Carol Kremer Acupuncture, LLC
New Patient Medical Health Intake Form

Today's Date _____

1. Name_____
   Nickname (if applicable) _____
2. Address_____
   City, State_____
   Zip _____
3. Email _____
4. Phone _____
   Type (circle one): Mobile Home Work
   May we leave a message? (circle one) Yes No

5. Birthdate (MM/DD/YY) _____
6. Gender (circle one): Male, Female, Transgender
7. Marital Status (circle one): Single, Married, Widow, Other
8. Employment Status (circle one)
   Employed, Student, Retired, Other

9. Emegency Contact
   Name _____
   Relationship _____
   Phone _____

10. Caregiver/Legal Guardian Details (If applicable)
   Name _____
   Relationship to Patient: _____
   Address same as above? Yes No
   Phone _____
   Email _____

11. How did you hear about Carol Kremer, L.Ac.?
   Internet, Friend, Co-worker, Doctor, Chiropractor,
   Other: _____
   _____
   _____

12. Name and address of referring medical provider (if applicable)
   _____
   _____

13. Cardiac Pacemaker or other electronic implanted device? Yes No
14. Epilepsy or seizure disorder? Yes No
15. What was your last blood pressure reading and when was it last taken (month/year)?
   BP_____/_____ Date:_____
16. Women only: Currently pregnant? Yes No
17. Travel outside the U.S. in the past year? Yes No
   If yes, where?_____
18. Any major contagious diseases at this time? Yes No
   If yes, describe:_____
19. Tobacco use (circle one)? Yes No
20. Surgeries, major procedures, major illnesses, and/or hospitalizations and dates (use other side if you run out of room)
   _____
   _____
   _____
   _____
   _____
   _____
21. Please list all medication(s) and reason for taking:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
22. Allergies /Sensitivities (food, drugs, or environmental) Latex, Fragrance, Seasonal, Other (please list):
   _____
   _____
23. Major diseases that run in your family:
   _____
   _____

1. Describe your main health concern that is the reason for today's visit:

_____

2. How does this affect your life? _____

3. When did your symptoms start? _____

4. What makes it better (e.g. heat, cold, activity)?_____

5. What makes it worse?_____

6. What other therapies have you tried for this this condition? _____

7. Please check all that apply:

- ☐ Headaches
- ☐ Sinus/allergies
- ☐ Asthma
- ☐ Acid reflux or GERD
- ☐ Gas, bloating, nausea
- ☐ Constipation
- ☐ Loose Stools
- ☐ Urinary issues
- ☐ Weight gain or loss
- ☐ Palpitations
- ☐ Chest pain
- ☐ Insomnia
- ☐ Neuropathy
- ☐ Dizziness
- ☐ Hot flash/night sweats
- ☐ Tend to be hot
- ☐ Tend to be cold
- ☐ Circle any that apply: fatigue, stress, anxiety, depression, frustration, anger, fear, worry, over-thinking

Women only:
- Date of last period: _____
- Circle all that apply: PMS, Fibroids, Ovarian Cysts, Endometriosis, Irregular Cycle
  Other_____

8. Any other issues we should be aware of?_____

_____

PAIN LEVEL SCALE: 1= very little pain, 10 = worst pain

1. Pain level ***right now*** on a scale of 1 to 10? _____

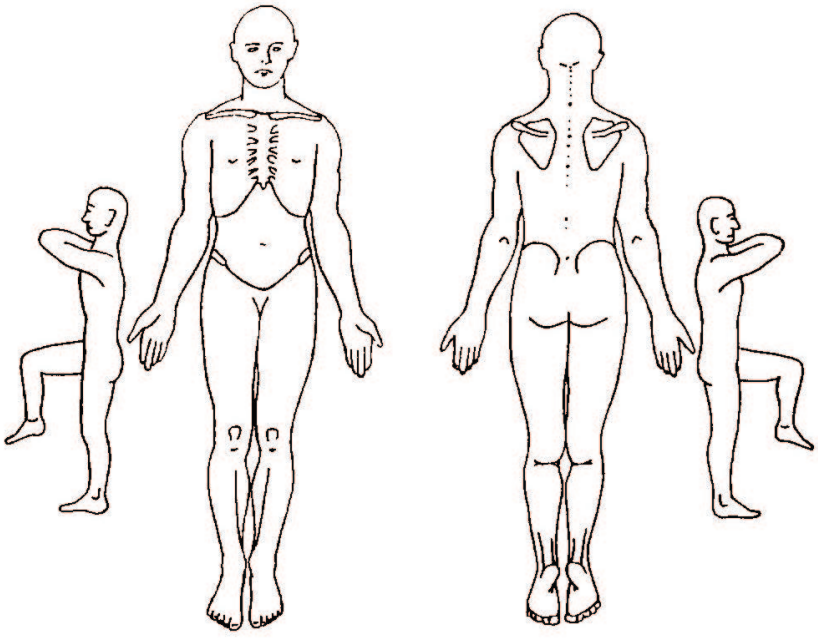
2. ***Average*** pain level on a scale of 1 to 10?_____

