INDIAN RIVER
Acupuncture
& INTEGRATIVE MEDICINE

1345 36th Street, Suite B/ Vero Beach, FL 32960/ 772-564-8383

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Social Security Number: _____ Marital Status: _____ Occupation: _____

Email: _____ Referred By: _____

Insurance Carrier: _____ Policy #: _____ Group #: _____

Emergency Contact- Name: _____ Phone Number: _____

Family Physician- Name: _____ Phone Number: _____

Have you tried Acupuncture or Chinese Herbal Medicine before? If yes, please explain: _____

_____

General Information

Why are you seeking treatment with us today?

_____

To what extent does your condition affect your daily activities (work, sleep, etc)?

_____

How long has it been since you first noticed any symptoms?

_____

Have you been given a diagnosis for the issue by your family physician? If yes, what is the diagnosis?

_____

Past Medical History (Please include dates)

___Allergies
___ Cancer
___ Diabetes
___ Hepatitis
___ High Blood Pressure
___ Heart Disease
___ Seizures
___ Rheumatic Fever
___ Surgeries
___ Asthma
___ Thyroid Disease
___ Birth Trauma (prolonged labor, forceps delivery, etc)
_____
___ Other significant illness (please describe)
_____
_____
___ Accidents or significant trauma (please describe)
_____
_____
_____

Other Relevant Medical History

_____

_____

Family Medical History

___ Allergies
___ Diabetes
___ Asthma
___ Cancer
___ Heart Disease
___ High Blood Pressure
___ Seizures
___ Stroke
___ Other _____

Occupation

Occupational stress factors (physical, psychological, chemical): _____

_____

Lifestyle

Do you follow a regular exercise program? If so, please describe:

_____

Please describe your average daily diet:

_____

Please check any of the following that apply with the frequency of use:

___ Cigarette smoking ___ Caffeine ___ Alcoholic beverages

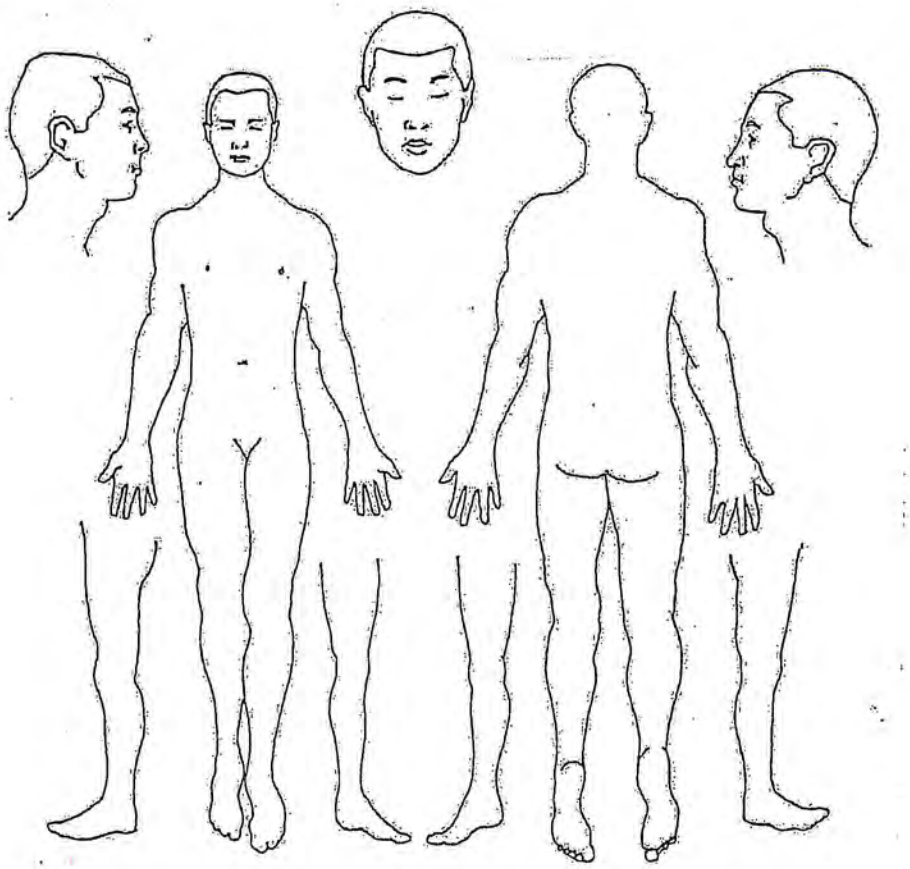
List any medications, supplements, herbs, etc taken within the last 2 months:

_____

List any use of drugs for non-medical purposes:

_____

****Please mark painful or distressed areas on the charts below****



Please check any conditions you have experienced within the last 3 months. Indicate the length of time you have had this condition

General

___ Poor Appetite
___ Insomnia
___ Disturbed Sleep
___ Localized weakness
___ Cravings
___ Strong thirst
___ Weight Gain
___ Weight Loss
___ Changes in appetite
___ Sweating easily
___ Tremors
___ Bleeding or bruising easily
___ Night Sweats
___ Fever
___ Chills
___ Sudden energy drop (time of day?)
___ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health:

