

**LYNETTE HIRABAYASHI, M.S., F.A.B.O.R.M.
KENJI HIRABAYASHI, M.S.
LICENSED ACUPUNCTURISTS**

NEW PATIENT INTAKE FORM

Name: _____ Today's Date: _____

Address (full): _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Birth Date: _____ Age: _____ M F Referred by: _____

Occupation: _____ Email: _____

Physician's Name: _____ Physician's Phone: _____

Have you had acupuncture before? When and for what reason? _____

What is the reason for today's visit? _____

Have you been given a diagnosis for this condition? If so, what? _____

How long have you had this condition? _____

What seemed to be the initial cause? _____

Do you have other health concerns? _____

Please describe a typical meal:

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

What type of exercise, if any, do you do regularly? _____

Coffee Y N Tobacco Y N

FAMILY HISTORY - only check the conditions that are affirmative.

	Allergies Asthma	Heart Disease	High Blood Pressure	Stroke/ Seizures	Cancer or Tumors	Diabetes	Blood Disorder	Mental Health Issues
Self								
Mother								
Father								
Sibling								
Child								

MAJOR HOSPITALIZATIONS - Please write serious illnesses and operations.

Year	Illness or Operation

MEDICATIONS: Please list those that you are presently taking.

- Blood thinners, High blood press., Cholesterol, Asthma, Diabetes, Sleep Aids,
 Psychological, Pain/anti-inflam., Acid Reflux, Allergies, Other _____
Vitamins/ Herbs _____
Food or Drug Allergies _____

MEDICAL HISTORY: Check whether condition is past and/or current.

General

past current

- Fatigue
 Insomnia
 Night sweats
 Strong thirst
 Poor coordination
 Poor appetite
 Excess appetite

Skin and Hair

- Eczema
 Psoriasis
 Acne
 Rashes
 Dry
 Other _____

Nose, Throat, and Mouth

- Nose bleeds
 Sinus infection
 Hay fever
 Recurring sore throat
 Grinding teeth
 Difficult swallowing
 Mouth sores
 TMJ
 Dry mouth
 Other _____

Eyes

- Blurred vision
 Dry eyes
 Visual changes
 Spots
 Cataracts
 Glasses/Contacts
 Eye inflammation
 Glaucoma
 Poor night vision
 Other _____

Ears

- Infections
 Congested
 Ringing
 Decreased hearing
 Other _____

Head and Neck

past current

- Headaches/migraines
 Dizziness
 Fainting
 Neck stiffness
 Concussion
 Other _____

Cardiovascular

- High blood press.
 Low blood press.
 Blood clots
 Racing heart beat
 Irregular heart beat
 Fainting
 Chest pain
 Cold hands/feet
 Swelling hands/feet
 Other _____

Respiratory

- Asthma
 Bronchitis
 Frequent colds
 COPD
 Pneumonia
 Shortness of breath
 Cough
 Coughing blood
 Other _____

Genito-urinary

- Pain on urination
 Frequent urination
 Unable to hold urine
 Urgency to urinate
 Blood in urine
 Wake to urinate
 Kidney Stones
 Other _____

Men's Issues

- Impotence
 Swollen/ Painful testes
 Enlarged prostate
 Low libido
 Other _____

Gastrointestinal

past current

- Nausea
 Vomiting
 Excess gas
 Indigestion
 Cramping
 Acid reflux
 Diarrhea
 Constipation
 Hemorrhoids
 Laxative use
 Black stools
 Bloody stools
 Rectal pain/itching
 Other _____

Neurological

- Seizures
 Numbness or tingling
 Paralysis
 Other _____

Psychological

- Depression
 Anxiety
 Easily stressed
 Irritability
 Seeing a therapist
 Other _____

Pain

- Neck
 Shoulder
 Elbow
 Wrist/Hand
 Back/Low back
 Hip
 Knee
 Ankle/foot
 Other _____

WOMEN'S GYNECOLOGICAL INFORMATION

General

past current

- Frequent UTI
- Frequent vaginal infection
- Excess vaginal discharge
- Breast Lumps
- Abnormal PAP smear

Age at Menopause _____

Difficulties with menses prior to menopause? Y N

Number of children _____

Number. of pregnancies _____

Present menstruation information

What date was the first day of your last period? _____

Is your menstrual cycle interval regular? Y N

Avg. number of days of flow _____

Avg. number of days of entire cycle _____

Do you experience any of the following **pre-menstrual symptoms**?

past current

- Nausea/ Vomiting
- Breast swelling/ tender
- Headaches/ Migraines
- Water retention
- Food cravings

past current

- Cramping
- Depression/ Anxiety
- Irritability
- Acne breakouts
- Other _____

Uterine bleeding or spotting between periods? Y N

How much and how often? _____

Do you practice birth control? Y N

What type and for how long? _____

Are you or is there a chance that you are pregnant now? Y N

During your menses, do you experience any of the following symptoms?

past current

- Clotting
- Heavy flow
- Scanty flow
- Nausea/ Vomiting
- Headaches/ Migraines

past current

- Pain/ Cramping
- Fatigue
- Pale/ Dark color blood
- Other _____

Informed Consent to Treatment

I, _____ consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Lynette Hirabayashi, L.Ac. / Kenji Hirabayashi, L.Ac. I understand that methods of treatment may include but are not limited to acupuncture, cupping, electrical stimulation, massage, Chinese medicinals, craniosacral therapy and nutritional counseling. I have discussed the nature and purpose of my treatment with the practitioner.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. I understand that while this document describes the major risks of treatment, other side effects and risk may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify the practitioner who is caring for me if I am or become pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment based upon the facts then known as in my best interest.

I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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.

Signature of Patient

Date

Cancellation Policy

I am aware that the practitioner's time is valuable and by making an appointment, I will be reserving that time. I will be sure to give a **minimum of 24 hours notice** if I am unable to make my appointment. If I do not provide adequate notice, this will adversely affect the practitioner and other patients wishing to make an appointment. Failure to provide proper notice will, therefore, result in a charge for the full cost of the missed appointment.

Signature of Patient

Date