Northfield
Acupuncture & Alternative Medicine Clinic
"Where Natural Healing Begins"

Intake Form

Name Last-_____First_____Middle_____SSN #_____/_____/_____

Date of Birth_____/_____/_____ **Gender** F ____M _____ **Email** _____

Address _____City _____State_____Zip Code_____

Telephone: Home (_____)_____-_____ Work (_____) _____-_____Ext._____

Marital Status: _____**Education** (Highest grade or degree achieved)_____

Option: Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic?_____

Have you been treated by Acupuncture or Oriental medicine before? _____

Name of your physician:_____Tel:_____

Address of your physician: _____City _____State _____Zip Code_____

In an Emergency Notify Name_____ Relationship to client_____

Phone (Day) (_____)_____-_____(Evening) (_____)_____-_____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____
3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? _____
5. Are you currently receiving treatment for your problem? _____If so, please describe:
   _____
6. Does anything improve your problem? _____

PAST MEDICAL HISTORY

Illnesses: _____
_____

Surgeries_____
_____

Significant Trauma (Auto accidents, falls, etc.) _____
Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐
If so, please describe _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Fatigue
- ☐ Tremors
- ☐ Seizures
- ☐ Night Sweats
- ☐ Change in Appetite
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drops?

What time of Day? _____

- ☐ Poor Sleep/ Insomnia
- ☐ Dream Disturbed Sleep
- ☐ Depression
- ☐ Mania
- ☐ Emotional Changes
- ☐ Day Sweating
- ☐ Poor Balance
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Poor Appetite
- ☐ Strong thirst for Hot or Cold drinks?
- ☐ Headaches
- ☐ Localized Weakness
- ☐ Bleeding or Bruising
- ☐ Joint Pain

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold Sweats
- ☐ Swelling of Feet
- ☐ Swelling of Hands
- ☐ Difficulty in Breathing
- ☐ Cold Hands/Feet
- ☐ Phlebitis
- ☐ Blood Clots
- ☐ Palpitations

RESPIRATORY

- ☐ Cough
- ☐ Asthma
- ☐ Easily Winded w/ Exertion when laying down
- ☐ Production of phlegm
- ☐ Pain w/ Deep Breaths
- ☐ Bronchitis

What Color? _____

- ☐ Difficulty in Breathing
- ☐ Shortness of Breath
- ☐ Coughing Blood

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Ulcers
- ☐ Hernia
- ☐ Abdominal Pain/ Cramps
- ☐ Parasites
- ☐ Belching
- ☐ Bad Breath
- ☐ Hemorrhoids
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools

GENITO-URINARY

- ☐ Pain on Urination
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Unable to Hold Urine
- ☐ Decrease in Urine
- ☐ Blood in Urine
- ☐ Impotency/ Infertility
- ☐ Genital Sores
- ☐ Kidney sores
- ☐ Waking up to Urinate

How often? _____

MUSCULOSKELETAL

- ☐ Muscular Weakness
- ☐ Muscle Cramps
- ☐ Injuries or Falls
- ☐ General Aches
- ☐ Arthritis
- ☐ Spasms
- ☐ Muscular Atrophy
- ☐ Joint Instability
- ☐ Recent Sprains

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies:

_____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____
Father's Side _____
Siblings _____
If any of the above is deceased, what was the cause? _____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____
Childhood health _____
Location of upbringing (Geographically prone to certain diseases, habits, etc.) _____
Current Emotional Health _____
Current Quality of Life _____
Current Relationship/Quality _____
Current Predominant Emotiom _____
Occupation _____ Stress Level _____
Have you had any unusual stresses recently? _____
Favorite time of year (body type) _____ Worst _____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe: _____
Have you traveled abroad in the past year? Yes ☐ No ☐ Where? _____
If applicable, please describe smoking or alcohol intake : _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Areas of Numbness	☐ Anxiety
☐ Concussion	☐ Lack of Coordination	☐ Poor Memory
☐ Dizziness	☐ Loss of Balance	☐ Easily Angered
☐ Headaches	☐ Fainting	☐ Depression
☐ Migraines	☐ Disorientation	☐ Mania
☐ Easily Susceptible to Stress		

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____
Any nervous habits? _____

PREGNANCY & GYNECOLOGY

___Age at First Menses	___ Number of Pregnancies	☐ Birth Control?
___Period between Menses	___ Number of Births	What type? _____
___Duration of Menses	___ Miscarriages	How long? _____
☐ Unusual Character	___Abortions	☐ Fertility Problems
☐ Heavy or ☐ Light	☐ Difficult Births	☐ Vaginal Discharge
☐ Irregular Periods	☐ Breast Lumps	☐ Vaginal Sores
☐ Painful Periods	☐ Clots	

First Date of Last Menstrual Cycle _____/_____/_____ Date of Last Pap Smear _____/_____/_____
Do you experience changes in Body and/or Psyche prior to menstruation ? _____

Welcome to…

Northfield
Acupuncture & Alternative Medicine Clinic
"Where Natural Healing Begins"

We are excited that you have chosen Dan Martin, O.M.D., D.O.M. as your health care practitioner. This letter is designed to help you understand more about Northfield Acupuncture and Alternative Medicine Clinic.