_____

Skin and Hair

___ Rashes
___ Ulcerations
___ Hives
___ Hair loss
___ Eczema
___ Pimples
___ Dandruff
___ Recent moles
___ Changes in texture of hair/skin
___ Itching

Any other hair or skin problems:

_____

Head, Eyes, Ears, Nose, & Throat

___ Dizziness
___ Concussions
___ Migraines
___ Glasses
___ Color blindness
___ Cataracts
___ Blurry vision
___ Earaches
___ Recurrent sore throats
___ Nose bleeds
___ Grinding teeth
___ Sores on lips or tongue

___ Spots in front of eyes
___ Eye pain
___ Poor vision
___ Night blindness
___ Ringing in ears
___ Poor hearing
___ Eye strain
___ Sinus problems
___ Facial Pain
___ Teeth problems
___ Headaches (where? when?)
___ Jaw clicks

Any other head or neck problems:

Cardiovascular

___ Dizziness
___ Low blood pressure
___ Chest pain
___ Irregular heartbeat
___ High blood pressure
___ Fainting
___ Cold hands or feet
___ Swelling of hands
___ Swelling of feet
___ Blood clots
___ Difficulty in breathing
___ Phlebitis

Any other heart or blood vessel problems:

Respiratory

___ Cough
___ Coughing up blood
___ Asthma
___ Bronchitis
___ Pain with deep inhalation
___ Pneumonia
___ Difficulty breathing when lying down
___ Excessive Phlegm (color?)

Any other lung problems:

Gastrointestinal

___ Nausea
___ Vomiting
___ Belching
___ Black stools
___ Rectal Pain
___ Hemorrhoids

___ Diarrhea ___ Blood in stools ___ Abdominal pain/cramps

___ Constipation ___ Indigestion ___ Chronic laxative use

___ Gas ___ Bad breath

Any other problems with stomach or intestines:

_____

Genitourinary

___ Pain on urination ___ Unable to hold urine ___ Prostate problems

___ Urgent/frequent urination ___ Decrease in flow ___ Impotence

___ Blood in urine ___ Kidney stones ___ Sores on genitals

Do you wake up at night to urinate? If so, how often? _____

Any particular color to your urine? _____

Any other genital or urinary problems:

_____

Reproductive and Gynecologic

___ Premenstrual changes ___ Heavy menstrual flow ___ Premature births

___ Menstrual clots ___ Light menstrual flow ___ Miscarriages---How many?___

___ Painful menses ___ Irregular menses ___ Abortions---How many?___

___ Unusual menses ___ Other problems

Age at first menses:_____ Age at menopause:_____ Number of pregnancies:_____

Time between cycles:_____ Duration of bleeding:_____ First day of last menses:_____

Do you practice birth control? If so, what type and for how long? _____

Any other gynecologic problems:

_____

Musculoskeletal

___ Neck pain ___ Back pain ___ Hand/wrist pains

___ Muscle pains ___ Muscle weakness ___ Shoulder pains

___ Knee pain ___ Foot/ankle pains ___ Hip pain

Any other joint or bone problems:

_____

Neuropsychological

___ Seizures ___ Poor memory ___ Anxiety

___ Dizziness ___ Lack of coordination ___ Bad temper

___ Loss of balance ___ Concussion ___ Easily susceptible to stress

___ Areas of numbness ___ Depression

Have you ever been treated for emotional problems?_____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems:

_____

Comments

Please list any other problems you would like to discuss:

_____

_____

_____

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list the 5 major health concern in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please check mark the appropriate number "0 - 3" on all questions below.
0 as the least/never to 3 as the most/always.

Category I	0	1	2	3
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relief by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard dry or small stool	☐	☐	☐	☐
Coated tongue of "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Do you use laxatives frequently	☐	☐	☐	☐

Category II	0	1	2	3
Excessive belching burping or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after meals	☐	☐	☐	☐
Difficulty digesting fruits and vegetables; undigested foods found in stools	☐	☐	☐	☐

Category II	0	1	2	3
Stomach pain, burning or aching 1- 4 hours after eating	☐	☐	☐	☐
Do you frequently use antacids	☐	☐	☐	☐
Feeling hungry an hour or two after eating	☐	☐	☐	☐
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief from antacids, food, milk, carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	☐	☐	☐	☐

Category IV	0	1	2	3
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullness lasts 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side Under rib cage bloated	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling, Mucous-like, greasy or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category V	0	1	2	3
Greasy or high fat foods cause distress	☐	☐	☐	☐
Lower bowel gas and or bloating several hours after eating	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates for clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gallbladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed	Yes ☐		No ☐	

Category VI	0	1	2	3
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep yourself going or started	☐	☐	☐	☐
Get lightheaded and if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, tremors	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory, forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

