceptible to stress - Loss of balance - Poor memory - Other _____
Endocrine	Goiter - Heat intolerance - Cold intolerance - Strong thirst - Change in skin pigment - Excess sweating - hyperthyroidism - hypothyroidism - adrenal fatigue - Other _____
Neurological	Seizures – Tremors – Migraines – Numbness - Dizziness/ vertigo - Loss of balance - Slurred speech - Stroke Other_____
Hem/Lymphatic	Low blood count - Easy bruising - Swollen lymph nodes – Transfusions - Prolonged bleeding - Blood clots Other _____
Allergic/Immun	Allergic reactions - Hay fever - Frequent infections – Hepatitis - HIV positive –Auto immune condition- Positive tuberculin skin test (PPD) - Other_____

Emotions: Please describe current emotions_____
Allergies: Please List All Allergies and Their Severity:_____
_____
Medications:_____
_____
Amount (per week) of: Coffee:_____ Alcohol:_____ Cigarettes:_____ Recreational Substances:_____
Pain: Please Mark Areas of Pain(P), Fatigue(F), Numbness(N), Other Sensations(O) Explain:_____
And give a number from 0-10 utilizing scale below



0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Moderate		Severe		Very Severe		Worst Possible

I authorize treatment by the practitioners at Golden Oak Acupuncture. All information on this form is correct. I understand that I am responsible for payment of all fees to Golden Oak Acupuncture on the day of services rendered unless other arrangements are made in advance. I understand that I will give Golden Oak Acupuncture at least 24h notification for a cancellation of my appointment or I will be charged full price for the missed appointment.
Patient's Printed Name: _____Patient's Signature: _____Date: _____
Consent to treat a minor child: I hereby authorize Golden Oak Acupuncture to administer treatment to my child
(Name) _____Parent/Legal Guardian Signature: _____Date:_____