



4910 Burnet Road Austin, TX 78756 • 512 363-2756 • truenatureclinic.com

Patient Intake Form

First Name: _____ Middle Initial: _____ Last Name: _____

Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address: _____ Please add me to your mailing list

Emergency Contact: _____ Phone Number: _____ Relationship to you: _____

Appointment Confirmations: We will contact you on the business day prior to your scheduled appointment with a reminder.

Please check your preferred location of contact: Home Phone Work Phone Mobile Phone Email

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

Gender: Female Male

Marital Status: _____ Number of Children: _____ Ages of Children: _____

Occupation: _____ Employer: _____

Physician's Name (and address if available) _____ Month/Year of your last doctor visit: _____

Have you ever received acupuncture before? Yes No

Who can we thank for the referral: A friend A physician Another healthcare practitioner

Their Name: _____

If you weren't referred, how did you find out about us?

Print advertisement (in _____) Brochure (where _____)

Online (search engine _____) Other _____

(continued)

Medical History

Reason for today's visit: _____

Please write a brief description of how this problem began:

How long has it lasted: _____ days weeks months years

Have you had this or a similar condition before? Yes No

Does anything make it better? _____

Does anything make it worse? _____

Have you received prior treatment for this condition? Yes No If yes, when? _____

Where? _____ By whom? _____ What was the diagnosis? _____

What type(s) of treatment were used? _____ Result of that treatment: _____

What medications and supplements are you currently taking?

Name:	Dose:	How Often:	Taking since:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any major surgeries, accidents, or injuries?

Date: Description:

Have you had any of the following illnesses?(check all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Spinal Injury/Problem |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Connective Tissue Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Neurological Disease |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Other | | | |

Do you have any food, drug, or environmental allergies? What are they? _____

Any other health related issue not mentioned above? _____

Family Medical History: (please indicate family member)

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Miscarriage _____ |
| <input type="checkbox"/> Other _____ | | |



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Patient Lifestyle

Name: _____

Your occupation: _____ Any physical strain at work? Yes No What kind? _____

How many hours do you work per week: _____ Stress levels: Low Medium High

Height: _____ Current Weight: _____

Do you exercise? Yes No _____ What kind? _____ How often? _____

Do you smoke? Yes No _____ How many per day? _____ When did you start? _____

Sleep

How much sleep do you typically get? _____ Do you feel rested in the morning? Yes No

Do you have a regular bedtime? Yes No When is it? _____

Do you have a regular wake up time? Yes No When is it? _____

Do dreams disturb your sleep? _____

Anything else we should know about your sleep? _____

Eating Habits

Meal	Do you eat this meal on most days?	Approximate time	A general list of the foods you tend to eat at this meal
Breakfast			
Lunch			
Dinner			

Snacking Habits

Approximate time	Types of food eaten

Foods

Food Type	How often?			
Sodas (regular and diet)	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Fried Foods (french fires, fried chicken etc.)	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Several cups of coffee in one day	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Donuts, ice cream, cookies, cakes	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Milk and cheese	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Meat products (chicken, lamb, beef and pork)	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Shellfish	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Freshwater and Ocean fish	<input type="checkbox"/> Daily	<input type="checkbox"/> Most days	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

Check all the symptoms you've had within the past three months

Office notes (leave blank)

Emotional

- I would generally describe myself as: Happy Easy going Restless Irritable
 Indecisive Angry Cry easily Hurried Depressed Stressed out Anxious
 Hard to express emotions Short attention span Other _____

Energy

- Fluxuates Low High Lower in the afternoon Normal Tired after meals
 Other _____

Body Temperature

- Hot where _____ Cold where _____ Night sweats Hot flashes Chilled
 Flushing Other _____

Digestion

- Indigestion Bloating Heartburn Nausea Vomiting Full feeling Belching Gas
 Abdominal pain or cramps Sensitivity to oily foods (upsets your stomach) Bitter taste in mouth
 Gallstones Other _____

Bowels

- Frequency: # _____ bowel movements _____ times per day week loose stools Diarrhea
 Constipation Hemorrhoids Constipation Colon Problems Pain or Cramps Using laxatives
 Other _____