Category VII	0	1	2	3
Fatigue after meals	☐	☐	☐	☐
Crave sweets during the day	☐	☐	☐	☐
Eating sweets does not relieve cravings for sugar	☐	☐	☐	☐
Must have sweets after meals	☐	☐	☐	☐
Waist girth is equal or larger than hip girth	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst & appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category VIII	0	1	2	3
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐

Category IX	0	1	2	3
Cannot fall asleep	☐	☐	☐	☐
Perspire easily	☐	☐	☐	☐
Under high amounts of stress	☐	☐	☐	☐
Weight gain when under stress	☐	☐	☐	☐
Wake up tired even after 6 or more hours of sleep	☑	☐	☐	☐
Excessive perspiration or perspiration with little or no activity	☐	☐	☐	☐

Category X	0	1	2	3
Tired, sluggish	☐	☐	☐	☐
Feel cold – hands, feel, all over .	☐	☐	☐	☐
Require excessive amounts of sleep to function properly	☐	☐	☐	☐
Increase in weight gain even with low-calorie diet	☐	☐	☐	☐
Gain weight easily	☐	☐	☐	☐
Difficult, infrequent bowel movements	☐	☐	☐	☐
Depression, lack of motivation	☐	☐	☐	☐
Morning headaches that wear off as the day progresses	☐	☐	☐	☐
Outer third of eyebrow thins	☐	☐	☐	☐
Thinning of hair on scalp, face or genitals or excessive falling hair	☐	☐	☐	☐
Dryness of skin and/or scalp	☐	☐	☐	☐
Mental sluggishness	☐	☐	☐	☐

Category XI	0	1	2	3
Heart palpations	☐	☐	☐	☐
Inward trembling	☐	☐	☐	☐
Increased pulse even at rest	☐	☐	☐	☐
Nervousness and emotional	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐

Category XII	0	1	2	3
Diminished sex drive	☐	☐	☐	☐
Menstrual disorders of lack of menstruation	☐	☐	☐	☐
Increased ability to eat sugars without symptoms	☐	☐	☐	☐

Category XIII	0	1	2	3
Increased sex drive	☐	☐	☐	☐
Tolerance to sugars reduced	☐	☐	☐	☐
"Splitting" type headaches	☐	☐	☐	☐

Category XIV (Male Only)	0	1	2	3
Urination difficulty or dribbling	☐	☐	☐	☐
Urination frequent	☐	☐	☐	☐
Pain inside of legs or heels	☐	☐	☐	☐
Feeling of incomplete bowel evacuation	☐	☐	☐	☐
Leg nervousness at night	☐	☐	☐	☐

Category XV (Males Only)	0	1	2	3
Decrease in libido	☐	☑	☐	☐
Decrease in spontaneous morning erections	☐	☐	☐	☐
Decrease in fullness of erections	☐	☐	☐	☐
Difficulty in maintain morning erections	☐	☐	☐	☐
Spells of mental fatigue	☐	☐	☐	☐
Inability to concentrate	☐	☐	☐	☐
Episodes of depression	☐	☐	☐	☐
Muscle soreness	☐	☐	☐	☐
Decrease in physical stamina	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Increase in fat distribution around chest and hips	☐	☐	☐	☐
Sweating attacks	☐	☐	☐	☐
More emotional then in the past	☐	☐	☐	☐

Category XVI (Menstruating Females Only)	0	1	2	3
Are you a menopausal	Yes ☐		No ☐	
Alternating menstrual cycle lengths	Yes ☐		No ☐	
Extended menstrual cycle, greater than 32 days	Yes ☐		No ☐	
Shortened menses, less than every 24 days	Yes ☐		No ☐	
Pain and cramping during periods	☐	☐	☐	☐
Scanty blood flow	☐	☐	☐	☐
Heavy blood flow	☐	☐	☐	☐
Breast pain and swelling during menses	☐	☐	☐	☐
Pelvic pain during menses	☐	☐	☐	☐
Irritable and depressed during menses	☐	☐	☐	☐
Acne break outs	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Hair loss/thinning	☐	☐	☐	☐

Category XVII (Menopausal Females only)	0	1	2	3
How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	Yes ☐		No ☐	
Hot flashes	☐	☐	☐	☐
Mental fogginess	☐	☐	☐	☐
Disinterest in sex	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Shrinking breast	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Increased vaginal, pain, dryness or itching	☐	☐	☐	☐

PART III

How many alcohol beverages they consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you workout? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke?_____ If yes, how many times a day _____ , a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

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 Rights section describing your rights under the law. You have the right to review our Notice before signing the 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, signed by you. However, such a revocation shall not affect any disclosures 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 may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

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Printed Name of Patient or Representative

Relationship to Patient

Signature of Patient or Representative

Date

Witness - Printed Name of Practice Representative

Date

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone number_____
Name_____ Phone number_____

III. Please print the address of where you would like you billing statements and/or correspondence from our office to be sent if other than your home:

_____

_____

IV. Please indicate if you want all correspondence from our office to be sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:_____

VI. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

PATIENT NAME_____(guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE