

Natural Life Therapy Clinic
Family Healthcare Through Oriental Medicine

Patient Intake Form

Date: _____

Name _____ SSN _____

Date of Birth _____ Age _____ Male Female Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Email Address _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Telephone _____

How did you learn of Natural Life Therapy Clinic? _____

Responsible Party (if dependent) _____ Relationship _____ Telephone _____

Insurance Company Name _____ Telephone _____

Insurance Plan Name _____

Insurance Company Address

Street _____ City _____ State _____ Zip _____

Patient's Policy Number _____ Group Number _____

Purpose of Visit:

Location of Pain/Discomfort:

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Date current problem began: _____ Have you had problem in the past? Yes No

If so, when? _____

Is your condition: Getting worse Constant Comes and goes

Is the pain Slight Moderate Severe

What makes it better? _____

What makes it worse? _____

How does it interfere with your daily activities (work, sleep, sex, etc.)?

Have you been given a diagnosis for this problem? If so, what was the diagnosis?

What kinds of treatment have you tried?

Any other complaints/pre-existing conditions?

What medications/drugs/herbs/supplements are you presently taking?

Are you presently under the care of a physical and/or mental health care provider? If so, by whom and for what condition(s)?

Date of your last physical exam _____ by whom? _____

Do you have, or have you had, any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other: _____ | | | |

Is there any history in your family of any of the above conditions? Who? What did they have?

List all surgeries/operations you have had and dates:

List any traumas you had and dates (accidents, injuries, etc.)

Lunch _____

Dinner _____

Snacks/Time of day eaten _____

MUSCULOSKELETAL: Please check all that apply

Pain, weakness, and/or numbness in:

- | | | | |
|-------------------------------------|------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Arms/Hands | <input type="checkbox"/> Feet/Legs |
| <input type="checkbox"/> Hips | <input type="checkbox"/> Knees | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Mid Back |
| <input type="checkbox"/> Lower Back | | | |

Are you experiencing cramps/spasms, stiffness, swelling? If so, where? _____

Do you have a feeling of heaviness in your body? _____

CARDIOVASCULAR/RESPIRATORY: Please check all that apply

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Persistent coughing | <input type="checkbox"/> Coughing phlegm | |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Dizziness/lightheaded | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Other _____ | |

HEAD: Please check all that apply.

Headaches (what area and how often?) _____

- | | | | |
|---|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Tooth problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Other _____ |

EYES: Please check all that apply.

- | | | | |
|---|---|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Dryness | <input type="checkbox"/> Pain/burning | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Other _____ | |

EARS: Please check all that apply.

- | | | | |
|---|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Earaches | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Ringing or buzzing in ears | <input type="checkbox"/> Other _____ | | |

NOSE: Please check all that apply.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Excessive mucus | <input type="checkbox"/> Blocked sinuses | <input type="checkbox"/> Sinus pressure/pain | <input type="checkbox"/> Allergies/hayfever |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Other _____ | | |

THROAT/MOUTH: Please check all that apply.

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Reoccurring sore throat | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Other _____ | | |

URINE: Please check all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Up at night to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Hard to urinate | <input type="checkbox"/> Pain/burning |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Water retention | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Other _____ | | | |

FEMALE:

Are you pregnant? _____ Date of last period: _____

Number of days between periods: _____ Age started: _____ Age stopped: _____

Form of birth control: _____

Number of pregnancies: _____ Number of deliveries: _____ Number of miscarriages: _____

Number of abortions: _____ Number of Cesareans: _____

Operations: Cervix Uterus Ovaries

Other:

- Menstrual pain/cramps Low back pain Leg cramps Painful breasts
- Clotting Heavy bleeding Light bleeding Dark color
- Water retention Irregular periods Missed periods Little/no sex drive
- Mood swings Hot flashes Food cravings Vaginal sores
- Infections Discharge - Color Other _____

MALE: Please check all that apply.

- Low sex drive Impotence Painful ejaculation Discharges
- Sores Painful urination Premature ejaculation Prostrate problems
- Nocturnal emissions Other _____

NEUROPSYCHOLOGICAL: Please check all that apply.

- Nervousness Depressed Easily angered/irritated Frequent crying
- Worry/anxiety Mood swings Memory confusion Poor concentration
- Suicidal Dizzy Seizures Neuralgia
- Numbness/tingling (Where?)
- Other _____

Is there anything else that you would like for us to know?

Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation and/or electrical impulse near the needle. Patients usually report little, or no pain during an acupuncture treatment. On occasion, there may be slight bruising where a needle was inserted. The duration of a treatment is usually 30 minutes to one hour.

Although, no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient. I UNDERSTAND THAT I HAVE THE RIGHT TO CONSENT TO, OR REFUSE, TREATMENT.

PATIENT CONSENT:

I consent to treatment by Oriental medicine therapies, including acupuncture.

SIGNED: _____ DATE: _____

PARENT OR GUARDIAN CONSENT:

I, _____, as parent or guardian of _____, authorize treatment of this minor by physicians at Natural Life Therapy Clinic, Inc.

SIGNED: _____ DATE: _____

CANCELLATION POLICY:

I understand that natural Life Therapy Clinic reserves the right to charge for appointments canceled or missed without *24 hours advance notice*.

SIGNED: _____ DATE: _____

PAYMENT POLICY:

I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Natural Life Therapy Clinic. I understand that Natural Life Therapy Clinic does not submit insurance claims, however, the staff of the clinic can assist me in my submission claims.

SIGNED: _____ DATE: _____