Urination

- Frequency of urination: _____ times per day **Color:** Clear Light yellow Yellow Bright Yellow
 Dark **Symptoms:** Burning Bladder Infection Urgency Nighttime Incontinence
 Kidney Stones Kidney Infections Other _____

Thirst

- Never thirsty Always thirsty Thirsty but doesn't drink Drinks _____ (number of drinks) per day
 Temperature preference for drinks: Cold Warm/hot Room Temperature

Cardiovascular

- Diagnosed heart problems Palpitations Bleeds easily Low blood pressure High blood pressure
 High Cholesterol Heart Murmur Varicose Veins Ankle Swelling Chest Pain
 Bruising easily Hands swelling Irregular Heart Beat Other _____

Sleep

- Falling asleep:** Easy Average Difficult **Staying asleep:** Easy Average Difficult
Waking up: Easy Average Difficult **Sleep quality:** Restless Lots of dreams Easily
 Awakened Nightmares Hard time getting back to sleep

Headaches/dizziness

- Headaches Migraines Vertigo Dizziness Motion sickness Poor Balance
 Faints easily Poor memory Other _____

Skin

- Dry Hives Itching Oily Acne Rashes Bruise easily Eczema
 Slowly healing cuts Other _____

Hair

- Dry Oily Dandruff Falling out Early greying Other _____

Nails

- Soft Spots Ridges/lines Grow slowly Grow fast Purple Pale Break easily
 Other _____

Ears

- Poor hearing High pitched ringing Low pitched ringing Discharges Ear aches
 Other _____

Eyes

- Wear contacts or glasses Puffy eyelids Dryness Itching Twitches Poor night vision
 Light sensitivity Color Blindness Watery Normal Other _____

Nose

- Congestion Hay fever Frequent sneezing Bleeding Loss of smell
 Sinusitis Rhinitis Normal Other _____

Mouth and Throat

- Dry Gum Problems Frequent colds Tight jaw muscles Lump in the throat
 Thyroid problems Grinding teeth Norman Other _____

Respiratory

- Short breath Difficulty inhaling Frequent sighing Dry cough Cough with phlegm
 Asthma Bronchitis Emphysema Coughing up blood Tight chest
 Other _____



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Form to be Completed by Patient, Notifying the Acupuncturist of Whether She/He Has Been Evaluated by a Physician, and Other Information

(Pursuant to the requirements of '183.6(e) of this title (relating to Denial of Licensee; Discipline of Licensee) and Texas Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) _____ am notifying True Nature Acupuncture of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist. (check one) Yes No Initials of patient _____ Date _____

I have received a referral from my chiropractor within the last 30 days for acupuncture. (check one) Yes No Initials of patient _____ Date _____

After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

I am seeking acupuncture and Oriental Medicine for one of more of the following: (please circle)

chronic pain weight loss smoking addiction alcoholism substance abuse

Patient or Patient Representative (Print)

Signature

Date

Relation to patient (if not patient)



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Notice of Privacy Policy

I understand that I have the right to review the document “Notice of Privacy Policy” prior to signing this document. This notice has been provided to me in my intake packet.

The Notice of Privacy Policy (Notice) describes the types of uses and disclosures of my “protected health information (PHI)” that will occur in my treatment, payment of bills, or in the performance of healthcare operations of this clinic. My protected health information means health information including my demographic information (name, address, phone number, etc.) that is collected from me and created or received by this clinic or its agents or employees. PHI is information that relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization, and my rights regarding my PHI.

By signing this form, you consent to our use and disclosure of your PHI as specified in the Notice of Privacy Policy, and acknowledge receipt of the Notice.

PLEASE NOTE: Unless you are claiming insurance for your treatments here, your protected health information (PHI) will NEVER be discussed, verbally or in writing, with anyone but you or your spouse. We will only disclose information to others (i.e. family members, other physicians, etc...) once we have obtained your express written permission. If you wish to keep your information private from your spouse as well, please indicate below.

_____ I wish to keep my PHI (protected health information) private from my spouse.

Patient or Patient Representative (Print)

Signature

Date

Patient or Patient Representative (Print)

Signature

Date

Relation to patient (if not patient)