

Julie Sutton, L.Ac.
 89 West Lee Street
 Hagerstown, MD 21740
 Phone 301-797-3737 Fax 301-302-7802

PATIENT INTAKE FORM

DATE: _____

NAME: _____
Last First Middle

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

PREFERRED CONTACT PHONE #: _____ SECONDARY PHONE #: _____

DATE OF BIRTH: _____ AGE: _____ GENDER (Please circle): M / F

IN CASE OF EMERGENCY CONTACT NAME: _____ PHONE: _____

YOUR OCCUPATION: _____ EMPLOYER: _____ PHONE: _____

MARITAL STATUS: M S W D NAME OF SPOUSE: _____ NUMBER OF CHILDREN: _____

NAME OF PARENT/GUARDIAN (if patient is a minor): _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

REASON(S) FOR TODAY'S VISIT: _____

YES, I HAVE BEEN TREATED BY ACUPUNCTURE BEFORE. DATE OF LAST TREATMENT _____

YES, I AM CURRENTLY UNDER A PHYSICIAN'S CARE FOR: _____

NAME OF PHYSICIAN: _____ PHONE: _____

YES, I AM CURRENTLY TAKING PRESCRIPTION DRUGS. PLEASE LIST BELOW:

DRUG NAME & DOSAGE	FOR WHAT PURPOSE/CONDITION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Julie Sutton, L.Ac.
 89 West Lee Street
 Hagerstown, MD 21740
 Phone 301-797-3737 Fax 301-302-7802

YES, I AM CURRENTLY TAKING SUPPLEMENTS AND/OR VITAMINS. PLEASE LIST BELOW:

SUPPLEMENT/VITAMIN NAME & AMOUNT	FOR WHAT PURPOSE/CONDITION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

YES, I HAVE AN INFECTIOUS DISEASE. PLEASE DESCRIBE: _____

YES, I HAVE ALLERGIES. PLEASE INDICATE BELOW:

- FOODS: _____
- MEDICATIONS: _____
- BITES / STINGS: _____
- SEASONAL: _____
- ANIMALS: _____
- OTHER: _____

FAMILY MEDICAL HISTORY: (Please check if any of the following applies to any blood relatives)

- | | | | |
|-------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> CANCER | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> DIABETES, TYPE I OR II | <input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> OTHER: _____ |

DESCRIBE THE FOLLOWING FAMILY MEMBER'S HEALTH:

MOTHER:		LIVING		DECEASED		UNKNOWN
FATHER:		LIVING		DECEASED		UNKNOWN
SIBLINGS:		LIVING		DECEASED		UNKNOWN
GRANPARENTS:		LIVING		DECEASED		UNKNOWN

Julie Sutton, L.Ac.
89 West Lee Street
Hagerstown, MD 21740
Phone 301-797-3737 Fax 301-302-7802

PERSONAL HEALTH HISTORY: (Please check if any of the following apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> CHILDHOOD ILLNESSES | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> DIABETES, TYPE I OR II | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ARTERIOSCLEROSIS | <input type="checkbox"/> ENDOCRINE DISORDER | <input type="checkbox"/> MULTIPLE SCLEROSIS |
| <input type="checkbox"/> BIRTH TRAUMA (YOURS) | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> CHILDHOOD FEVERS | <input type="checkbox"/> GOUT | |
- MAJOR SURGERIES (Please list all with approximate dates): _____
- _____
- SIGNIFICANT TRAUMA (auto accidents, falls, etc. Please list with approximate date of injury): _____
- _____

