

**METAMORPHOSIS ACUPUNCTURE**  
**4939 State Hwy 23**  
**Norwich NY 13815**  
**Tel 607-373-3797**  
**PATIENT INFORMATION**

| PATIENT INFORMATION  |                                    |  |
|--|------------------------------------|--|
| Date _____   |                                    |  |
| Name _____   |                                    |  |
| Address _____  |                                    |  |
| _____  | _____                              | _____                                      |
| City   | State                              | Zip  |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F |                                    | Age _____ Birthdate _____                  |
| <input type="checkbox"/> Single                            | <input type="checkbox"/> Married   | <input type="checkbox"/> Significant Other |
| <input type="checkbox"/> Widowed                           | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced          |
| Occupation _____   |                                    |  |
| Employer _____   |                                    |  |
| Emp. Address _____   |                                    |  |
| Emp. Phone _____   |                                    |  |
| Whom may we thank for referring you? _____                 |                                    |  |
| PHONE NUMBERS  |                                    |  |
| H _____  | W _____                            | Cell _____                                 |
| Best time & place to reach you _____                       |                                    |  |
| Email address: _____                                       |                                    |  |
| IN CASE OF EMERGENCY, CONTACT                              |                                    |  |
| Name _____   | Relationship _____                 |  |
| Home phone _____   | Work phone _____                   |  |

| INSURANCE  |            |
|--|------------|
| Who is responsible for this account? _____   |            |
| Relationship to Patient _____  |            |
| Insurance Co. _____  |            |
| Group # _____  |            |
| Subscriber's Name _____  |            |
| Birthdate _____  |            |
| ASSIGNMENT AND RELEASE   |            |
| I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. |            |
| Responsible Party Signature _____  |            |
| Relationship _____   | Date _____ |
| ACCIDENT INFORMATION   |            |
| Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No  |            |
| Date _____   |            |
| Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other  |            |
| To whom have you made a report of your accident?<br><input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> Other   |            |
| Attorney Name (if applicable) _____  |            |

| GENERAL INFORMATION   |   |
|---|---|
| Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No   | Have you used Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you currently under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, for what? _____ |   |
| Physician's name: _____   | Physician's phone: _____  |

# METAMORPHOSIS ACUPUNCTURE

Tel 607-373-3797

## ORIENTAL MEDICINE INTAKE FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other \_\_\_\_\_

2. \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other \_\_\_\_\_

3. \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other \_\_\_\_\_

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Please list **allergies** that you have to any of the following:

Drugs: \_\_\_\_\_ Foods: \_\_\_\_\_ Other (i.e. pollen, paint, etc.): \_\_\_\_\_

### HEALTH HISTORY

**Past Medical History:** Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Personal Habits:

Tobacco packs/day \_\_\_\_\_

Alcohol drinks/wk \_\_\_\_\_

Coffee/tea/cola cups/day \_\_\_\_\_

Recreational drugs times/wk \_\_\_\_\_

High Stress Level Reason \_\_\_\_\_

Do you follow any diet regimens/restrictions?

Yes No

If Yes, describe: \_\_\_\_\_

#### Work Activity:

Sitting % of time \_\_\_\_\_

Standing % of time \_\_\_\_\_

Light labor % of time \_\_\_\_\_

Heavy labor % of time \_\_\_\_\_

#### Exercise:

Do you exercise regularly? Yes No

If Yes, describe & tell how

often: \_\_\_\_\_

\_\_\_\_\_

### FAMILY INFORMATION

Do you have children? Yes No If Yes, how many? \_\_\_\_\_ Ages \_\_\_\_\_

Are you, or could you be currently pregnant? Yes No Due date \_\_\_\_\_

Please check if you have had (in the **last three months**)

#### GENERAL

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Fevers/Chills         | <input type="checkbox"/> Tremors               |
| <input type="checkbox"/> Heavy appetite      | <input type="checkbox"/> Sweat easily          | <input type="checkbox"/> Poor sleeping         |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Localized weakness    | <input type="checkbox"/> Heavy sleeping        |
| <input type="checkbox"/> Weight loss/gain    | <input type="checkbox"/> Bleed / bruise easily | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Cravings            | <input type="checkbox"/> Sudden energy drop    | <input type="checkbox"/> Night sweats          |
| <input type="checkbox"/> Peculiar tastes     | (time?)  | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Strong thirst       | <input type="checkbox"/> Fatigue               |  |

#### SKIN AND HAIR

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Ulcerations      | <input type="checkbox"/> Fungal infections              |
| <input type="checkbox"/> Itching      | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Recent moles                   |
| <input type="checkbox"/> Dry skin     | <input type="checkbox"/> Loss of hair     | <input type="checkbox"/> Change in hair or skin texture |
| <input type="checkbox"/> Dandruff     | <input type="checkbox"/> Pimples/Acne     |   |

Other hair or skin concerns:

#### HEAD, EYES, EARS, NOSE, AND THROAT

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Concussions                                      | <input type="checkbox"/> Spots in front of eyes        | <input type="checkbox"/> Swollen glands       |
| <input type="checkbox"/> Glasses/Contacts                                 | <input type="checkbox"/> Earaches/Infections           | <input type="checkbox"/> Sores on lips/tongue |
| <input type="checkbox"/> Eye strain/pain                                  | <input type="checkbox"/> Ringing in ears               | <input type="checkbox"/> Dry mouth            |
| <input type="checkbox"/> Red eyes   | <input type="checkbox"/> Poor hearing                  | <input type="checkbox"/> Excessive saliva     |
| <input type="checkbox"/> Itchy eyes                                       | <input type="checkbox"/> Sinus problems                | <input type="checkbox"/> Teeth problems       |
| <input type="checkbox"/> Dry eyes   | <input type="checkbox"/> Post nasal drip               | <input type="checkbox"/> Gum problems         |
| <input type="checkbox"/> Excessive tearing                                | <input type="checkbox"/> Excessive phlegm – color_____ | <input type="checkbox"/> TMJ disorder         |
| <input type="checkbox"/> Poor/blurry vision                               | <input type="checkbox"/> Nose bleeds                   | <input type="checkbox"/> Grinding teeth       |
| <input type="checkbox"/> Night blindness                                  | <input type="checkbox"/> Recurrent sore throats        |   |
| <input type="checkbox"/> Cataracts/Glaucoma                               |  |   |
| <input type="checkbox"/> <b>Headaches</b> (location, triggers, severity)? |  |   |

Other head & neck concerns:

#### CARDIOVASCULAR

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations      | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Blood clots      |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cold hands/feet   | <input type="checkbox"/> Phlebitis        |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands |   |

Other heart or blood vessel concerns:

#### RESPIRATORY

- |   |   |
|---|---|
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Pain with deep breath                        |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Shortness of breath                          |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Tight chest                                  |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Production of phlegm - color? _____          |
| <input type="checkbox"/> Bronchitis     | Is it <input type="checkbox"/> thick or <input type="checkbox"/> thin |
| <input type="checkbox"/> Pneumonia      |   |

Other lung related concerns:



## GASTROINTESTINAL

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Belching           | <input type="checkbox"/> Abdominal pain       |
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Bad breath         | <input type="checkbox"/> Itchy anus           |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Blood in stools    | <input type="checkbox"/> Burning anus         |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Black stools       | <input type="checkbox"/> Hemorrhoids/fissures |
| <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Mucus in stools    |   |
| <input type="checkbox"/> Hiccups      | <input type="checkbox"/> Acid Regurgitation |   |

History of chronic laxative use?

Other concerns with your general digestion:

## GENTIO-URINARY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain on urination    | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Premature ejaculation             |
| <input type="checkbox"/> Frequent urination   | <input type="checkbox"/> Kidney stones    | <input type="checkbox"/> Nocturnal emissions               |
| <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Impotency        | <input type="checkbox"/> Sores on genitals                 |
| <input type="checkbox"/> Urgency to urinate   | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Chronic yeast infection           |
| <input type="checkbox"/> Decrease in flow     |   |  |

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

## MUSCULOSKELETAL

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Muscle weakness              | <input type="checkbox"/> Knee pain                                |
| <input type="checkbox"/> Upper back pain  | <input type="checkbox"/> Cramps/spasms                | <input type="checkbox"/> Foot/ankle pain                          |
| <input type="checkbox"/> Lower back pain  | <input type="checkbox"/> General joint pain/stiffness | <input type="checkbox"/> Hip pain                                 |
| <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Shoulder pain                | <input type="checkbox"/> Joint with limited range of motion _____ |
| <input type="checkbox"/> Muscle pains     |   |   |

Other muscle, joint or bone concerns:

## NEUROPSYCHOLOGICAL

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Memory loss  | <input type="checkbox"/> Easily susceptible to stress        |
| <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Concussion   | <input type="checkbox"/> History of emotional/physical abuse |
| <input type="checkbox"/> Areas of numbness    | <input type="checkbox"/> Depression   |  |
| <input type="checkbox"/> Tics                 | <input type="checkbox"/> Anxiety      |  |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Irritability |  |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

## GYNECOLOGY

Age of first menses \_\_\_\_\_ If no longer menstruating, approximate date ceased \_\_\_\_\_

First day of last menses \_\_\_\_\_ Length between menses: \_\_\_\_\_ days Duration of period: \_\_\_\_\_ days

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Unusual flow ( <input type="checkbox"/> heavy or <input type="checkbox"/> light) | <input type="checkbox"/> Clots in flow                   | <input type="checkbox"/> Vaginal dryness       |
| <input type="checkbox"/> Painful periods  | <input type="checkbox"/> Vaginal discharge – color _____ | <input type="checkbox"/> Vaginal sores         |
| <input type="checkbox"/> Irregular periods  | <input type="checkbox"/> Vaginal odor                    | <input type="checkbox"/> Hot flashes           |
|   |  | <input type="checkbox"/> Breast lumps/soreness |

**GYNECOLOGY (continued)**

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP: \_\_\_\_\_ Results were:        normal    abnormal    unsure  
If you use birth control, what type & for how long?Have you ever used hormonal methods for contraception or period regulation?  
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

**PREGNANCY HISTORY**Number of pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_  
Were your births relatively normal? Explain:

Other related concerns:

**COMMENTS**

Please let us know of any other concerns you would like to address:

**Family History:** Please fill in the boxes for each condition that applies to one of your family members.

|  | Yes | Who | Comments |
|--|-----|-----|----------|
| Addiction (alcohol/drugs)                                      |     |     |          |
| Cancer   |     |     |          |
| Cardiac disorders (heart disease, high blood pressure, stroke) |     |     |          |
| Diabetes   |     |     |          |
| Digestive/Gastro-intestinal disorders                          |     |     |          |
| Immune disorders (hepatitis, HIV, etc.)                        |     |     |          |
| Mental illness   |     |     |          |
| Respiratory disorders (asthma, allergies, etc)                 |     |     |          |
| Skin disorders (eczema, psoriasis, etc.)                       |     |     |          |
| Seizure disorders  |     |     |          |