3. History of accident(s) or injury? Yes No

4. ***Circle*** areas of pain on the diagram

5. ***Type*** of pain (circle all that apply):
   Stabbing
   Burning
   Throbbing
   Shooting
   Prickling
   Tingling
   Dull
   Aching
   Heavy

6. ***When*** do you have pain?
   Constant
   Intermittent (better at times)
   Daily
   Weekly
   Monthly
   Rarely



CONSENT TO TREATMENT and POTENTIAL SIDE EFFECTS

1. General

- By initialing and signing below I voluntarily consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Carol Kremer, a nationally certfied and Ohio licensed acupuncturist.
- I understand that no guarantees concerning the use and effects of acupuncture and other treatment modalities offered in this clinic are given.
- I understand I am free to refuse or stop treatment at anytime.
- I understand I am encouraged ask questions at any time regarding treatment.

2. Acupuncture Scope of Practice

- I understand that licensed acupuncturists in Ohio are ***not*** primary care providers.
- I understand that other treatment modalities, which are outside of the scope of practice for this acupuncturist, may be better suited to the condition for which I am seeking treatment.

3. Diagnostic Exam Recommendation - Ohio Law

This acupuncturist recommends that you receive a diagnostic exam from a physician or chiropractor regarding the condition for which you are seeking treatment. (Choose one)

☐ ***I have*** received a diagnostic exam by a physician or chiropractor within the last six (6) months regarding the condition for which I am seeking treatment

☐ ***I have NOT*** received a diagnostic exam by a physician or chiropractor within the last six (6) months regarding the condition for which I am seeking treatment

4. Potential Side Effects

Below is a brief description of modalities that may or may not be utilized by this acupuncturist depending on the patient's condition and treatment plan. I understand that **the list of side effects may include, but is not limited to, those listed below.**

4.1 Acupuncture

I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. ***Potential Side Effects: local bruising, minor bleeding, fainting or dizziness, pain or discomfort, numbness or tingling near the needling sides that may last a few days, possible aggravation of symptoms existing prior to acupuncture treatment. Unusual risks: spontaneous miscarriage, nerve damage, or organ puncture. Another possible side effect is infection although the clinic uses sterile disposable needles and maintains a clean and safe environment.***

4.2 Heat Therapy (TDP Lamp)

I understand that heat may be applied either alone or in combination with acupuncture at certain points on or near the surface of the body. ***Potential Side Effects: local burning or scarring.***

4.3 Electrical Stimulation

I understand that electro-stimulation may be applied either alone or in combination with acupuncture at certain points on or near the surface of the body. ***Potential Side Effects: electrical shock, pain or discomfort, possible aggravation of symptoms existing prior to treatment.***

4.4 Acupressure, Tuina

I understand that I may be given acupressure (aka tuin-na or guasha) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***Potential Side Effects: bruising, sore muscles or aches, possible aggravation of symptoms existing prior to treatment.***

I understand I may be given lifestyle education according to traditional Chinese Medicine principles; which may include information about nutritional principles, breath awareness, and movement. I have carefully read (or have had read to me) the Consent to Treatment form. I understand all of the above information including potential adverse side effects listed above and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I understand that I am free to refuse or stop treatment at anytime.

I give my permission and consent to treatment.

X _____ _____

Signature of patient or legal guardian **Date**

Authorization to Release Personal Health Information

In order to comply with patient privacy regulations, including the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations on patient privacy and confidentiality 45 C. F. T Parts 160 and 164, I hereby authorize the use or disclosure of personal health information about me as described below:

1. I authorize the disclosure of my clinical health information by Kremer Acupuncture, LLC for the duration of my treatment in accordance with federal HIPAA regulations.
2. I understand I may request and receive a copy of the full Notice of Privacy Practices at any time.
3. I further authorize Kremer Acupuncture, LLC to release my health information to the following person(s).

Name	Relationship	Phone

4. I understand that I may revoke this authorization in writing at any time, by sending a written request to Kremer Acupuncture, LLC.

Printed Patient Name:_____

X _____ _____
Signature of patient or legal guardian **Date**

X _____ _____
Signature of witness Date