Indiana Reproductive Acupuncture

Patient Intake Form

Contact Information

Prenatal

12188-A North Meridian, Suite 225 I Carmel, IN 46032 I **317.846.8777** I Fax 317.846.8834 I www.IndianaReproductiveAcupuncture.com

NAME (First, Middle Initial, Last)	DATE

AGE	DATE OF BIRTH	

HOME ADDRESS		
CITY	STATE	ZIP

CELL PHONE	HOME PHONE	WORK PHONE

WHAT IS THE BEST DAY TIME PHONE NUMBER TO REACH YOU?	MAY WE CALL YOU AT WORK?
❑ CELL PHONE ❑ HOME PHONE ❑ WORK PHONE	❑ YES ❑ NO

E-MAIL ADDRESS	IS E-MAIL A GOOD WAY TO CONTACT YOU?
	❑ YES ❑ NO

EMPLOYER	OCCUPATION

SPOUSE/PARTNER NAME		
EMERGENCY CONTACT	RELATIONSHIP	EMERGENCY CONTACT PHONE

OBGYN	

HOW DID YOU HEAR ABOUT US? (Doctor's name, Nurse, Doctor office staff, website, brochure, friend, etc)	DO WE HAVE PERMISSION TO SEND THANK-YOU TO REFERRAL SOURCE?

CONSENT FOR ACUPUNCTURE

I, _____, understand that I will be receiving a treatment from a licensed acupuncturist. I understand that
treatment involves any or all of the following health care practices: Massage, Acupuncture.

Acupuncture is the insertion of one or more thin needle(s) into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment. On occasion, there may be slight bruising or bleeding where a needle was inserted.

The duration of a treatment is usually 30 minutes to 1 hour. Although no outcome of treatment is guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the condition of the patient. I understand that I have the right to consent to, or refuse treatment.

Quality patient care is our primary concern. The optimal timing of your treatment is an important aspect of that care. If it is necessary to reschedule your appointment, we ask to be given 24 hours notice. We understand that sometimes scheduling conflicts arise that are unavoidable but we ask that you give us a 24 hour notice to avoid a $50 cancellation fee.

Signed: _____ **Date:** _____

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Patient Intake Form
Medical History

NAME

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune Disease
- ❑ AIDS
- ❑ Cancer
- ❑ Connective Tissue Disease
- ❑ Diabetes
- ❑ Gallstones
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hypertension
- ❑ Kidney Stones
- ❑ Rheumatic Fever
- ❑ Ruptured Appendix
- ❑ Seizures
- ❑ Thyroid Disease
- ❑ Venereal Disease
- ❑ Other: _____

LIST ANY MEDICATIONS AND/OR SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

MEDICATION	DOSAGE	DATE STARTED

PRENATAL PATIENTS ONLY:

- ❑ Abnormal fetal positioning
- ❑ Backache
- ❑ Edema
- ❑ Fatigue
- ❑ Heartburn
- ❑ Hypertension
- ❑ Insomnia
- ❑ Labor Induction
- ❑ Miscarriage Prevention
- ❑ Mood Swings
- ❑ Nausea
- ❑ Sciatica
- ❑ Other: _____

DUE DATE _____

HOW MANY PREGNANCIES HAVE YOU HAD? _____ DATE: _____

HOW MANY MISCARRIAGES HAVE YOU HAD? _____ DATE: _____

HOW MANY ABORTIONS HAVE YOU HAD? _____ DATE: _____

HOW MANY CHILDREN HAVE YOU HAD? _____

Thank you for filling out this form so that we can better serve your health needs. All information will remain confidential.