

## Intake form for Silvia Vidas, Dr. TCM

All information provided is confidential and will not be released unless authorized by you.

Date \_\_\_\_\_ Care card# \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_

Email: \_\_\_\_\_

Contact tel. number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Married: \_\_\_\_\_ or Single: \_\_\_\_\_ Children: \_\_\_\_\_

Physician's Name/Phone \_\_\_\_\_

Emergency contact (name/phone # & relationship to you) \_\_\_\_\_

Who referred you to this clinic? \_\_\_\_\_

Main reason(s) for being here today: \_\_\_\_\_

How long have you had issue(s)? \_\_\_\_\_

Is there anything that makes this condition better? \_\_\_\_\_

Is there anything which makes this condition worse? \_\_\_\_\_

Have you ever seen an Acupuncturist/Dr. of TCM before?     \_\_\_yes     \_\_\_no

### Medical history & general Information

How would you describe your level of energy (1- little energy; 10- lots of energy) \_\_\_\_\_

Do you get tired easily?                     \_\_\_yes                     \_\_\_no

Do you catch colds easily?                 \_\_\_yes                     \_\_\_no

### Check if you have had or currently have any of the following:

- |                 |                       |                       |
|-----------------|-----------------------|-----------------------|
| ___allergies    | ___asthma             | ___bleeding tendency  |
| ___cancer       | ___cirrhosis of liver | ___diabetes           |
| ___epilepsy     | ___heart disease      | ___hepatitis          |
| ___HIV or AIDS  | ___migraines          | ___multiple sclerosis |
| ___tuberculosis | ___STDs               | ___seizures           |
| ___stroke       | ___thyroid disorder   |                       |

Are you being treated for any medical conditions at the present time or have you been treated in the past year?     \_\_\_yes     \_\_\_no.

If yes, please list \_\_\_\_\_

Please list any other significant diseases, injuries or diagnosis that you currently have or have had in the past: \_\_\_\_\_

Have you ever had any surgeries? If so, list \_\_\_\_\_

When was your last medical check-up? \_\_\_\_\_

**Current Meds:** Please list any medications you are taking (include dosage if known): \_\_\_\_\_

List of vitamins/ supplements (include dosage if known) \_\_\_\_\_

Do you have any allergies:  yes  no If yes, please list \_\_\_\_\_

Have you ever had any peculiar or adverse reaction to any medicines?  yes  no

If yes, please describe \_\_\_\_\_

Do you have any heart or blood pressure problems?  yes  no

Please describe \_\_\_\_\_

High blood pressure:  yes  no

Low blood pressure:  yes  no

Have you ever been told not to give blood?  yes  no

Have you ever had a blood transfusion?  yes  no

Do you bruise easily or bleed for prolonged period of time after a cut?  yes  no

**General Health Information:**

What exercise do you do & how often per week? \_\_\_\_\_

How would you describe your diet? \_\_\_\_\_

**Please note amount of cigarettes, alcohol & caffeine, if applicable:**

\_\_\_ cigarettes: number /day \_\_\_\_\_

\_\_\_ coffee & tea number cups/day \_\_\_\_\_

\_\_\_ alcohol: drinks/week \_\_\_\_\_

\_\_\_ recreational drugs-if so please describe: \_\_\_\_\_

**Aches & pain:** Do you have any body aches/pains? If so, please describe location of pain, how long you have had the pain: \_\_\_\_\_

**Please note additional factors regarding aches & pain:**

<input type="checkbox"/> pain better with heat	<input type="checkbox"/> pain associated with bloating, fullness and or distention
<input type="checkbox"/> pain improved with pressure on affected area	<input type="checkbox"/> pain that moves from location to location
<input type="checkbox"/> pain worse with pressure	<input type="checkbox"/> dull pain that is worse with fatigue
<input type="checkbox"/> pain worse with damp weather	<input type="checkbox"/> sharp pain

**Body temperature:**

Do you usually feel cold?  yes  no. Do you usually feel hot?  yes  no

If you feel cold, does your whole body feel cold or just your hands or/and feet? \_\_\_\_\_

**Sweating:** please mark if you are experiencing any of the following:

\_\_\_ daytime sweating with no or little exertion

\_\_\_ hot flashes

\_\_\_ night sweats

\_\_\_ sweating of whole body

\_\_\_ sweating on palms, soles & chest

**Head & face:**

Do you have headaches? \_\_\_yes \_\_\_no

What triggers headache? \_\_\_\_\_

**Please indicate words that best describe your headache:** \_\_\_acute \_\_\_chronic

\_\_\_Severe \_\_\_Dull pain \_\_\_Distend or throb pain \_\_\_Stabbing pain

\_\_\_Worse with fatigue \_\_\_Frontal headache

\_\_\_Posterior or occipital headache \_\_\_Worse during the day \_\_\_Worse in evening