CURRENT SYMPTOMS: (Please check if any of the following apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> GOUT | <input type="checkbox"/> WEIGHT GAIN |
| <input type="checkbox"/> VISION PROBLEMS | <input type="checkbox"/> URINATION DIFFICULTIES | <input type="checkbox"/> CONSTIPATION / DIARRHEA |
| <input type="checkbox"/> JAW / TEETH PAIN | <input type="checkbox"/> INFERTILITY | <input type="checkbox"/> SKIN DISORDERS |
| <input type="checkbox"/> EAR PAIN | <input type="checkbox"/> IMPOTENCE | <input type="checkbox"/> PMS |
| <input type="checkbox"/> SINUS PAIN / PROBLEMS | <input type="checkbox"/> MUSCULAR PAIN | <input type="checkbox"/> MENSTRUAL DISORDERS |
| <input type="checkbox"/> THROAT PAIN / PROBLEMS | <input type="checkbox"/> JOINT DYSFUNCTION / PAIN | <input type="checkbox"/> MENOPAUSAL PROBLEMS |
| <input type="checkbox"/> BREATHING DIFFICULTIES | <input type="checkbox"/> HIGH / LOW BLOOD PRESSURE | <input type="checkbox"/> EXCESS THIRST |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LACK OF THIRST |
| <input type="checkbox"/> CHILLS | <input type="checkbox"/> OVERLY EMOTIONAL | <input type="checkbox"/> SPONTANEOUS SWEATING |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> NIGHT SWEATING |
| <input type="checkbox"/> INDIGESTION | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> LACK OF SWEATING |
| <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> DIZZINESS | |
| <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> WEIGHT LOSS | |
- OTHER: _____

Julie Sutton, L.Ac.
89 West Lee Street
Hagerstown, MD 21740
Phone 301-797-3737 Fax 301-302-7802

LIFE STYLE: (Please check if any of the following apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> LIVE ALONE | <input type="checkbox"/> ENJOY YOUR SOCIAL LIFE | <input type="checkbox"/> STUDENT PART TIME |
| <input type="checkbox"/> LIVE WITH | <input type="checkbox"/> WORK 1 ST SHIFT | <input type="checkbox"/> HAVE FAMILY SUPPORT |
| <input type="checkbox"/> SPOUSE / SIGNIFICANT OTHER | <input type="checkbox"/> WORK 2 ND SHIFT | <input type="checkbox"/> HAVE FINANCIAL SUPPORT |
| <input type="checkbox"/> LIVE WITH ROOMMATE(S) | <input type="checkbox"/> WORK 3 RD SHIFT | <input type="checkbox"/> ENJOY HOBBIES |
| <input type="checkbox"/> LIVE WITH PARENTS | <input type="checkbox"/> WORK INCONSISTENT HOURS | <input type="checkbox"/> RELIGIOUS |
| <input type="checkbox"/> LIVE WITH CHILDREN | <input type="checkbox"/> MANAGE OWN BUSINESS | <input type="checkbox"/> SPIRITUAL CONNECTION |
| <input type="checkbox"/> ENJOY YOUR WORK | <input type="checkbox"/> UNEMPLOYED | |
| <input type="checkbox"/> ENJOY YOUR HOME | <input type="checkbox"/> STUDENT FULL TIME | |

DIET AND PERSONAL HABITS: (Please check if any of the following apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> USE TOBACCO | <input type="checkbox"/> EXERCISE REGULARLY | <input type="checkbox"/> CONSUME A LOT OF SWEETS |
| <input type="checkbox"/> FORMER TOBACCO USER | <input type="checkbox"/> VEGETARIAN / VEGAN | <input type="checkbox"/> CONSUME A LOT OF DAIRY |
| <input type="checkbox"/> DRINK ALCOHOL | <input type="checkbox"/> HEALTHY DIET | <input type="checkbox"/> CONSUME A LOT OF RED MEAT |
| <input type="checkbox"/> USE OF RECREATIONAL DRUGS | <input type="checkbox"/> CONSUME A LOT OF FRIED FOOD | |

Please check if you experience any of the following on a regular basis:

HEAD, EYES, EARS, NOSE, THROAT:

- | | | |
|---|--|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SPOTS IN VISION | <input type="checkbox"/> SORE THROAT |
| <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> SWOLLEN GLANDS |
| <input type="checkbox"/> CONCUSSIONS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> LUMP IN THROAT |
| <input type="checkbox"/> HEAVINESS OF HEAD | <input type="checkbox"/> CATARACTS | <input type="checkbox"/> ENLARGED THYROID |
| <input type="checkbox"/> FACIAL PAIN | <input type="checkbox"/> EAR RINGING | <input type="checkbox"/> TEETH REMOVED |
| <input type="checkbox"/> FACIAL NUMBNESS | <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> NUMEROUS CAVITIES |
| <input type="checkbox"/> GLASSES / CONTACTS | <input type="checkbox"/> EARACHES | <input type="checkbox"/> TEETH GRINDING |
| <input type="checkbox"/> NIGHT BLINDNESS | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> EYE STRAIN | <input type="checkbox"/> NOSEBLEEDS | <input type="checkbox"/> GUM PROBLEMS |
| <input type="checkbox"/> EYE PAIN | <input type="checkbox"/> SINUS PROBLEM | <input type="checkbox"/> LIP SORES |
| <input type="checkbox"/> RED EYES | <input type="checkbox"/> SINUS DRAINAGE | <input type="checkbox"/> MOUTH SORES |
| <input type="checkbox"/> ITCHY EYES | <input type="checkbox"/> THROAT DRAINAGE | <input type="checkbox"/> EXCESSIVE SALIVA |
| <input type="checkbox"/> SPOTS IN EYES | <input type="checkbox"/> THROAT TICKLE | |

RESPIRATORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> DIFFICULTY BREATHING | <input type="checkbox"/> WHEEZING | <input type="checkbox"/> PLEURISY |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> PHLEGM / CONGESTION |
| <input type="checkbox"/> TIGHT CHEST | <input type="checkbox"/> CHRONIC COUGH | <input type="checkbox"/> RATTLING SOUND WITH BREATH |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ACUTE COUGH | <input type="checkbox"/> CAN'T SLEEP LYING DOWN |

CARDIOVASCULAR:

- | | | |
|---|---|---|
| <input type="checkbox"/> HYPERTENSION (HIGH BLOOD PRESSURE) | <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> HYPOTENSION (LOW BLOOD PRESSURE) | <input type="checkbox"/> SLOW HEART RATE | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> RAPID HEART RATE | <input type="checkbox"/> EDEMA (SWELLING) |
| | <input type="checkbox"/> IRREGULAR HEART RATE | |

Julie Sutton, L.Ac.
89 West Lee Street
Hagerstown, MD 21740
Phone 301-797-3737 Fax 301-302-7802

GASTROINTESTINAL:

- | | | |
|--|--|--|
| <input type="checkbox"/> NAUSEA | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> BLOOD IN STOOL |
| <input type="checkbox"/> VOMITING | <input type="checkbox"/> RECTAL PAIN / ITCHING | <input type="checkbox"/> INTESTINAL PAIN |
| <input type="checkbox"/> VOMITING BLOOD | <input type="checkbox"/> FISSURES | <input type="checkbox"/> POOR APPETITE |
| <input type="checkbox"/> ACID REGURGITATION / REFLUX | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> BLOATING |
| <input type="checkbox"/> GAS / FLATULENCE | <input type="checkbox"/> CONSTIPATION | |

URINARY:

- | | | |
|--|---|---|
| <input type="checkbox"/> PAIN WITH URINATION | <input type="checkbox"/> INCOMPLETE URINATION | <input type="checkbox"/> BLOOD IN URINE |
| <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> BED WETTING | <input type="checkbox"/> KIDNEY STONES |
| <input type="checkbox"/> URGENT URINATION | <input type="checkbox"/> FREQUENT UTI'S | |

MUSCULO-SKELETAL:

- | | | |
|--|--|---|
| <input type="checkbox"/> MUSCLE WEAKNESS | <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> GENERAL ACHES |
| <input type="checkbox"/> MUSCLE CRAMPS | <input type="checkbox"/> JOINT INSTABILITY | <input type="checkbox"/> CHRONIC PAIN (LONG-TERM) |
| <input type="checkbox"/> MUSCLE SPASMS | <input type="checkbox"/> LIMITED RANGE OF MOTION | <input type="checkbox"/> ACUTE PAIN (SHORT-TERM) |
| <input type="checkbox"/> MUSCLE ATROPHY | <input type="checkbox"/> ARTHRITIS | |

NEUROLOGICAL:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> FAINTING / SYNCOPE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> VERTIGO |
| <input type="checkbox"/> DROWSINESS | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> POOR MEMORY |
| <input type="checkbox"/> TREMOR | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> PARALYSIS |
| <input type="checkbox"/> STROKE / CVA / TIA | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> NUMBNESS |

NEUROPHYSIOLOGICAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> EASILY FRUSTRATED | <input type="checkbox"/> FRIGHTENED EASILY |
| <input type="checkbox"/> IRRITABLE | <input type="checkbox"/> WORRY EASILY - ANXIETY | <input type="checkbox"/> POOR MEMORY |
| <input type="checkbox"/> EASILY STRESSED | <input type="checkbox"/> UNRESOLVED GRIEF | |

SKIN AND HEAR:

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> RASHES / HIVES | <input type="checkbox"/> PSORIASIS | <input type="checkbox"/> HAIR LOSS |
| <input type="checkbox"/> ULCERATIONS | <input type="checkbox"/> ACNE | <input type="checkbox"/> THIN, SLOW GROWING NAILS |
| <input type="checkbox"/> ECZEMA | <input type="checkbox"/> ITCHING | <input type="checkbox"/> SKIN CHANGES |
| <input type="checkbox"/> FUNGAL INFECTION | <input type="checkbox"/> DANDRUFF | |

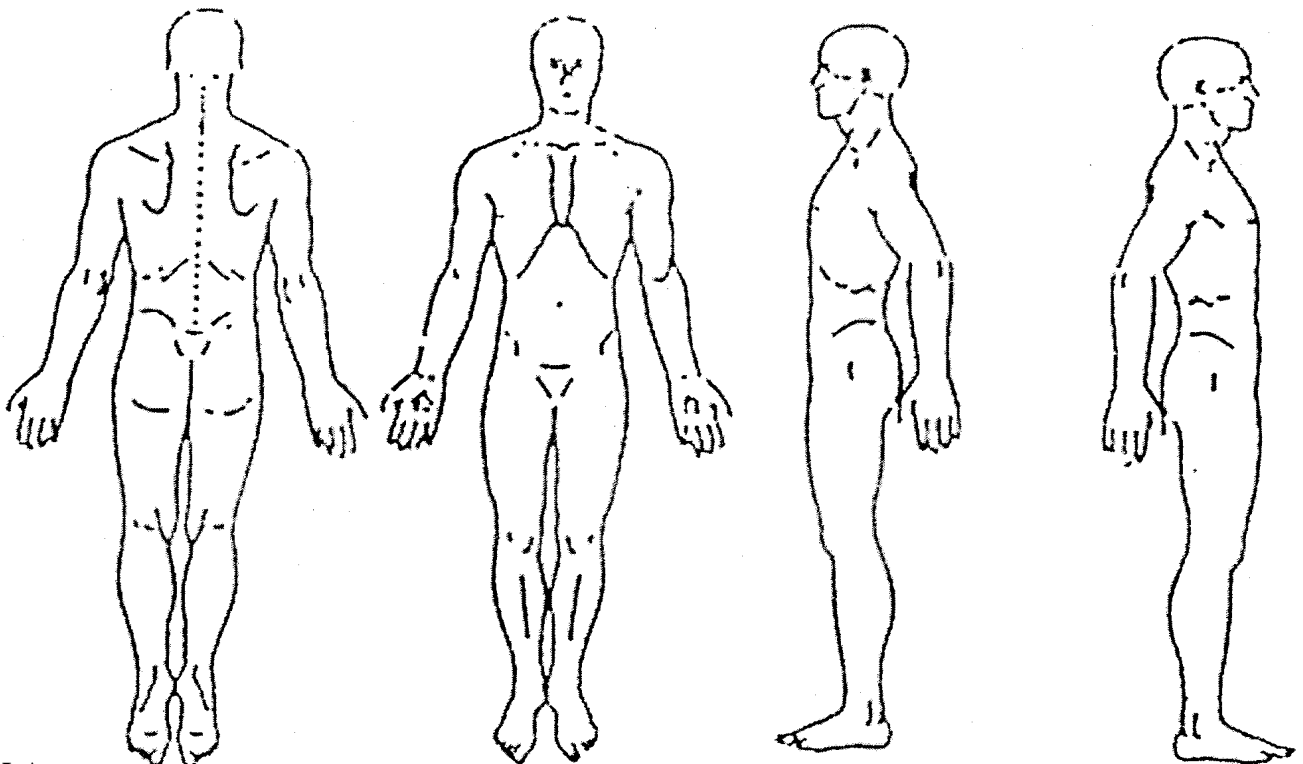
VITALITY AND IMMUNITY SYSTEM:

