

Sara Layton –New Patient Information Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please use ink.

Name _____ Date _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

E-Mail Address _____ Occupation _____

Single ___ Married ___ Divorced ___ Widowed ___ Living with _____

Referred by: _____

Have you had acupuncture before? _____ Name of practioner _____

Reason for acupuncture _____

Other concerns _____

Initial cause _____

How long have you had this condition? _____ Have you experienced this before? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your: Sleep _____ Work _____ Other _____

Other therapies you have tried for this condition _____

In case of emergency: Person to contact _____ Phone _____

Physicians name _____ Phone _____ Date last seen _____

Medicines:

Prescription drugs you are currently taking:

For what condition?

Over the counter medication

For what condition?

Vitamins



Major hospitalizations and Surgeries:

Year _____ Operation or Illness _____

Personal Lifestyle Habits (How much, how many, how often)

Cigarettes _____ Coffee/tea _____ Alcohol _____ glasses of water per day _____

Marijuana _____ Other recreational drugs _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, meditation, TV, music, etc.) _____

Diet: any dietary restrictions _____ Food cravings _____

What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

PLEASE CHECK ALL THAT APPLY:

- | | |
|---|---|
| <input type="checkbox"/> Anxiety, uneasiness | <input type="checkbox"/> Are you passionate about things? |
| <input type="checkbox"/> Agitated | <input type="checkbox"/> Is there enough fun in your life? |
| <input type="checkbox"/> Irritable/ angry/frustrated | <input type="checkbox"/> Are you a thrill seeker? |
| <input type="checkbox"/> Often feeling lonely, sad, isolated | <input type="checkbox"/> Do you get sick easily? |
| <input type="checkbox"/> Feel as if carrying a heavy burden | <input type="checkbox"/> Are you susceptible to drafts, wind? |
| <input type="checkbox"/> Worrying a lot | <input type="checkbox"/> Seasonal affective disorder? |
| <input type="checkbox"/> Tendency to be shy or sensitive | <input type="checkbox"/> Fatigued a lot |
| <input type="checkbox"/> Do you feel a lot of grief or regret | <input type="checkbox"/> Trouble falling asleep routinely |
| <input type="checkbox"/> Difficulty relaxing, hard to sit still | <input type="checkbox"/> Trouble staying asleep |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Tired when you wake in the morning |
| <input type="checkbox"/> Feeling clingy or needy | <input type="checkbox"/> Frightening dreams or thoughts? |
| <input type="checkbox"/> Do you cry often? | <input type="checkbox"/> Hot more than others? |
| <input type="checkbox"/> Do you feel depressed? | <input type="checkbox"/> Cold more than others? |
| <input type="checkbox"/> Do you feel overwhelmed? | <input type="checkbox"/> Forgetfulness/ poor memory |
| <input type="checkbox"/> Are you afraid of the unknown? | <input type="checkbox"/> Trouble focusing/ easily distracted |
| <input type="checkbox"/> Are you frightened a lot? | <input type="checkbox"/> Disturbed by work or family problems |
| <input type="checkbox"/> Trouble making decisions? | <input type="checkbox"/> Bouts of crying and laughing |
| <input type="checkbox"/> Have you ever considered suicide? | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Are you seeing a therapist? | <input type="checkbox"/> Can you easily let go of things |
| <input type="checkbox"/> Sense of Hopelessness | <input type="checkbox"/> Same thoughts often churning in the mind |

PLEASE PUT A **"C"** IF THE CONDITION IS CURRENT OR A **"P"** IF THE CONDITION IS PAST. IF YOU ARE NOT SURE HOW TO ANSWER, PLEASE CIRCLE.

GENERAL

- AIDS/ HIV
- Alcoholism
- Cancer
- Diabetes
- Tumors
- Seizures
- Osteoporosis
- Emphysema
- Liver disease
- Drug Abuse
- Polio
- Rheumatic Fever
- Tuberculosis
- Hepatitis
- Thyroid Disorders
- Epilepsy
- Anemia
- Bleeding disorders
- High blood pressure
- Kidney disorders
- Other _____

SKIN & HAIR

- Rashes
- Hives
- Eczema
- Psoriasis
- Acne
- Hair loss
- Fungal infections
- Itching
- Night sweating
- Excess sweating
- No sweating
- Dry skin
- Changes in moles/lumps
- Other _____
- Feeling cold a lot
- Feeling hot a lot

RESPIRATORY

- Short of breath
- Tightness in chest
- Difficulty Breathing
- Allergies
- Wheezing
- Asthma
- Wet cough
- Dry cough
- Chronic Cough
- Phlegm
- Color of phlegm _____
- Post nasal drip
- Coughing blood
- Pneumonia

GASTROINTESTINAL

- Acid reflux
- Recent weight gain/ loss
- Gas
- Bad breath
- Bloating
- Diarrhea
- Irritable Bowel
- Constipation
- Laxative use
- Heartburn
- Cramping/ pain
- Gurgling
- Intestinal pain
- Poor appetite
- Excessive hunger
- Nausea
- Vomiting
- Mucus in stools
- Bloody stools
- Strongly Prefer cold drinks
- Strongly prefer hot drinks
- Indigestion
- Gall bladder disorder
- Bowel movement formed
- Bowel movement in pellets

Frequency of bowel movements a week _____

CARDIOVASCULAR

- Anemia
- Blood clots
- Shortness of breath
- Chest pain
- Chest tightness
- Phlebitis
- Heart palpitations
- Swelling in legs, ankles, feet
- Poor circulation
- Fainting
- Irregular heartbeat
- High blood pressure
- Low blood pressure
- Cold hands or feet
- Bleed or bruise easily
- History of heart attack