\_\_\_worse with wind or cold \_\_\_Feels heavy "like a damp towel around head"

**Do you have dizziness?** \_\_\_yes \_\_\_no. If yes, how often? \_\_\_\_\_

\_\_\_Dizziness with loss of balance

\_\_\_Dizziness with heavy feeling in head

\_\_\_Dizziness worse with fatigue

\_\_\_Dizziness comes on suddenly

\_\_\_Dizziness with gradual onset

**Do you have palpitations?** \_\_\_yes \_\_\_no. If yes, how often? \_\_\_\_\_

<b>Eyes:</b>	<b>Ears:</b>
___eye pain, well and or redness	___sudden onset ringing in ears (tinnitus)
___blur vision or with floaters	___chronic ringing in ears (tinnitus)
___dry eyes	___Sudden onset deafness
___yellow sclera	___Gradual onset deafness
___abnormal eye movements	

**Digestion & water metabolism:**

<b>Thirst:</b>	<b>Appetite:</b>
___lack of thirst	___lack of appetite
___desire for warm liquids	___insatiable appetite
___strong thirst especially for cold drinks	___fullness/bloating or distention after eating
___dry mouth with desire to sip liquids	___preference for warm/hot foods
___thirst but no desire to drink	___preference for cold/cool foods

**Do you have any tastes in your mouth such as:** \_\_\_bitter taste \_\_\_sweet taste

\_\_\_sour taste \_\_\_salty taste \_\_\_metallic taste \_\_\_lack of taste

**Do you experience any of the following?**

\_\_\_nausea/vomiting

\_\_\_heartburn

\_\_\_excess gas

\_\_\_bloating after meals

\_\_\_indigestion

\_\_\_other: \_\_\_\_\_

**Urination & stools:**

<b>Urination:</b> Do you have any of following:	<b>Bowels:</b>
<input type="checkbox"/> lack of urine control	<input type="checkbox"/> normal stools
<input type="checkbox"/> urine retention	<input type="checkbox"/> Constipation
<input type="checkbox"/> incomplete urination	<input type="checkbox"/> diarrhea/loose stools
<input type="checkbox"/> pain with urination	<input type="checkbox"/> alternating diarrhea & constipation
<input type="checkbox"/> pale colored urine	<input type="checkbox"/> diarrhea in the early morning
<input type="checkbox"/> dark color urine	<input type="checkbox"/> rectal bleeding
<input type="checkbox"/> copious amounts of urine	<input type="checkbox"/> hemorrhoids
<input type="checkbox"/> scanty urination	Average # of bowel movements per
<input type="checkbox"/> need to get up at night to urinate	day: _____

**Sleep quality & habits:** Do you have any problems falling asleep or do you wake up often at night?  yes  no

- difficulty falling asleep but sleeps well
- wakes up often
- nightmares a/or violent dreams
- restless sleep after eating late

**Thorax & Abdomen:** Do you have any of the following?

- Shortness of breath
- pain in chest area
- persistent cough
- pain in costal region or region below the ribs
- pain in the upper abdomen above belly button
- pain in lower abdomen below belly button

**Emotions:** Please mark emotions that seem to be affecting your life:

- |  |                                |                                    |                                |
|--|--------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> anger         | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> irritability  | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> nervousness   | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> depression    | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> anxiety       | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> stress        | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |
| <input type="checkbox"/> sadness       | <input type="checkbox"/> often | <input type="checkbox"/> sometimes | <input type="checkbox"/> never |

## CONSENT FORM

I do hereby voluntarily consent to be treated with acupuncture and Chinese medicinal herbs by Silvia Vidas, Dr. TCM.

**Initial here \_\_\_\_\_ Acupuncture:** I understand that acupuncture is performed by the insertion of sterile single use needles through the skin in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture is a typically safe method of treatment however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Initial here \_\_\_\_\_ Chinese Herbs:** I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. ***Should I experience any problems, which I associate with these substances, I should suspend taking them and call Silvia Vidas, Dr. TCM as soon as possible.***

**Initial here \_\_\_\_\_ Acupressure/Tui-Na Massage, Qi Gong:** I understand that I may also be given acupressure/tui-na massage and/or Qi Gong as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Initial here \_\_\_\_\_ Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass or plastic cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perceptions and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and through unsightly are not normally painful.*** However, certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

**Initial here \_\_\_\_\_** I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I do not expect Silvia Vidas, Dr. TCM to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask Silvia Vidas, Dr. TCM for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent/legal guardian signature:** \_\_\_\_\_ **(if patient is under 18 years of age)**

**Printed Name:** \_\_\_\_\_