- | | | |
|--|---|--|
| <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> LOW ENERGY | <input type="checkbox"/> TENDER / ACHY ALL OVER |
| <input type="checkbox"/> FREQUENT FLU | <input type="checkbox"/> LETHARGIC | <input type="checkbox"/> CHRONIC MENTAL CLOUDINESS |
| <input type="checkbox"/> MENTAL CLOUDINESS | <input type="checkbox"/> SLOW WOUND HEALING | <input type="checkbox"/> INABILITY TO ADAPT |

GYNEOLOGICAL:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> PREGNANT | <input type="checkbox"/> NURSING | <input type="checkbox"/> HEAVY MENSES |
| <input type="checkbox"/> COULD BE PREGNANT | <input type="checkbox"/> MENOPAUSAL | <input type="checkbox"/> PAIN WITH MENSTRUATION |

**** Please **MARK** any areas of pain on the diagram located on this form ****



CONSENT FOR TREATMENT: I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF ACUPUNCTURE TREATMENTS AND OTHER COMPLEMENTARY MEDICINE PROCEDURES INCLUDING VARIOUS MODES OF PHYSIO-THERAPY ON ME (OR ON THE PATIENT NAMED BELOW, FOR WHOM I AM LEGALLY RESPONSIBLE) BY JULIE SUTTON, L.Ac.

I UNDERSTAND THAT METHODS OF TREATMENT MAY INCLUDE, BUT ARE NOT LIMITED TO ACUPUNCTURE, MOXIBUSTION, CUPPING, CHINESE OR WESTERN HERBAL MEDICINE, SUPPLEMENT RECOMMENDATIONS, AND NUTRITIONAL COUNSELING.

ACUPUNCTURE IS A SAFE TREATMENT INVOLVING THE INSERTION OF TINY, STERILE NEEDLES THROUGH THE SKIN, TO ATTEMPT TO NORMALIZE PHYSIOLOGICAL FUNCTIONS, MODIFY THE PERCEPTION OF PAIN, AND TREAT CERTAIN DISEASES OR DYSFUNCTIONS OF THE BODY. ACUPUNCTURE CAN OCCASIONALLY CAUSE SLIGHT BLEEDING, BRUISING OR TINGLING NEER THE NEEDLING SITES THAT MAY LAST A FEW DAYS. I WILL REPORT TO THE ACUPUNCTURIST ANY DIZZINESS OR LIGHT-HEADEDNESS THAT OCCURS DURING OR AFTER AN ACUPUNCTURE TREATMENT.

