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niseema@sbcglobal.net

Niseema Agarwal, L.Ac.
826 3rd Street, Encinitas, CA 92024
(760) 943-7500 niseema@sbcglobal.net

Mobile Device Users:
Use Adobe Reader App
to fill out this form.

COMPREHENSIVE ORIENTAL MEDICAL INTAKE FORM

Name:_____ **Birthdate:** _____ **Height:** _____ **Weight:**_____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

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

Email:_____ **Occupation:**_____ **Referred by:** _____

In Case of Emergency Contact: _____**Phone:** _____

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY: CLICK **1st box** of any of the following conditions which **YOU** have had in the past.
CLICK **2nd box** of any of the following conditions, anyone in **YOUR FAMILY** has had.

Cancer: ☐☐ **Diabetes:**☐☐ **Hepatitis:** ☐☐ **Heart Disease:** ☐☐ **Blood Clots:**☐☐ **Anemia:**☐☐

Stroke: ☐☐ **Obesity:** ☐☐ **Asthma:** ☐☐ **Tuberculosis:** ☐☐ **Blood Pressure:** High☐☐Low ☐☐

Herpes:☐☐ **HIV/AIDS:**☐☐ **Alcoholism:**☐☐**High Cholesterol:** ☐☐ **Suicide**:☐☐ **Thyroid:** High ☐☐Low☐☐

Autoimmune:_____ **Mental Illness:** _____ **Drug**/Other **Addiction:** _____

ARE YOU **PREGNANT** RIGHT NOW? _____ DO YOU HAVE A **PACEMAKER** OR **DEFIBRILLATOR**? _____

PLEASE LIST ANY SIGNIFICANT ITEMS IN THE FOLLOWING CATEGORIES:

MEDICATIONS: _____

_____

VITAMINS / HERBS / SUPPLEMENTS: _____

_____

ALLERGIES: _____

SURGERIES / HOSPITALIZATIONS : _____
(include year)

_____

ACCIDENTS (include year): _____

STRESSES (Mental, Emotional, Physical, etc.): _____

EXERCISE (Type and Frequency per week): _____

HABITS: PLEASE LIST TIMES PER WEEK YOU USE THE FOLLOWING SUBSTANCES:

Tobacco: _____ **Alcohol:** _____ **Sugars:**_____ **Recreational Drugs:** _____

Coffee: _____ **Tea:** _____ **Sodas:** _____ **Energy Drinks:** _____ Other:_____

List the areas of your body where you are experiencing pain:

Where?_____

When?_____

Radiates? To Where?_____

Tingling/Numbness?_____

Limited range of Motion_____

Pain is aggravated by what?_____

Herniated discs at which level?_____

Click the box next to the symptoms you experience frequently:

- ☐ Fever/Chills
- ☐ Sneezing/runny nose
- ☐ Cough
- ☐ Phlegm
  - ☐ Color_____
- ☐ Dry, sore throat
- ☐ Itchy, watery eyes

- ☐ Dry skin
- ☐ Asthma/Wheezing
- ☐ Nasal Congestion
- ☐ Post nasal drip
- ☐ Nose bleeding
- ☐ Loss of voice / hoarseness
- ☐ Frequent colds or flu

- ☐ Loss of smell/taste
- ☐ Hemorrhoids/Fissures
- ☐ Constipation
- ☐ Blood or mucous in stool
- ☐ Itchy/burning anus
- ☐ # Bowel movements/day

- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives/rashes
- ☐ Itchy skin
- ☐ Acne
- ☐ Excessive sadness or grief

- ☐ Low back pain/weakness
- ☐ Knee pain/weakness
- ☐ Ear ringing/Tinnitus
- ☐ Sex drive (High or Low)
- ☐ Night sweats
- ☐ Don't sweat easily

- ☐ Cold hands/feet
- ☐ Water retention/edema
- ☐ Nocturnal emission
- ☐ Premature ejaculation
- ☐ Impotence
- ☐ Prostatitis

- ☐ Urinary Problems:
  - ☐ burning
  - ☐ frequent urination
  - ☐ dribbling
  - ☐ bloody
- ☐ Night Urination #times:____

