CAROLE PAINE, MS, L.AC.

Traditional Chinese Acupuncture

WELCOME

This letter is to confirm your appointment with Carole Paine at Cincinnati Acupuncture. Please complete your new patient information and assessment questionnaire before your visit. You will need to bring this paperwork with you for your first visit.

It will be beneficial to wear loose comfortable clothing and to have something to eat shortly before your appointment. It is also suggested not to engage in demanding physical activity several hours prior to your appointment and for several hours after your appointment. Acupuncture has numerous benefits and most people experience a deep relaxation and sense of well being during and after the treatment.

Payment is due at the time of service; payable by either cash, check, or credit card, or HSA/FSA. If there is any need to cancel or reschedule it is essential to give a minimum of twenty four hours notice or cancellation fees may apply. This allows your time to be taken by someone else if you are unable to keep your appointment. This consideration is strongly requested and greatly appreciated. If you have insurance that covers acupuncture you will be given a superbill to submit to your insurance. Insurance billing is not done by the office, but you will be assisted in any way possible. It is my honor to assist you with your healthcare. I look forward to our work together. Please call if any questions or issues arise that need attention.

Sincerely,

Carole Paine, MS, L.Ac.

4960 Ridge Ave., Suite 4, Cincinnati, Ohio 45209 513.317.3660

CLIENT INTAKE FORM

Name (last, first) _____ **Date** _____

Address _____

City/ State/ Zip _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email** _____

Occupation _____ **Birth Date/Age** _____

Emergency contact _____
(Name & phone)
Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed
___ Caregiver for dependent ___ Children _____

Have you ever had acupuncture? _____ **If yes, when?** _____

For what condition? _____

Are you currently under the care of a physician? _____

If so, who, and for what condition(s)?
_____

Main reason(s) for seeking acupuncture _____

_____

How long have you experienced symptoms? _____

_____

You condition is improved by _____

_____

Your condition is aggravated by _____

_____

For Patient Review Regarding Diagnostic Exam
Please sign one of the two options listed below:

Option 1:

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

_____

Patient Signature Date

Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

_____

Patient Signature Date

_____

Licensed Acupuncturist Signature Date

CC: Patient file
Provided to patient

Patient Name:_____Date:_____

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood disorder/anemia							
Diabetes							
Cancer or tumors							
Seizures							
High Blood Pressure							
Kidney or bladder disorder							
Stomach or intestinal disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other							
Age at Death							

MAJOR HOSPITALIZATIONS – If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.

YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE

PREVIOUS PREGNANCIES:
Total Pregnancies_____ Living_____ Ectopic_____ Miscarriages_____ Induced Abortions_____

MEDICINES – Mark an X in the box next to any of the following that you are now taking:

☐ aspirin	☐ ibuprofen	☐ acetaminophen (Tylenol)	☐ Other:_____
☐ antacids	☐laxatives	☐ cold tablets	_____
☐ oral contraceptives	☐ diet pills	☐ tranquilizers	_____
☐ fiber supplements	☐ sleeping pills	☐ hay fever tablets	_____
☐ blood pressure pills	☐ blood thinning pills	☐ insulin, diabetic pills	_____

Vitamins (please list)_____
Herbs (please list)_____
DRUG ALLERGIES_____

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Caffeine	Yes ☐ No ☐	cups per day/week_____	age started_____	age quit_____
Tobacco	Yes ☐ No ☐	# cigarettes per day_____	age started_____	age quit_____
Marijuana	Yes ☐ No ☐	use per day/week_____	age started_____	age quit_____
Alcohol	Yes ☐ No ☐	use per day/week_____	age started_____	age quit_____
Recreational Drugs	Yes ☐ No ☐	use per day/week_____	age started_____	age quit_____
Other_____			age started_____	age quit_____

