Surfacing Wellness & Health

Lisa Reichert, L.Ac

Client Intake Form

Welcome to my practice. Here, we will establish a relationship to work on what is most important to you. Along the way concerns in other realms may arise, please feel free to bring those to me. We are partners in your well-being for the long term.

Thank you for providing a complete account of your health and well-being. Please bring any aspect of the questions or your responses to me. Details which seem inconsequential are usually useful in a TCM diagnosis. Provide as much detail as you would like for all the following questions and lists. Thank You.

Name____Referred by_______________________

Address ____

City, State, Zip____

Phone: Home_____________________Work_______________Cell/Pager________________________

Age____Ht_____Wt_____Occupation_____________________________________

Relationship Status ☐ Single, Live Alone ☐ Single, Shared Living ☐ Married ☐ Divorced

Emergency Contact____Phone: ____________________

Primary Care Practitioner/Physician:

Primary Concern

Please include, briefly, complaint, time of onset, cause (if known), factors that aggravate symptoms, and any other pertinent information.

What outcome would you like from acupuncture services?

Have you received acupuncture before? No Yes When? Condition?

How would you rate your current level of physical health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of mental health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Our Consent for your Treatment

I consent to receiving acupuncture and/ or other TCM procedures (for the patient named below, for whom I am legally responsible) by Lisa Reichert, L.Ac. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, Tui-Na (Chinese massage), and Chinese herbal supplements. All modalities will be fully explained prior to application.

I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to benefit the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese herbs. I understand that I may stop treatment at any time.

I further understand that the evaluation is an energetic assessment of the acupuncture meridian network, and in no way replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various “organs”, such as the heart, liver, spleen, kidneys, etc., which actually refers to the *energetic* channels of the same name.

I acknowledge that Lisa Reichert L.Ac is not, and does not profess to be, a western-trained medical doctor and does not advise on the use of medically-prescribed pharmaceuticals or medical treatment; nor does she provide any substances by injection. I acknowledge that Lisa Reichert L. Ac has completed a minimum of three years training in Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the state of Illinois.

Appointments

Payment for appointments are due at the time of service. I realize emergencies do arise. If you need to cancel, I do appreciate 24 hour notice. A $40 charge for late cancellations of private appointments could occur. Call my cell phone at any time: 773 805 1216. Do not cancel via email. Thank You.

HIPAA

The privacy of every patient's protected health information is mandatory. Since Surfacing Wellness & Health and Lisa Reichert, L.Ac maintain patient records; gather information from patients; engage in oral communication; and possibly transmit records (whether electronic or not), I am a "covered entity" and need a patient’s written authorization to contact you by phone, email, or mail and cannot assist in insurance reimbursement. Without your authorization I cannot confirm appointments, follow up a treatment, or update you with newsletters or flyers. If you are able to receive insurance reimbursement for acupuncture services, I cannot provide your information to assist in processing claims.

Signature ____ Date_________________

Patient or guardian

Witnessed by ____ Date_________________

Practitioner

Do you have any medical conditions ? Are you taking any prescribed medications for these?

Do you have any family history (siblings, parents, grandparents) of any illnesses, conditions, or diseases?

Within a week, how many cups of these do you consume daily?

Coffee | Soda
Espresso drinks | Water
Tea | Alcohol

Within a week, if you smoke, how many cigarettes or packs to do consume ?

List any known or suspected allergies or sensitivities to foods, medications or drugs.

Do you crave or have a preference for any of these

Sweet Salty Crunchy Spicy Sour Bitter Chocolate

How many servings a day to you consume of

Vegetables Fruit Protein Carbs (sandwich bread, bagels, muffins, pasta, rice, grains) Snacks or sweets

With what frequency do you exercise and which activities?

Male Patients Please check any that you experience now or experienced in the past

Urinary Frequency	Urinary Difficulty	Testicular Pain/Swelling
Penile Discharge	Breast Lumps	Reduced or Excessive Libido
Premature Ejaculation	Impotence	Other Concern/Condition

If Applicable:

Approximate date and results

PSA	Testicular exam	Fertility lab work

Female Patients

Pregnancy Are you presently pregnant? Y N Not sure

Number of pregnancies______ Births________ Abortions______ Miscarriages__________

What form of birth control have you or do you use?____

Date of last **Pap exam** and results

Have you ever had any gynecological surgeries or any abnormal findings on any tests?

If Applicable:

Approximate Date of last breast exam or mammogram and results

Approximate Date of last bone density scan and results

Fertility Have you had difficulty conceiving and what length of time?

Have you consulted with a physician and received any testing?

Are you charting basal body temperatures or pursuing allopathic fertility treatments?

Do you experience any

☐ Hot (warm) flashes ☐ Dry vaginal fluids ☐ Copious vaginal discharge ☐ Nipple discharge

Menstruation Age of first menses Age of menopause, if applicable

Date of Last Menstrual Period: Number of days of flow: General length of complete monthly cycle:

Are your cycles:

☐ Less than 28 days ☐ Greater than 32 days ☐ Varied ☐ Regular

Painful? ☐ Before ☐ During ☐ After

Is the flow ☐ Heavy ☐ Light ☐ Between periods ☐ After intercourse

Do clots or tissue accompany flow? No ☐ Early in the cycle ☐ Throughout

Relative to the blood **color and consistency** of a cut, is your menstrual blood:

☐ Same **color** ☐ Paler ☐ Purple ☐ Bright Red ☐ Brown

☐ Same **consistency** ☐ Watery ☐ Thick or Sticky ☐ Contains cervical fluid

If you experience **Pre-Menstrual Symptoms**, do you have any of the following ? How many days prior to flow do you notice them?

☐ Irritability/Frustration ☐ Depression ☐ Crying ☐ ☐ Anger/Rage ☐ Breast Tenderness

☐ Nausea ☐ Bloating/Water retention ☐ Headaches/Migraines Cravings ☐ Sleep disturbance

Are you experiencing any low or high sexual desires? Do you have any concerns surrounding this?

Do you have any other gynecological concerns or complaints?