MOXIBUSTION CONSISTS OF BURNING AN HERB FROM THE MUGWORT PLANT CALLED MOXA. YOUR ACUPUNCTURIST WILL BURN THIS HERB DIRECTLY ON THE SKIN ON CERTAIN ACUPUNCTURE POINTS, ON TOP OF A NEEDLE OR HOOVERING JUST ABOVE THE SKIN. THERE ARE MINIMAL TO NO RISKS IN THIS TECHNIQUE. SHOULD A MILD BURN OCCUR, EXPECT FOR ALL TO BE RESOLVED IN 3-5 DAYS.

CUPPING INVOLVES A LOCALIZED SUCTION PRODUCED BY A SMALL PLASTIC OR GLASS CUP. THERE IS A POSSIBILITY OF LOCAL BRUISING FROM THE SUCTION WHICH USUALLY RESOLVES WITHIN 3-7 DAYS.

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. I UNDERSTAND THAT SOME HERBS MAY BE INAPPROPRIATE DURING PREGNANCY. IF I EXPERIENCE ANY GASTROINTESTINAL UPSET OR ALLERGIC REACTIONS TO THE HERBS, I WILL INFORM THE ACUPUNCTURIST.

FINANCIAL RESPONSIBILITY: THE UNDERSIGNED AGREES THAT IN CONSIDERATION FOR THE SERVICES TO BE RENDERED TO THE PATIENT, HE/SHE HEREBY INDIVIDUALLY OBLIGATES HIMSELF/HERSELF TO PAY THE ACCOUNT OF JULIE SUTTON, L.Ac. IN ACCORDANCE WITH THE REGULAR RATES AND TERMS.

RELEASE OF INFORMATION: THE UNDERSIGNED DOES HEREBY AUTHORIZE JULIE SUTTON, L.Ac. TO RELEASE ANY AND ALL INFORMATION REGARDING THE PATIENT'S MEDICAL HISTORY AND TREATMENT ADMINISTERED DURING OUTPATIENT TREATMENT, TO ANY PHYSICIAN OR HOSPITAL OR TO ANY INSURANCE COMPANY, EMPLOYER, LEGAL COUNSEL OR OTHER ORGANIZATION RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS MEDICAL EXPENSES. THE UNDERSIGNED CONSENTS TO ALLOW MESSAGES TO BE LEFT ON THE PERSONAL PHONE NUMBERS PROVIDED BY THE PATIENT ON THE INTAKE FORM REGARDING FUTURE APPOINTMENTS.

ASSIGNMENT OF INSURANCE BENEFITS: THE UNDERSIGNED AUTHORIZES, WHERE HE/SHE AS AGENT OR AS PATIENT, DIRECT PAYMENT TO JULIE SUTTON, L.Ac. OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO OR ON BEHALF OF THE UNDERSIGNED FOR ACUPUNCTURE SERVICES. IT IS THE UNDERSIGNED'S RESPONSIBILITY TO SUPPLY THE OFFICE WITH A REFERRAL IF REQUIRED BY HIS/HER INSURANCE AND IF NOT SUPPLIED THE UNDERSIGNED WILL BE RESPONSIBLE FOR PAYMENT. IT IS UNDERSTOOD BY THE UNDERSIGNED THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: THE UNDERSIGNED HAS REVIEWED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND A COPY WAS PROVIDED TO ME, IF REQUESTED.

BY SIGNING THIS FORM, I ADMIT THAT THE CONTENTS OF THIS FORM HAVE BEEN FULLY EXPLAINED TO ME AND I DO UNDERSTAND THE CONTENTS OF THIS FORM.

SIGNATURE (PATIENT, PARENT, or GUARDIAN) **X** _____ DATE _____

Relationship (circle one): Self Parent Guardian

PRINT PATIENT NAME _____ DATE OF BIRTH _____