WEEM

Susan Sandlin, L.Ac., MSOM, RYT500
West End Eastern Medicine
1891 Billingsgate Circle, Suite B
Richmond, VA 23238-4242
(804) 437 · 1947
www.westendeasternmedicine.com

Patient Intake Form 1

Date _____

First name _____

Last name _____

Gender: ❒ Female ❒ Male Age _____ Birth date _____

Height _____ Weight _____

Relationship status: ❒ Married ❒ Widowed ❒ Single ❒ Minor ❒ Separated
❒ Divorced ❒ Partnered for: _____ (# of years)

Occupation _____

Address _____

City, State and Zip _____

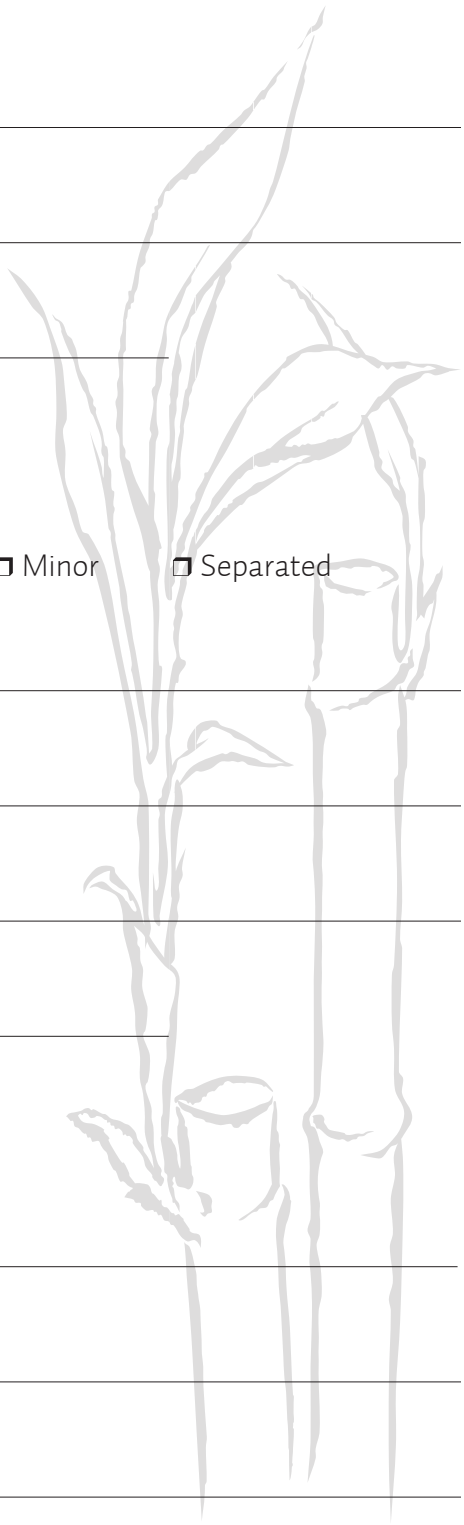
Home phone _____ Work phone _____

Cell phone _____

E-mail address _____

Emergency contact person & phone number _____

Referred to WEEM by _____



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Patient Intake Form 2

Reason for visit today _____

Have you had acupuncture before? ❒ YES ❒ NO

Have you taken Chinese herbs before? ❒ YES ❒ NO

How long have you had this condition? _____

Is it getting worse? _____

Does it bother your: ❒ Sleep ❒ Work Other: _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What makes it worse? _____

Are you under the care of a physician now? ❒ YES ❒ NO

If yes, for what? Physician's number _____

Who is your physician? _____

Other concurrent therapies _____

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Patient Intake Form 3

Family Medical History

Allergies:	Cancer type:	❒ Arteriosclerosis ❒ Asthma ❒ Alcoholism	❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure	❒ Seizures ❒ Stroke

Your Past Medical History

Check any of the following conditions you currently have or have had in the past.
Also check if you feel any of the following are a significant part of your medical history.