- ☐ Impaired hearing
- ☐ Hair Loss
- ☐ Poor memory
- ☐ Excessive fear

- ☐ Migraines
- ☐ Dizziness / Vertigo
- ☐ Rib area pain
- ☐ Spasms/twitching/tics
- ☐ Soft / Brittle nails

- ☐ Hernia
- ☐ Trouble digesting oily food
- ☐ Grinding teeth at night
- ☐ Bitter taste in the mouth
- ☐ Light-colored stool

- ☐ Dry eyes
- ☐ Red, sensitive eyes
- ☐ Impaired vision
  - ☐ explain_____
- ☐ Blurry vision

- ☐ Depression
- ☐ Easily angered or frustrated
- ☐ Indecisiveness
- ☐ Moodiness

- ☐ Insomnia
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Many dreams/nightmares

- ☐ Chest pain
- ☐ Palpitations (flutters)
- ☐ Irregular heart beat
- ☐ Shortness of breath

- ☐ Faint easily
- ☐ Mental restlessness or excitability
- ☐ Anxiety or nervousness

- ☐ Excessive sweating
- ☐ Mouth/Tongue ulcer
- ☐ Heat sensation in palms

- ☐ Fatigue/When?_____
- ☐ Excess/reduced appetite
- ☐ Abdominal pain
  - ☐ When_____
- ☐ Bloating
- ☐ Belching/Burping

- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Recent weight gain/loss
- ☐ Bleeding gums
- ☐ Bad breath

- ☐ Black/Tarry stools
- ☐ Loose stools or diarrhea
- ☐ Flatulence
- ☐ Bruise easily
- ☐ Difficulty to stop bleeding
- ☐ Excessive worrying

- ☐ Dry Mouth
- ☐ Excessive thirst
- ☐ Lack of thirst
- ☐ Prefer hot drinks
- ☐ Prefer cold drinks

Women Only:

Date of last menses:_____
Age menses started_____
Duration of flow_____
Frequency of menses_____
Number of pregnancies_____
Number of births_____

- ☐ PMS
- ☐ Menstrual cramping
- ☐ Irregular menses
- ☐ Excessive bleeding
- ☐ Clots in menses
- ☐ Spotting

- ☐ Breast swelling, tenderness, or lumps
- ☐ Abnormal vaginal discharge
  - Texture:____(watery) ____(thick)_____
  - Color:_____ Odor:_____
- ☐ Menopause since_____
- ☐ Hot flashes

Please type your name below to confirm all statements and information supplied by you are true to the best of your knowledge.

Patient Signature:_____**Date:**_____

INFORMED CONSENT FORM

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient named below for whom I am legally responsible) by Niseema Agarwal, L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Herbal medicine and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days. Bruising is a common side effect of cupping. Burns and/or scarring area potential risk of moxabustion and cupping. Rarely fainting or dizziness may occur. Unusual risks of acupuncture include nerve damage, organ puncture, including lung puncture, or spontaneous miscarriage.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally safe in the practice of Oriental Medicine, although some may be toxic in large dosages. I understand that some herbs may be inappropriate during pregnancy . Some possible side effects of consumption of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will report any adverse side effects to the acupuncturist immediately. I will notify the acupuncturist if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I understand that the results are not guaranteed.

I understand that the acupuncturist and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about risks and benefits of acupuncture, moxabustion, cupping and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PLEASE TYPE YOUR NAME BELOW TO CONFIRM THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS.

PATIENT SIGNATURE DATE:
(Or patient representative, indicate relationship if signing for patient)

_____ _____

24-HOUR CANCELLATION NOTICE REQUIRED

I understand that a 24 hour cancellation notice is required otherwise I will be charged the full amount of the fee for the missed appointment. (Note: Monday appointments need to cancel by Friday 5pm.)

PLEASE TYPE YOUR NAME BELOW TO CONFIRM THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS.

PATIENT SIGNATURE DATE:
(Or patient representative)

_____ _____

Remember to SAVE your data.
Send as an E-mail attachment
to: niseema@sbcglobal.net