NOSE, THROAT, MOUTH

- Grinding teeth
- TMJ
- Frequent sore throat
- Mouth / tongue ulcers
- Frequent colds
- Nosebleeds
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- Facial problems
- Dry mouth
- Sinus infections
- Feeling lump in throat
- Dry, brittle fingernails

HEAD and NECK

- Headaches
 - Frequency _____
 - Duration _____
 - Location _____
- Migraines
 - Frequency _____
 - Duration _____
- Cause of HA or migraines

- Other Head problems

- Neck pain/ stiffness
- Dizziness

GENITO-URINARY

- Pain with urination
- Frequent urination
- Urgent urination
- Blood in urine
- Incomplete urination
- Wake to urinate
- Kidney stones
- Burning with urination
- Burning or itching
 - Around anus
- Hemorrhoids
- Increased libido
- Decreased libido
- Clear urine
- very yellow or dark urine
- Bedwetting

MUSCULAR- SKELETAL

- Knee pain
- Shoulder/ neck pain
- Joint pain
- Muscle cramps or
Spasms
- Hand pain
- Low back
- Upper back
- Limited range of motion
- Hip pain
- Other _____
- Pain changes in response
 - To weather
- Numbness
- Tics or tremors
- Foot pain
- Muscular pain

EYES

- Red eyes
- Itchy eyes
- Blurred vision
- Pain behind eyes
- Spots/ floaters
- Glaucoma/ cataracts

EARS

- Tinnitus
- Ringing in the ears
- Vertigo
- Hearing
- Earache/ infection

NEUROLOGICAL

- Seizures
- Tremors
- Paralysis
- Other _____

MEN ONLY

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching /redness
of genitalia
- Lumps in testicles
- Prostrate problems
- Burning on urination

INFECTION SCREENING

- Venereal disease
- HIV risks-self or partner
- TB self or household
- Hepatitis risk self or other
- Genital warts
- Herpes-oral or genital

OTHER _____

PRIVACY PRACTICES ACKNOWLEDGEMENT FROM THE OFFICE OF SARA LAYTON M.AC.

You have received a copy of the office “HIPAA notice of privacy practices,” regarding your privacy rights. You have received the HIPAA form electronically; whether by reading the privacy practices notice on the website, or by downloading and printing it out from a computer. This form is listed on the website as a separate heading underneath the patient intake forms.

If you wish to receive a paper copy of this notice, you have the right to request one by asking the person in charge of this office. By signing this, you state that you have either received and reviewed the HIPAA privacy practices or that you have been provided with an opportunity to review them, but waive your rights to read them.

Patient or guardian signature

Date

For diagnostic purposes, it is better not to wear any perfume, or scented lotions, and minimal make-up to your treatments.

CANCELLATION POLICY

You agree to pay for any charges not covered by my insurance for acupuncture services rendered. This includes any co-pays and treatment offered that is not covered by insurance. Payment will be made within 30 days of a statement from Sara Layton.

Your appointments are time that is set aside just for you. Last minute cancellations mean that someone else who needed the time may have been turned away. I ask that you accept responsibility for each appointment time that you schedule with me, and in doing so, I request that 24 hrs. notice is given when appointments must be changed. Except for the emergency cancellation, the late cancellation/ missed appointment policy will go into effect and you will be charged the full price for the treatment. Cancelled appointments are not covered by insurance, and are the sole responsibility of the patient.

COMMITMENT TO TREATMENT

The progress of your healing depends on your commitment. This requires regular appointments, where the treatments build upon one another. Success in your treatment may also require lifestyle changes to benefit your health. Your treatments are geared to producing overall good health, and not just treating your symptoms. Please participate in any “homework” I may recommend.

I understand this agreement and all questions have been answered by Sara.

Signature of patient

Date

I look forward to being with you and supporting you on your journey to wellness.

GYNECOLOGY

Age of first menses _____ Date of last menstrual period _____ Duration of flow _____

Menopause (date of onset) _____ Symptoms from menopause _____

Any breakthrough bleeding since? _____ Are you on hormone replacement therapy? _____

How long have you been on HRT? _____ Any side effects? _____

Current method of contraception? _____ Past method of contraception _____

Any complications from birth control? _____

Are you currently trying to be pregnant? _____ How long have you been trying? _____

Any known reason for not conceiving? _____ Has your mate been tested? _____

Are you currently pregnant? _____ If so, how many weeks? _____ Any problems? _____

Pap smear: normal abnormal Date of last pap smear _____

Color of Blood: Pale Bright red Dark red Brown

Consistency of menstrual blood: thick thin watery normal

____ Number of pregnancies

____ Number of live births

____ Number of miscarriages

____ Number of abortions

____ Premature births

____ Night sweats

____ Regular periods

____ Heavy bleeding

____ Hysterectomy

____ Age at time of
hysterectomy

____ Cysts

____ Fibroids

____ Endometriosis

____ Irregular periods

____ Light bleeding

____ Vaginal sores/itching, pain

____ Vaginal discharge

____ Vaginal odor

____ Uterine prolapse

____ Urinary tract infections

____ How frequent?

____ Breast lumps, fibroids

____ days between cycles

SYMPTOMS BEFORE OR DURING THE PERIOD

____ abdominal distension

____ Breast soreness

____ Irritability, moodiness

____ depression, sadness

____ Tiredness

____ poor sleep

____ dizziness

____ sore back and knees

____ poor sleep

____ feeling hot, esp. hands and feet

____ feeling cold

____ low sexual desire

____ frequent, pale urination

____ clots in the blood

____ feeling agitation, aggressiveness

____ oppression in chest

____ red face, bloodshot eyes

____ cramps: how many days _____ When? _____