Patient Name:_____Date:_____
Current = Past 6-9 months

GENERAL

past	current	
☐	☐	Poor Appetite
☐	☐	Excessive Appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night Sweats
☐	☐	Sweat Easily
☐	☐	Chills
☐	☐	Localized Weakness
☐	☐	Poor Coordination
☐	☐	Change in Appetite
☐	☐	Strong Thirst
☐	☐	Other_____

SKIN AND HAIR

past	current	
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors, Lumps

HEAD AND NECK

past	current	
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck Stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Other_____

EARS

past	current	
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other_____

EYES

past	current	
☐	☐	Blurred Vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses/Contacts
☐	☐	Eye inflammation
☐	☐	Other_____

NOSE THROAT AND MOUTH

past	current	
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Hay fever or allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing
☐	☐	Changes in taste or smell

CARDIOVASCULAR

past	current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Fainting
☐	☐	Phlebitis
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Swelling of hands/feet
☐	☐	Other_____

RESPIRATORY

past	current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Chronic obstructive pulmonary disease
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other_____

GASTRO-INTESTINAL

past	current	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black stools
☐	☐	Bad breath
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	Other_____

GENITO-URINARY

past	current	
☐	☐	Kidney stones
☐	☐	Pain on urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other_____

MALE

past	current	
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Other_____

FEMALE

past	current	
☐	☐	Frequent Urinary tract infection
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Pelvic Inflammatory disease
☐	☐	Abnormal Pap Smear
☐	☐	Irregular periods
☐	☐	Painful menstrual periods
☐	☐	Premenstrual syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Other_____

NEUROLOGICAL

past	current	
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness or tingling of limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other_____

PYSCHOLOGICAL

past	current	
☐	☐	Depression
☐	☐	Anxiety/Stress
☐	☐	Irritability
☐	☐	Treated for emotional/ psychological problems
☐	☐	Other_____

INFECTION SCREENING

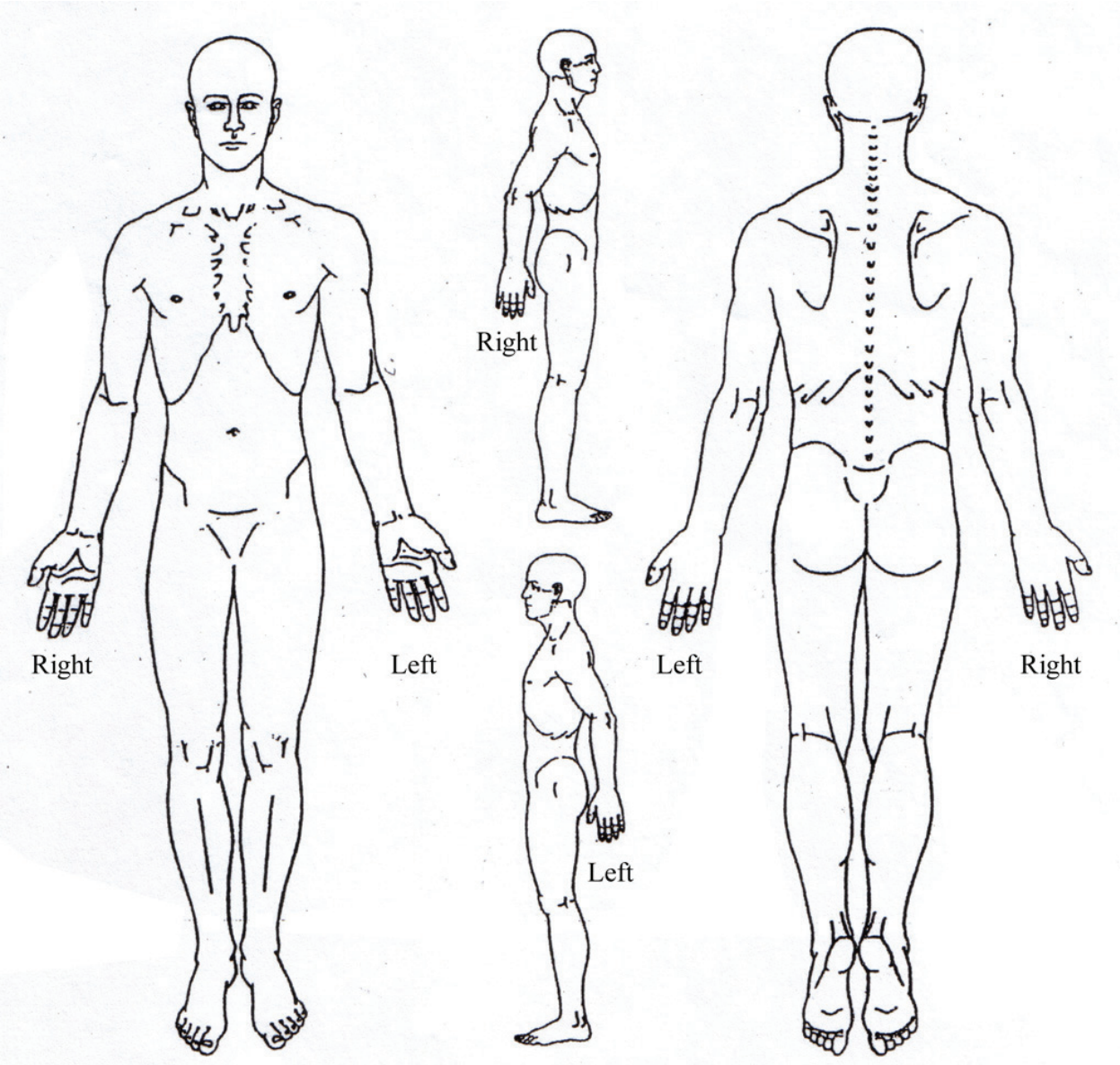
past	current	
☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Herpes:oral/genital

