# Yuki-Sachiko Itaya, DAOM, L.Ac.

Acupuncture & Moxibustion Clinic | www.okyu-do.com

**PATIENT INTAKE FORM**

Confidential Medical Record

## 1. GENERAL PATIENT INFORMATION

**Full Name:** _____ **DOB:** _____ **Sex:** ☐ M ☐ F ☐ Other

**Address:** _____ **Date:** _____

**Email:** _____ **Phone:** _____

**May we leave messages regarding your visits?** ☐ Yes ☐ No **How did you hear about us?** _____

**Emergency Contact:** _____ **Relationship:** _____ **Phone:** _____

### Primary Health Care Providers (MD, Chiropractor, Physiotherapist, etc.)

**1.** _____ **2.** _____

## 2. TREATMENT GOALS & PRIOR ACUPUNCTURE EXPERIENCE

**Main Reasons for Seeking Treatment / Health Goals:**

1. _____
2. _____
3. _____

**Have you had Acupuncture before?** ☐ Yes ☐ No **Have you had Moxibustion before?** ☐ Yes ☐ No

**Do needles bother/fear you?** ☐ Yes ☐ No If yes, explain: _____

## 3. MEDICAL HISTORY & CONDITIONS

**Do you see a medical doctor regularly?** ☐ Yes ☐ No **Do you get regular blood work?** ☐ Yes ☐ No

**Please check all conditions you currently have or have had in the past:**

| | | | |
|---|---|---|---|
| ☐ AIDS / HIV | ☐ Deep Vein Thrombosis | ☐ High / Low Blood Pressure | ☐ Respiratory Condition |
| ☐ Allergies | ☐ Depression / Anxiety | ☐ Jaw Pain / TMJ | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Diabetes | ☐ Kidney Disease / Stones | ☐ Sinus Problems |
| ☐ Arthritis | ☐ Digestive Disorders | ☐ Liver Condition | ☐ Skin Condition |
| ☐ Asthma | ☐ Epilepsy / Seizures | ☐ Migraines / Headaches | ☐ Spinal Injury |
| ☐ Bipolar Disorder | ☐ Fibromyalgia | ☐ Multiple Sclerosis | ☐ Sprains / Fractures |
| ☐ Cancer | ☐ Gall Stones | ☐ Osteoporosis | ☐ Stroke |
| ☐ Chronic Fatigue Syndrome | ☐ Heart Condition / Pacemaker | ☐ Hemophilia / Bleeding | ☐ Thyroid Problem |
| ☐ Drug Addiction History | ☐ Ulcers / Ulcerative Colitis | ☐ Tuberculosis | ☐ Other: _____ |

## 4. MEDICATIONS, INJURIES & LIFESTYLE FACTORS

**Current Medications / Supplements:** _____

_____

**Past Surgeries / Surgeries / Traumas:** _____

_____

**Known Allergies (Medication/Env):** _____

### Substance & Frequent Product Use

**Antacids:** ☐ Y ☐ N Freq: _____ **Painkillers:** ☐ Y ☐ N Freq: _____ **Laxatives:** ☐ Y ☐ N Freq: _____

**Birth Control:** ☐ Y ☐ N Type: _____ **Tobacco:** ☐ Y ☐ N Freq: _____ **Caffeine:** ☐ Y ☐ N Cups/day: ___

**Alcohol:** ☐ Y ☐ N Freq: _____ **Recreational Drugs:** ☐ Y ☐ N Form & Freq: _____

## 5. LIFESTYLE & DAILY HABITS

**Diet Description:** _____ **Food Cravings:** _____

**Exercise Routine:** _____ **Stress Level (1-10):** Low 1 2 3 4 5 6 7 8 9 10 High

**Sleep Hours/Night:** _____ **Rested in AM?** ☐ Yes ☐ No ☐ Trouble Falling / Staying Asleep

**Occupation:** _____ **Hobbies / Kids:** _____

## 6. TRADITIONAL CHINESE MEDICINE (TCM) SYSTEMS REVIEW

**Rating Scale: 0 = Never | 1 = Rarely | 2 = Occasionally | 3 = Frequently | 4 = Always**

| Digestive & Metabolic | Respiratory & Immune | Musculoskeletal & Circulatory | Mind, Energy & Sleep |
|---|---|---|---|
| [ ] Low appetite | [ ] Catch colds easily | [ ] Neck / shoulder tension | [ ] Fatigue / General weakness |
| [ ] Ravenous appetite | [ ] Shortness of breath | [ ] Low back pain | [ ] Fatigue after eating |
| [ ] Heartburn / Acid reflux | [ ] Frequent cough | [ ] Sore, cold or weak knees | [ ] Insomnia / Disturbing dreams |
| [ ] Gas / Abdominal bloating | [ ] Asthma / Allergies | [ ] Muscle spasms / Twitches | [ ] Anxiety / Restlessness |
| [ ] Belching or vomiting | [ ] Sinus congestion / Discharge | [ ] Numb extremities | [ ] Irritable / Easily angered |
| [ ] Loose stools / Diarrhea | [ ] Dry nose / throat / skin | [ ] Joint / Tendon stiffness | [ ] Poor memory / Foggy thinking |
| [ ] Constipation / Alternating | [ ] Tight feeling in chest | [ ] Bruise easily / Swelling | [ ] Dizziness upon standing |
| [ ] Mouth sores / Bleeding gums | [ ] Excessive phlegm | [ ] Chest pain / Palpitations | [ ] Night sweats / Afternoon fever |

**Temperature Pref:** ☐ Tend to feel Hot ☐ Tend to feel Cold ☐ Normal

**Beverage Pref:** ☐ Warm ☐ Cold ☐ Room Temp

## 7. GENDER-SPECIFIC HEALTH REVIEW

### Women's Health

Pregnant? ☐ Y ☐ N ☐ Unsure | Pregnancies: ___ Live Births: ___ Miscarriages: ___

Age at 1st Period: ___ | Cycle Length: ___ days | Flow Duration: ___ days

Flow: ☐ Light ☐ Normal ☐ Heavy | Color: ☐ Pale ☐ Red ☐ Dark/ Purple

Clots? ☐ Y ☐ N | Cramps? ☐ Y ☐ N (Sharp / Dull / Aching)

Menopause? ☐ Y ☐ N | Peri-menopausal symptoms: _____

**PMS Symptoms:** ☐ Breast Tenderness ☐ Bloating ☐ Mood Swings ☐ Headaches

### Men's Health

☐ Groin / Testicular Pain ☐ Enlarged Prostate

☐ Painful / Difficult Urination ☐ Erectile Dysfunction / Impotence

☐ Premature Ejaculation ☐ Nocturnal Emissions

Libido Level: ☐ Low ☐ Normal ☐ High

## 8. CLINIC POLICIES & FEE STRUCTURE

| Service Description | Duration | Fee | Details |
|---|---|---|---|
| **Initial Consultation & Acupuncture** | 60 - 90 mins | **£120** | Includes full intake assessment & initial treatment session. |
| **Follow-up Acupuncture Treatment** | 60 mins | **£85** | Recommended weekly for first 4 weeks for optimal results. |
| **Missed Appointment / Late Cancellation** | N/A | **Full Fee** | Applied if cancelled with less than 24 hours notice, regardless of reason. |

**Important Clinic Guidelines:**

- **Appointment Arrival:** Appointments may be scheduled outside standard office hours. If the door is locked upon arrival, please wait patiently as a treatment session may be concluding.
- **What to Bring:** Please bring a list of current medications (or original containers) and any recent blood work, X-rays, or medical reports.
- **Payment & Insurance:** Payment is due at the conclusion of each visit (Cash, Debit, or Credit accepted). We do not bill insurance companies directly; official receipts are provided for claim submission.
- **Scent-Free Policy:** Please refrain from wearing fragranced products (perfumes, lotions, scented hair products) on the day of your appointment to accommodate sensitive patients.

## 9. INFORMED CONSENT FOR TREATMENT

> Traditional Chinese Medicine (TCM) involves acupuncture (insertion of sterile single-use disposable needles), moxibustion, botanical/herbal therapies, and dietary recommendations aimed at balancing bodily functions and restoring health.

Please read carefully and initial each statement below prior to signing:

_____ **InitialsRisks & Disclosure:** I understand that potential risks of acupuncture treatment include temporary bruising, mild pain, local soreness, bleeding, or dizziness/fainting. I agree to notify the practitioner immediately of any pre-existing conditions, medications, or if I am pregnant/suspect pregnancy.

_____ **InitialsPrivacy & Records:** I understand that my medical records will be kept confidential and will not be disclosed to third parties without my explicit written consent, unless required by law.

_____ **InitialsFinancial Responsibility:** I acknowledge full responsibility for all consultation fees incurred at the time of service, as well as any applicable missed appointment fees (full charge for <24h cancellation).

_____ **InitialsHerbal Recommendations:** I understand that supplement or herbal recommendations are not included in standard acupuncture visits and require a separate dedicated Herbal Consultation visit following the initial assessment.

_____ **InitialsOutcome Disclaimer:** I acknowledge that no guarantee of specific clinical outcomes or results can be made by the practitioner.

I have read, understood, and voluntarily agree to the above terms and consent to treatment for the course of my care. I understand I may revoke my consent at any time.

**Patient / Legal Guardian Name (Printed)**

**Date (DD/MM/YYYY)**

**Patient / Legal Guardian Signature**

**Practitioner Signature**