The office is open for appointments Tuesday through Friday 9am to 5pm and Saturday 9am to 12 pm. Please make your appointment in advance if possible. If you are unable to keep your scheduled appointment, please call at least 24 hours in advance to reschedule for a more convenient time. Any appointment that is not rescheduled in advance or is a "no-call no-show" will be charged a $42 rescheduling fee. Walk-ins are welcome, although scheduled appointments will be given priority.

At Northfield Clinic, your health is our top priority. Cooperation and consistency on your part will speed you down the road to better health. All new patient paperwork, surveys, and questionnaires are required to be filled out prior to seeing the doctor. The information they provide us is very important. Please do not "over think" your answers on the questionnaires and surveys. There is no wrong or right answer, only what best describes your situation.

Your treatment may require multiple visits to get you to where you need to be. For example, if you are receiving acupuncture for back pain or neck pain, the number of treatments required can vary from 5 to 20. IV therapy can be up to and above 20 treatments. Long gaps between treatments can set back your recovery and extend the number of treatments required. These are examples, and your case will vary depending upon your condition. Following the recommended dietary, supplement, exercise, and rest regimens will also increase the effectiveness of your treatments.

Payment is due when services are rendered. If you have questions about the price of your treatment, please ask the office manager.

Good health takes time, commitment and cooperation. If you feel that your treatments are working, tell us! If you feel that your treatments are not working or if you do not feel that you are healing as you anticipated, let us know. We do not know how you feel or if your treatments are working unless you inform us. Our ability to treat you depends on your input. We are a team, and your health is our long term goal. If you have any questions, feel free to ask us.

CANCELLATION POLICY

Patients must call to cancel all appointments at least 24 hours prior to appointment time & date.

If appointment is not cancelled, a $42 office visit charge will be posted to your account.

Initial after reading _____

F.D.A STATEMENT

The statements and opinions expressed by Dan Martin O.M.D., D.O.M. of Northfield Acupuncture and Alternative Medicine Clinic. Written, audio, video and other formats have not been evaluated by the Food and Drug Administration (FDA).

Information and/or treatments received from Dan Martin O.M.D., D.O.M. / Northfield Acupuncture and Alternative Medicine Clinic are not approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent any disease.

I have read and understand the above policies. I understand that my health will take time and commitment on my part.

Signed: _____ Date:_____

Northfield Acupuncture & Alternative Medicine Clinic, Inc.

619 E. 6th St.

Texarkana, AR 71854

(870)772-8622

CONSENT FOR ORIENTAL MEDICINE

The practice of oriental medicine in Arkansas is a distinct system of primary health care with the goal of prevention, cure, or correction of any illness, injury pain or other physical or mental condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health. Oriental medicine includes all traditional and modern diagnostic, prescriptive and therapeutic methods utilized by practitioners of acupuncture and oriental medicine worldwide. The scope of practice of Doctors of Oriental Medicine shall include but is not limited to:

1. Evaluation and management services;
2. Examination and diagnostic testing;
3. The ordering of radiological, laboratory or other diagnostic tests;
4. The procedures of acupuncture, injection therapy and other related procedures;
5. The stimulation of points or areas of the body using needles, heat, cold, light, lasers, sound, vibration, magnetism, electricity, bleeding, suction, pressure, or other devices or means;
6. Physical medicine modalities and procedures;
7. Therapeutic exercises, breathing techniques, meditation, and the use of biofeedback and other devices that utilize color, light, sound, electromagnetic energy and other means therapeutically;
8. Dietary and nutritional counseling and the administration of food, beverages and dietary supplements therapeutically;
9. The prescription or administration of any herbal medicine, homeopathic medicine, or substances such as vitamins, minerals, enzymes, glandulars, amino acids and nutritional or dietary supplements; and
10. Counseling regarding physical, emotional and spiritual balance in lifestyle.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Side effects may include, but are not limited to the following: pain following treatment in insertion area, minor bruising, infection, needle sickness, broken needle, temporary discoloration of the skin, aggravation of symptoms existing prior to the treatment.

Patients with bleeding disorders, pacemakers, seizure disorders, or women who are currently pregnant, please notify the Doctor of Oriental Medicine.

Potential benefits: Relief of presenting symptoms, improved general health, elimination of the presenting problem, reduction of pain and associated symptoms.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dan L. Martin, D.O.M. regarding cure or improvement of my condition. I hereby release Dan L. Martin, D.O.M. from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of Patient or Guardian_____

Date_____