Please use the drawing below to characterize your symptoms as best as possible.

USE THE LETTERS BELOW TO INDICATE THE TYPE OF SENSATIONS.
USE AN X TO MARK THE LOCATION OF SENSATIONS.

KEY:

D = Dull Ache	T = Tingling	B = Burning
S = Sharp Stabbing	N = Numbness	O = Other



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DIRECTIONS TO 4960 RIDGE AVE. SUITE 4
Located Between Urgent Care and Sherwin Williams

From Downtown Cincinnati And South of Cincinnati Traveling...

I-71 NORTH
Take **Exit 8A-Ridge** Avenue South, Turn Right onto Ridge Avenue
Get Into The Left lane As Soon As Possible
Just Past **URGENT CARE** On Your Left, You Will Turn Left Into the Parking Lot For **4960 Ridge**
Parking Is Available In Front Of The Building, On Both Sides, And In The Rear Of The Building

I-75 NORTH
Take The **Norwood Lateral** (Route 562), Turn Right Onto Ridge Avenue
Get Into The Left lane As Soon As Possible
Just Past **URGENT CARE** On Your Left, You Will Turn Left Into the Parking Lot For **4960 Ridge**
Parking Is Available In Front Of The Building, On Both Sides, And In The Rear Of The Building

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From North of Cincinnati Traveling...

I-71 SOUTH
Take I-71 South of the I-275 Beltway
Take **Exit 8** Ridge Avenue/Kennedy Avenue, Turn Left at the end of the Ramp onto Highland
Turn Left at the next intersection of Highland and Ridge Road and Stay in the Left Lane
Just Past **URGENT CARE** On Your Left, You Will Turn Left Into the Parking Lot For **4960 Ridge**
Parking Is Available In Front Of The Building, On Both Sides, And In The Rear Of The Building

I-75 SOUTH
Take I-75 South Bound to the **Norwood Lateral** (Route 562)
Take the Ridge Avenue Exit and Turn Right onto Ridge Avenue
Get into the Left Lane As Soon As Possible
Just Past **URGENT CARE** On Your Left, You Will Turn Left Into the Parking Lot For **4960 Ridge**
Parking Is Available In Front Of The Building, On Both Sides, And In The Rear Of The Building