❒ AIDS / HIV	❒ Chicken Pox	❒ Herpes	❒ Polio	❒ Major Trauma
❒ Alcoholism	❒ Diabetes	❒ High Blood Pressure	❒ Rheumatic Fever	❒ Tuberculosis
❒ Allergies	❒ Emphysema	❒ Measles	❒ Scarlet Fever	❒ Typhoid Fever
❒ Appendicitis	❒ Epilepsy	❒ Multiple Sclerosis	❒ Seizures	❒ Ulcers
❒ Arteriosclerosis	❒ Goiter	❒ Mumps	❒ Stroke	❒ Venereal Disease
❒ Asthma	❒ Gout	❒ Pacemaker	❒ Thyroid Disorders	❒ Whooping Cough
❒ Birth Trauma	❒ Heart Disease	❒ Pleurisy	Surgeries:	Other:
❒ Cancer	❒ Hepatitis	❒ Pneumonia		

Your Diet / Appetite

❒ Low appetite	❒ Coffee	❒ Artificial Sweetener	❒ Sugar	❒ Thirst for water.
❒ High appetite	❒ Soft Drinks	❒ Cravings _____	❒ Salty Food	# of glasses per day: _____

Average Daily Food Intake

Morning:	Snack:	Noon:	Snack:	Evening:

Pharmaceuticals taken in the last 2 months:

Vitamins / supplements taken in the last 2 months:

Your Lifestyle

❒ Alcohol, qty: _____	❒ Marijuana	❒ Stress	Regular Exercise: Type / Frequency
❒ Tobacco, qty: _____	❒ Recreational Drugs	❒ Occupational Hazards	

General Symptoms

❒ Poor appetite	❒ Recent weight gain	❒ Lack of strength	❒ Fever	❒ Vertigo
❒ Heavy appetite	❒ Poor sleep	❒ Bodily heaviness	❒ Chills	❒ Dizziness
❒ Strongly like cold drinks	❒ Heavy sleep	❒ Cold hands or feet	❒ Night sweats	❒ Bleed or bruise easily
❒ Strongly like hot drinks	❒ Dream-disturbed sleep	❒ Poor circulation	❒ Sweat easily	Peculiar taste:
❒ Recent weight loss	❒ Fatigue	❒ Shortness of breath	❒ Muscle cramps	

Head, Eyes, Ears, Nose, Throat, Mouth

❒ Glasses	❒ Blurred vision	❒ Facial pain	❒ Color of phlegm	❒ Poor hearing
❒ Eye strain	❒ Night blindness	❒ Gum problems	❒ Recurrent sore throat	❒ Earaches
❒ Eye pain	❒ Glaucoma	❒ Sore on lips or tongue	❒ Swollen glands	❒ Headaches
❒ Red eyes	❒ Cataracts	❒ Dry mouth	❒ Lumps in throat	❒ Migraine
❒ Itchy eyes	❒ Teeth problems	❒ Excessive saliva	❒ Enlarged thyroid	❒ Concussions
❒ Spots in eyes	❒ Grinding teeth	❒ Sinus problems	❒ Nose bleeds	Head or neck trauma:
❒ Poor vision	❒ TMJ	❒ Excessive phlegm	❒ Ringing in ears	

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Patient Intake Form 4

Respiratory

❒ Difficulty breathing when lying down
❒ Shortness of breath
❒ Tight chest
❒ Asthma / wheezing
❒ Cough
❒ Wet or ❒ Dry?
❒ Thick or ❒ Thin?
Color of phlegm:
❒ Coughing blood
❒ Pneumonia
❒ Frequent colds

Cardiovascular

❒ High blood pressure
❒ Blood clots
❒ Low blood pressure
❒ Fainting
❒ Chest Pain
❒ Difficulty breathing
❒ Tachycardia
❒ Heart palpitations
❒ Phlebitis
❒ Irregular heartbeat

Gastrointestinal

❒ Nausea
❒ Vomiting
❒ Acid regurgitation
❒ Gas
❒ Hiccup
❒ Bloating
❒ Bad breath
❒ Diarrhea
❒ Constipation
❒ Laxative use
❒ Black stools
❒ Bloody stools
❒ Mucous stools
❒ Intestinal pain or cramping
❒ Itchy anus
❒ Burning anus
❒ Rectal pain
❒ Hemorrhoid
❒ Anal fissures
Bowel movements
Frequency:
Color:
Texture / form:
Odor:

Musculoskeletal

❒ Neck / shoulder pain
❒ Muscle pain
❒ Upper back pain
❒ Low back pain
❒ Joint pain
❒ Rib pain
❒ Limited range of motion
❒ Limited use
Other:

Skin and Hair

❒ Rashes
❒ Hives
❒ Ulcerations
❒ Eczema
❒ Psoriasis
❒ Acne
❒ Dandruff
❒ Itching
❒ Hair loss
❒ Change in hair/ skin texture
❒ Fungal infections
Hair or skin problems:

Neuropsychological

❒ Seizures
❒ Numbness
❒ Tics
❒ Poor memory
❒ Depression
❒ Anxiety
❒ Irritability
❒ Easily stressed
❒ Abuse survivor
❒ Considered or attempted suicide
❒ Seeing a therapist
Other:

Genito-urinary

❒ Pain on urination
❒ Frequent urination
❒ Urgent urination
❒ Blood in urine
❒ Unable to hold urine
❒ Incomplete urination
❒ Venereal disease
❒ Bed wetting
❒ Wake to urinate
❒ Increased libido
❒ Decreased libido
❒ Kidney stone
❒ Impotence
❒ Premature ejaculation
❒ Nocturnal emission

Gynecology

Age menses began: _____
Length of cycle (day 1 to day 1): _____
Duration of flow: _____
❒ Irregular periods
❒ Painful periods
❒ PMS
❒ Vaginal discharge
❒ Vaginal sores
❒ Vaginal odor
❒ Clots
❒ Breast lumps
Pregnancies _____
Live births _____
Premature births _____
Age at Menopause _____
Date of last PAP:
Date last period began:

Other:

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Recommendation for Examination by a Physician

Please insert your name, sign and date. The practitioner will complete her portion.

I, Susan Sandlin, L.Ac, recommend to you _____ that you be examined by a Physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Client Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment.
(Code of Virginia 54-2956.9 18 VAC 85-110-10)

_____ _____
Acupuncturist Date

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Policies and Practices of West End Eastern Medicine

The practice is based on the commitment to mutual respect and accountability. I am strongly dedicated to working in partnership with you to enhance your life quality.

Please initial each policy

____ **Appointments** All treatments are by appointment only. In the spirit of mindfulness for all involved, please arrive at your scheduled appointment time. As I do not answer the phone when I am in with a patient, please leave a message including your phone number. If you call after hours I will return your call during business hours the next business day. Calls on Friday evening or on the weekend will be returned during business hours on the following Monday.

If you are having a Medical Emergency call 911 or go to the nearest emergency room!

____ **Cancellations** *Because this is an appointment-only business, a late cancellation does not allow for an appointment time to be utilized.* **In the event that a scheduled appointment is cancelled with less than 24 hours notice,**

I, _____, understand that I will be required to pay in full for the missed appointment. (Exceptions will be made for sudden illness or other emergency situations)

____ **Payment** Payment is due at the time of treatment. Payment may be made in the form of Cash, Check, Visa or MasterCard. There is a $25.00 charge for returned checks.

____ **Insurance** I am glad to provide you with an insurance form that you may submit to your carrier, but I do not accept insurance. I would encourage you to call your insurance carrier to check and see if acupuncture is covered. If so, check to see if you need your primary care physician's referral and diagnostic codes.

____ **Safety** Only pre-packaged sterilized, disposable needles are used and are inserted according to clean procedures based on nationally prescribed standards. To prevent the transmission of infectious disease by physical contact, such as conjunctivitis, the practitioner practices strict hand washing before seeing each patient. If the practitioner is ill, she may postpone treatment until a later day, or use a mask during treatment.

____ **Possible Side Effects/Healing Reactions** As with any treatment, some side effects are possible. These may include temporary pain or discomfort, local bruising, slight bleeding, or swelling. It is also important to be aware of the fact that sometimes a healing reaction follows acupuncture treatment. This may involve the temporary aggravation of pre-existing symptoms. If such a healing reaction occurs, the symptoms typically abate within 24-48 hours after they appear (72 hours for skin problems)

____ **Confidentiality** Information regarding treatment will be kept strictly confidential. Charts and documents are stored safely. No one will have access to treatment records without your written permission.

