

New Patient Information Yume Takeuchi, M.S., L.Ac.

Patient Information

Patient's Name _____ Today's Date _____
Street Address _____ Apt. # _____
City _____ State _____ Zip _____
Home Phone (_____) _____ Office (_____) _____
Other Phone (_____) _____ Email _____
Birth Date _____ Age _____ Gender _____

single married divorced widowed domestic partnership other _____

Referred by _____

Emergency Contact _____ Relationship _____
Emergency Contact Phone # home (_____) _____ Office or Cell _____
Physician's Name _____ Phone _____
Date of last visit _____

Employment - Please check all that apply

full-time part-time self-employed student unemployed retired

Occupation _____ Number of hours of work/study per week _____

Employer's Name _____ Phone (_____) _____

Billing and Insurance

Note on Insurance

Payment in full is due at the time services are rendered. \$80 per visit. Upon request a Superbill will be provided. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance _____ Phone (_____) _____
Primary Insurance Address _____
Policy Holder's Name _____ Relationship _____
Policy # / ID # _____ Group # _____

Superbill requests No, thanks! Once a month At the end of each treatment

Missed Appointment Policy

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged \$80.

I understand cancellation policy.

Yume Takeuchi, M.S. L.Ac.

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Health History

Patient Name _____ Date _____

Have you had acupuncture treatment before? If so, for what reason? _____

Pain

l, r, b = left, right, or both sides

past current	past current	past current	past current
<input type="checkbox"/> _ <input type="checkbox"/> _ head	<input type="checkbox"/> _ <input type="checkbox"/> _ forearm l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ upper back	<input type="checkbox"/> _ <input type="checkbox"/> _ shin l r b
<input type="checkbox"/> _ <input type="checkbox"/> _ jaw	<input type="checkbox"/> _ <input type="checkbox"/> _ wrist l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ mid-back	<input type="checkbox"/> _ <input type="checkbox"/> _ ankle l r b
<input type="checkbox"/> _ <input type="checkbox"/> _ neck	<input type="checkbox"/> _ <input type="checkbox"/> _ hand l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ low back	<input type="checkbox"/> _ <input type="checkbox"/> _ foot l r b
<input type="checkbox"/> _ <input type="checkbox"/> _ throat	<input type="checkbox"/> _ <input type="checkbox"/> _ fingers l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ hip l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ heel l r b
<input type="checkbox"/> _ <input type="checkbox"/> _ shoulder l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ chest	<input type="checkbox"/> _ <input type="checkbox"/> _ thigh l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ toes l r b
<input type="checkbox"/> _ <input type="checkbox"/> _ upper arm l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ rib / flank	<input type="checkbox"/> _ <input type="checkbox"/> _ knee l r b	
<input type="checkbox"/> _ <input type="checkbox"/> _ elbow l r b	<input type="checkbox"/> _ <input type="checkbox"/> _ abdomen	<input type="checkbox"/> _ <input type="checkbox"/> _ calf l r b	

other current related symptoms _____

ST

past current

- _ _ nausea / vomiting
- _ _ belching
- _ _ heartburn
- _ _ bad breath
- _ _ bleeding gums
- _ _ ulcers
- _ _ excessive appetite
- _ _ change in appetite
- _ _ nose bleeds
- _ _ difficulty swallowing
- _ _ recurring sore throat
- _ _ laryngitis / hoarse voice

Sp

past current

- _ _ gas
- _ _ abdominal bloating
- _ _ abdominal pain
- _ _ decreased appetite
- _ _ indigestion
- _ _ low energy / fatigue
- _ _ crave sweets
- _ _ decreased sense of taste / smell
- _ _ sweet taste in mouth
- _ _ often feel pensive / thoughtful
- _ _ edema

past current

- _ _ diarrhea
- _ _ constipation
- _ _ blood in stools / black
- _ _ pus in stools
- _ _ hemorrhoids
- _ _ anal fissures
- _ _ rectal pain

other current related symptoms _____

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Lu

past current

- _ _ frequent colds
- _ _ sinus infection
- _ _ cough
- _ _ cough with blood
- _ _ production of phlegm
- _ _ hay fever or allergies

past current

- _ _ asthma
- _ _ bronchitis
- _ _ pneumonia
- _ _ COPD

past current

- _ _ often feel sad
- _ _ crave pungent foods
- _ _ dry skin
- _ _ itching
- _ _ acne
- _ _ rashes, hives, eczema or psoriasis

other current related symptoms _____

K

past current

- _ _ frequent urination
- _ _ urgency to urinate

- _ _ pain on urination
- _ _ urine/bowel incontinence
- _ _ weak urine stream

- _ _ blood in urine

- _ _ kidney stones
- _ _ low back pain

- _ _ sore / weak knees

- _ _ crave salty foods

- _ _ often feel afraid

past current

- _ _ frequent urinary tract infections
- _ _ frequent vaginal infections

- _ _ pelvic inflammatory disease
- _ _ abnormal PAP smear
- _ _ irregular periods

- _ _ premenstrual syndrome

- _ _ painful menstrual periods
- _ _ abnormal bleeding

- _ _ menopause symptoms

- _ _ breast lumps

past current

- _ _ impotence
- _ _ premature ejaculation

- _ _ testicular lumps
- _ _ prostatitis
- _ _ genital itching / pain
- _ _ genital lesions/ discharge
- _ _ decreased libido
- _ _ ear ringing – low pitch
- _ _ ear ringing – high pitch
- _ _ decreased hearing
- _ _ ear infections

Total Pregnancies _____ Living _____ Ectopic _____ Miscarriages _____

Induced Abortions _____

other current related symptoms _____

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Lv.

X

past current)

- _ _ dry eyes
- _ _ red eyes
- _ _ eye inflammation
- _ _ blurred vision
- _ _ poor night vision
- _ _ floaters (spots in the visual field)

past current

- _ _ insomnia
- _ _ excessive /vivid dreams
- _ _ grinding teeth
- _ _ depression
- _ _ anxiety / stress
- _ _ irritability

past current

- _ _ migraine
- _ _ dizziness
- _ _ fainting
- _ _ seizures
- _ _ localized weakness
- _ _ numbness or tingling of

- _ _ visual changes
- _ _ glasses / contact lenses
- _ _ cataracts
- _ _ crave sour foods

- _ _ treated for emotional /
- psychological problems
- _ _ indecisiveness
- _ _ often feel angry

- limbs
- _ _ tremors
- _ _ poor concentration
- _ _ paralysis
- _ _ aversion to wind
- _ _ tendinitis
- _ _ gallstones

other current related symptoms _____

Ht

past current

- _ _ high blood pressure
- _ _ low blood pressure
- _ _ palpitations
- _ _ irregular heart beat

past current

- _ _ chest pain or pressure
- _ _ jaw, neck, shoulder or arm pain
- _ _ nausea
- _ _ swollen hands or feet

past current

- _ _ blood clotting disorders
- _ _ phlebitis
- _ _ poor memory
- _ _ crave bitter foods

other current related symptoms _____

YM

past current

- _ _ fevers
- _ _ frequent or strong thirst
- _ _ tend to feel warmer than others
- _ _ night sweats
- _ _ sweat easily
- _ _ prefer cold food and drink

past current

- _ _ chills
- _ _ hands / feet
- _ _ tend to feel colder than others
- _ _ cold sweats
- _ _ prefer warm food and drink

past current

- _ _ headache
- _ _ neck stiffness
- _ _ concussion
- _ _ enlarged lymph

tumors or lumps _____

past current

- _ _ HIV
- _ _ TB
- _ _ chicken pox
- _ _ meningitis
- _ _ hepatitis

past current

- _ _ gonorrhea
- _ _ chlamydia
- _ _ syphilis
- _ _ genital warts
- _ _ herpes oral / genital

past current

- _ _ SARS
- _ _ west nile

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other past or current infectious diseases _____

recent tests and indicate results

cholesterol _____ blood pressure _____ mammography _____

prostate _____ blood work _____ STD Check _____

other tests and results _____

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

Major Hospitalizations – Please list any hospitalization or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State

Medicines, Herbs, Supplements – Please check any that you are currently taking

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> _ aspirin | <input type="checkbox"/> _ antacids | <input type="checkbox"/> _ blood thinners | <input type="checkbox"/> _ sleeping pills |
| <input type="checkbox"/> ibuprofen | <input type="checkbox"/> _ fiber / laxatives | <input type="checkbox"/> _ blood pressure pills | <input type="checkbox"/> _ tranquilizers |
| <input type="checkbox"/> _ acetaminophen (Tylenol) | <input type="checkbox"/> _ diet pills | <input type="checkbox"/> _ insulin | |
| <input type="checkbox"/> _ oral contraceptives | <input type="checkbox"/> _ allergy medication | <input type="checkbox"/> _ antidepressants | |

other, please list _____

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Western Drugs

Herbs

Vitamins and Supplements

Medication Allergies _____

Food Allergies _____

Habits – Please check any habits which apply to you now or in the past

Coffee	<input type="checkbox"/> _ yes <input type="checkbox"/> _ no	# per day _____	age started _____	age quit _____
Tobacco	<input type="checkbox"/> _ yes <input type="checkbox"/> _ no	# per day _____	age started _____	age quit _____
Marijuana	<input type="checkbox"/> _ yes <input type="checkbox"/> _ no	# per day _____	age started _____	age quit _____
Alcohol	<input type="checkbox"/> _ yes <input type="checkbox"/> _ no	# per day _____	age started _____	age quit _____
Crack/Cocaine	<input type="checkbox"/> _ yes <input type="checkbox"/> _ no	# per day _____	age started _____	age quit _____
Heroin	<input type="checkbox"/> _ yes <input type="checkbox"/> _ no	# per day _____	age started _____	age quit _____

Please describe any restricted diet you follow(ed) now or in the past _____

Please describe you typical daily diet

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack _____

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Please list your health concerns in order of importance –

Please describe any regular program of exercise -

Do you have a religious or spiritual practice? If so, please describe -

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.