Rising Sun Natural Health Solutions

acupuncture - supplements - nutrition

Patient Intake Form

Welcome! Please help me provide you with the best care by filling out this questionnaire carefully.
All your information will be confidential. If you have questions, please ask. Thank you.

Name:	Sex: □F □M Age: Date:
Birthday:	Marital Status □S □M □D □W
Address: _____ City _____ State___ Zip _____	Cell Phone: _____ Email: _____
Have you had acupuncture before? _____ Are you scared of needles? _____ Are you a vegetarian/vegan?	In Emergency Notify: _____ Phone # _____ Relationship:
Blood Type: O A B AB Occupation:	How did you hear about us?

Current Health Condition:

#1 Health Concern - _____
#2 Health Concern - _____
#3 Health Concern - _____
What is the most important thing I can do to help you? _____
_____
If you are experiencing pain, please rate your pain or discomfort on a scale of 1 to 10:
Very slight 1 2 3 4 5 6 7 8 9 10 Unbearable
How did it happen? _____
When did this problem begin? _____
What makes it feel better? _____ Worse? _____
Who else have you seen for this condition? _____
Type of treatment? _____ Results? _____

Past Medical History (include dates):

Surgeries_____
Major illness _____
Significant trauma (emotional or physical) _____
Allergies _____
Medications, vitamins, herbs taken within the last 3 months_____
_____
Occupational stress (chemical, physical, psychological) _____
Diet/Lifestyle (circle all that apply & how many daily): Coffee Black Tea Soda Alcohol Sugar/Sweets Salty Foods Margarine Fried Foods Artificial Sweetener Tobacco Recreational drugs Dairy Gluten Soy
How many glasses of water do you drink daily? _____

Exercise (please describe) _____
Do you have any root canals or mercury fillings? _____
Are you taking a statin drug for high cholesterol? _____
What vaccines have you had in the past year? _____
Did you get the Covid Vaccines? How many?_____
Do you sleep with your phone next to you? _____
Do you spend time outside without your shoes on (grounding)? _____
Do you have any scars on your body? Where? _____

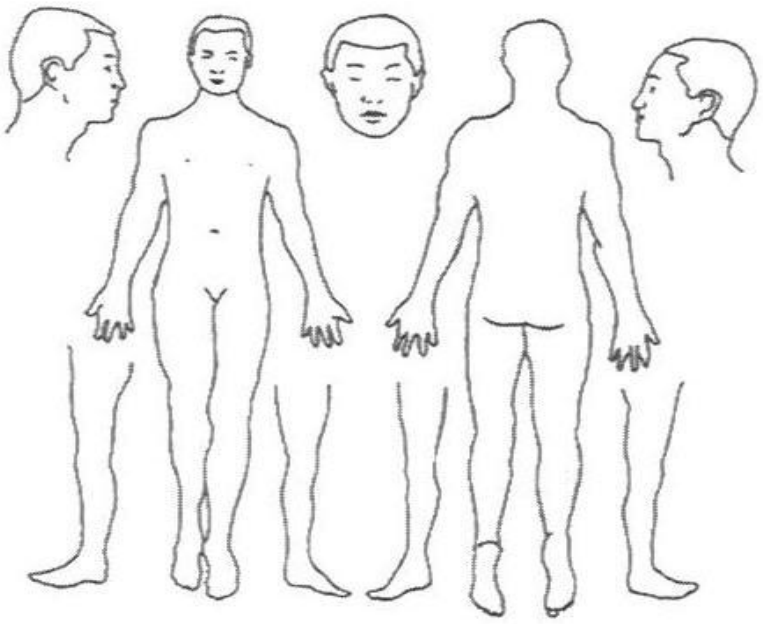
Average Daily Menu – Please list food & drinks:
Breakfast: _____
Lunch: _____
Dinner: _____

Please check any of the following that applies to you within last 3 months:

☐ Loose stools or diarrhea	☐ Indigestion	☐ Nausea or vomiting
☐ Flatulence	☐ Belching	☐ Varicose Veins
☐ Anemia	☐ Bruise easily	☐ Lack of Appetite
☐ Feeling of retention of food in stomach	☐ Bloating	☐ HIV positive or AIDS
☐ Sweat easily	☐ Prolapsed organs	☐ Eating disorder
☐ Tendency to be obsessive in your work/relationships		☐ Suicidal feelings
☐ Insomnia (what time?)_____	☐ Heart palpitations	☐ Restlessness
☐ Dream disturbed sleep/nightmares	☐ Anxiety attacks	☐ Easily startled
☐ Chest pain	☐ Racing of the heart	☐ Irregular heartbeat
☐ Headaches/migraines (where and when) _____		☐ Easily angered
☐ Poor vision	☐ High/Low Blood Pressure	☐ Arthritis
☐ Spots before eyes	☐ Ringing in ears/tinnitus	☐ Cataracts
☐ Gallstones	☐ Shingles	☐ Dizziness
☐ Eczema	☐ Shoulder or neck tension	☐ Herpes
☐ Difficult bowel movements	☐ Hemorrhoids	☐ Sciatica
☐ Hepatitis	☐ Soft or brittle nails	☐ Impatience
☐ Fullness behind ribs	☐ Indecisiveness	☐ Depression
☐ Cough	☐ Bronchitis	☐ Sadness
☐ Sinus congestion/infections	☐ Shallow breathing	☐ Sore throat
☐ Shortness of breath	☐ Asthma	☐ Emphysema
☐ Constipation	☐ Recent use of antibiotics	☐ Weak voice
☐ Nasal discharge (circle): Clear White Yellow Green Bloody Thick Thin and Watery		
☐ Skin problems: (what? where?) _____		
☐ Hearing loss	☐ Low back pain	☐ Weak knees
☐ Edema or swelling	☐ Hair loss	☐ Prostate disorders
☐ Impotence	☐ Urinary disorders	☐ Osteoporosis
☐ Teeth/gum problems	☐ Reduced sexual energy	☐ Fearfulness
☐ Spontaneous sweating	☐ No energy to speak	☐ Lack of strength
☐ Dislike physical movement	☐ General physical weakness	☐ General fatigue
☐ Blurred vision	☐ Dry, brittle hair	☐ Poor memory
☐ Skin rashes	☐ Numbness (where?) _____	
☐ Aversion to cold	☐ Cold hands and feet	☐ Easily chilled
☐ Frequent clear urination	☐ Lack of thirst	☐ Desire for hot drinks
☐ Frequently thirsty	☐ Hot hands and feet	☐ Night sweats
☐ Low-grade afternoon fever	☐ Dry throat	☐ Red, flushed cheeks

Family Medical History: (please circle): Diabetes Cancer High Blood Pressure Stroke Asthma Allergies Alcoholism/Addiction Hysterectomy Heart Disease Prostate Disorders Kidney Disorders Digestive Disorders Depression/Mental Disorders

Please indicate areas of discomfort/pain:



Gynecological:

Is there any possibility that you are pregnant? □Yes □No Birth Control _____
Pregnancies___ # Births____ # Premature births____ # Miscarriages____ # Abortions____
Menstrual Flow: □ Heavy □ Light □ Clots □ Painful Color of menses_____
Number of days between periods: _____ Length of Period:_____
Date of last period: _____ Date of Last Pap: _____ Pap Result: _____
Age at first menses: ___ Spotting between periods: □Yes □No Vaginal sores:□Yes □No
PMS: □Breast Soreness □Bloating □Moodiness □Irritability □Cramps other: _____
Perimenopausal: □Skipped/Irregular periods □Hot Flashes □Moodiness □Vaginal Dryness
Menopause : Age____ Hysterectomy (age and reason):_____
□Vaginal Discharge (describe) _____
□ Breast lumps/cysts _____
□ Endometriosis (when) _____
Other_____

Other:

Please let me know if there are any other issues that you would like to discuss:_____
_____
_____

Financial agreement:

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $30 returned check charge in the event that my check is returned.

Date_____ Patient's Signature_____

Notification Form Regarding Evaluation of Patient by Physician

(The following documentation is required by law pursuant to the Texas Revised Civil Statutes, Article 4495, Medical Practice Act of Texas, Subchapter F., regarding Acupuncture Practice, Sec. 6.11, subsections (b) through (d):

Please read and check the appropriate answers:

1) I have been evaluated by a physician or dentist for the condition being treated within the last 12 months prior to having acupuncture performed. □ Yes □ No

2) I have received a referral from my chiropractor within the last 30 days for acupuncture. □ Yes □ No

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. In being referred by my chiropractor, if after 120 days or 30 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

Patient signature _____ Date _____

If you answered no to both of the above questions, I, Kimberly A. Kraus LAc, am requesting that you see a physician. It is your responsibility and choice whether to follow this advice.

The Rising Sun Natural Health Solutions is not responsible for untrue statements made by patients.

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