KIRK & KIRK HEALTH CLINIC, P.C.

1539 W. Andrew Johnson Hwy, Morristown, TN 37814
(423) 585-5556

ACUPUNCTURE

Intake Form

Name (last, first)_____ Date_____

Address_____

City / State / Zip_____

Date of Birth_____ Age _____ Height_____ Weight_____

Home #_____ Work # _____

Cell #_____ Occupation_____

Emergency contact (name and #) _____

Referred by_____

____ Single ____Married ____ Divorced ____ Significant Other ____ Widowed

Have you ever had acupuncture? _____ If yes, when?_____ for what condition?_____ by whom?_____

Are you currently under the care of a physician? _____ If yes, who and for what condition(s)? _____

Have you seen any other health care provider for this condition? If yes, please explain diagnosis& treatment:_____

Main reason(s) for seeking acupuncture today: _____
_____

Date it began or when did you first notice symptoms: _____

Your condition is improved by? _____

Your condition is aggravated by? _____

List all current medications (prescribed or over the counter), vitamins, herbs and other supplements: _____
_____

Please list any surgeries you've had including dates: _____
_____

Please list any allergies: _____

Please list any major emotional or physical traumas you've experienced: _____
_____

Lifestyle (please check all that apply and note frequency of use):

____ Tobacco Frequency_____
____ Alcohol Frequency_____
____ Coffee Frequency_____
____ Soft Drinks Frequency_____
____ Tea Frequency_____
____ Water Frequency_____

Do you exercise? _____ Please list types of activity & frequency: _____
_____

Do you east the following foods?

_____ Red Meat ____ X per week
_____ Fish ____ X per week
_____ Artificial sweeteners ____ X per week
_____ Fast Food ____ X per week
_____ White flour breads, pretzels, etc.
_____ Salads
_____ Cooked Vegetables
_____ Eggs

EMOTIONAL STRESS SCALE (1 is low, 10 is high)

1 2 3 4 5 6 7 8 9 10

Do you suffer from? ____ Depression ____ Anxiety ____ Cry easily ____ Irritability

Are you pregnant? _____ Due date?_____
Have you miscarried in the past 12 months? _____

Are you experiencing menopausal symptoms? _____ Please explain:_____
_____

Are you on Hormone Replacement Therapy? ____ Which type? _____

PLEASE CHECK ANY OF THE FOLLOWING APPLY TO YOU:

WATER ELEMENT

___ Hearing Loss
___ Dizziness
___ Lower back/neck pain
___ Sinus congestion
___ Edema
___ Darkness under eyes
___ Emotional instability
___ Aversion to cold
___ Hair thinning or loss
___ Pre-mature aging
___ Frequent urination
___ Kidney stones
___ Perspire very easily
___ Weakness of legs/knees
___ Asthmatic cough
___ Rapid weight change
___ Loose teeth
___ Reduced sexual energy
___ Thyroid problems
___ Diabetes

WOOD ELEMENT

___ Headaches
___ Migraines
___ Ringing in ears
___ Poor eyesight
___ Eye infections
___ Dry eyes
___ Eczema
___ Shingles
___ Herpes simplex
___ Warts
___ Nervousness
___ Convulsion, spasms
___ Irritability
___ Constipation
___ Hemorrhoids
___ Hepatitis
___ Ulcer
___ Vomiting
___ Gallstones
___ Indecisive
___ Fullness below ribs
___ Shoulder / neck tension
___ Insomnia 11PM – 3AM

FIRE ELEMENT

___ Dry Scalp
___ Rashes, skin eruptions
___ Cysts, tumors
___ Ear infections
___ Sore throat/tonsillitis
___ Lymphatic swelling
___ Hot palms & soles
___ Heart Palpitations
___ Aversion to heat
___ Bitter taste in mouth
___ Gum problems
___ Nose bleed
___ Facial redness
___ Itching / burning skin
___ Hot hands / feet
___ Thirst
___ Vivid dreaming
___ Dark urine
___ Night sweats

METAL ELEMENT

___ Bronchitis
___ Asthma
___ Shallow breathing
___ Cough
___ Sinus congestion
___ Nasal infection

EARTH ELEMENT

___ Indigestion
___ Flatulence
___ Food allergy
___ Stomach ache / ulcer
___ Diarrhea
___ Anemia
___ Halitosis
___ Sores in mouth
___ Heartburn
___ Strong appetite
___ Weak appetite
___ Nausea
___ Abdominal bloating
___ Low body weight

OTHER

___ Fatigue
___ Arthralgia
___ Sciatica / nerve pain
___ Cold hands / feet
___ Tendonitis
___ Bursitis

FEMALE CLIENTS ONLY

___ Vaginal infection
___ Yeast infection
___ Urinary tract infection
___ Ovarian cyst
___ Pelvic inflammatory disease
___ Excessive bleeding
___ Breast lumps
___ Irregular periods
___ Menstrual cramping
___ Pre-menstrual syndrome
___ Infertility
___ Genital burning
___ Positive PAP
___ Hemorrhoids
___ Anal fissure

_____ # of children you have had

MALE CLIENTS ONLY

___ Prostatitis
___ Urinary incontinence
___ Nocturnal emission
___ Burning urination
___ Pre-mature ejaculation
___ Impotence

Anything you wish to add? _____
_____

CONSENT FOR TREATMENT

I authorize Dr. Mike D. Kirk to perform acupuncture and to administer whatever treatment deemed necessary to treat my present condition (symptoms).

In addition to the above, I understand that I have been given the opportunity to read and review the Kirk & Kirk Health Clinic, P.C. Notice of Privacy Policies.

The above information is true to the best of my knowledge. I clearly understand, accept and agree that all services rendered me are charged directly to me and that I am personally responsible for payment in full at the time of service. If payment is collected by an attorney, by suit or otherwise, I, or we, agree to pay all fees and collection costs.

Patient's Signature_____ Date_____

Guardian /Spouse's signature authorizing care_____ Date_____

1/29/2010

KIRK & KIRK HEALTH CLINIC, P.C.
1539 WEST ANDREW JOHNSON HIGHWAY
MORRISTOWN, TN 37814

NAME:_____**DATE OF BIRTH:**_____

I hereby authorize the following individual(s), other than myself, to receive information regarding my healthcare, diagnostic results, appointments, billing and/or collections:

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

Name:_____Date of birth:_____Relationship:_____

Signature of patient:_____**Date**:_____

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I hereby authorize Kirk & Kirk Health Clinic, P.C. to leave messages pertaining to my appointments, billing, and / or collections at the following numbers (on file or given on current message):

____ cell phone

____home phone

____work phone

____other_____

Signature of patient:_____**Date:**_____