_____ Print Name of Patient

_____ Today's Date

_____ Signed by Patient (or Guardian)

_____ Signed by Practitioner / Witness

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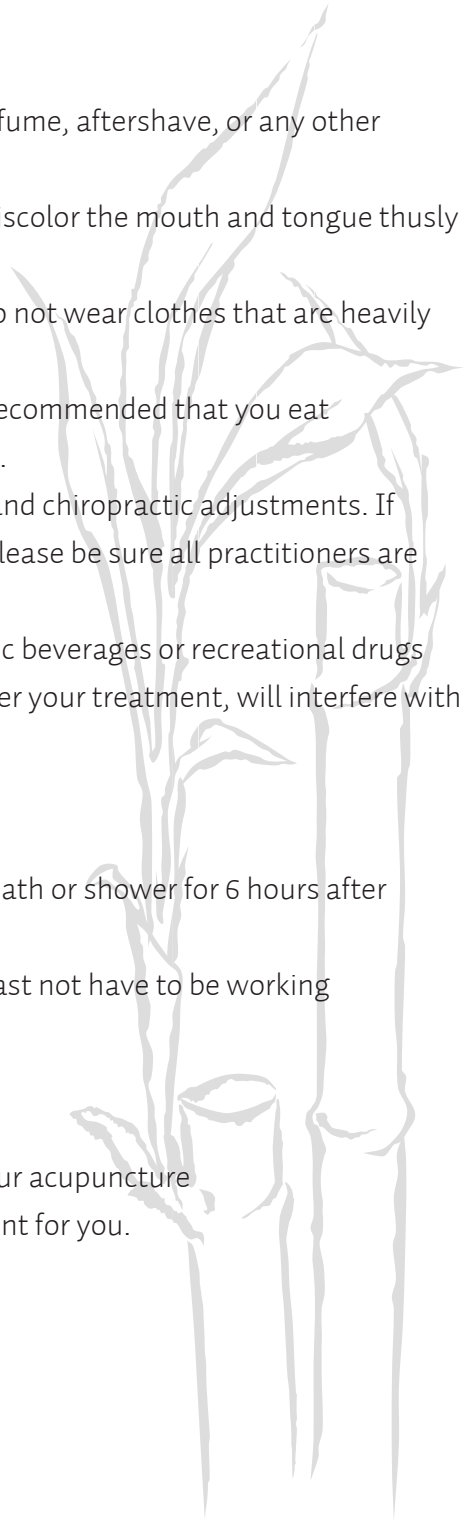
Patient Guidelines

Pre-Treatment

- Due to patients with sensitivities to scents, please refrain from wearing perfume, aftershave, or any other products that are heavily scented to your appointment.
- Please avoid tongue brushing, and chewing gum or eating candy that can discolor the mouth and tongue thusly making the tongue diagnosis less accurate.
- Smoking is not advisable within 1 hour prior to your appointment. Please do not wear clothes that are heavily scented with smoke.
- Please do not eat a large meal immediately before your appointment. It is recommended that you eat something light. It is best not to receive acupuncture on an empty stomach.
- Acupuncture is an excellent adjunct therapy to massage, physical therapy and chiropractic adjustments. If these treatments are on the same day as your acupuncture appointment, please be sure all practitioners are aware of this so that treatments can be adjusted to enhance your therapy.
- Please do not engage in heavy exercise, sexual activity, or consume alcoholic beverages or recreational drugs within 6 hours before or after your treatment. These activities, before or after your treatment, will interfere with the effectiveness of that treatment.

Post-Therapy

- Please refrain from entering a jacuzzi or sauna, or taking an extremely hot bath or shower for 6 hours after your treatment.
- Plan your activities so that after a treatment you can get some rest, or at least not have to be working strenuously. This especially important for the first few visits.
- Continue to take any prescription medications as directed by your doctor.
- Be sure to drink plenty of water after your treatment.
- Remember to keep good mental or written notes on how you respond to your acupuncture treatment. This will help the practitioner design the best follow-up treatment for you.



Please keep for your reference.