Karen Chan
ACUPUNCTURE
4220 H Street, Sacramento, CA 95819
916-452-5170

Patient Intake Form

Today's Date: _____

Patient Name: _____ Date of birth: _____Gender: _____ Age: _____

Address: _____ City:_____State: ____ Zip: _____

Birthplace: _____Number of Children:_____

Email: _____

Cell Phone: _____ Home phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's name: _____ Phone: _____

Emergency Contact Name and Relationship: _____ Phone: _____

How did you hear about Karen Chan Acupuncture? _____

Who referred you so we can thank them?_____

_____

Is there a family history of:

___ Cancer ___ TB ___ Diabetes ___ Arthritis ___ High Blood Pressure ___ Mental Illness ___ Asthma

___ Allergies ___ Other, please list: _____

_____

Please check all that apply to you:

___ Allergies ___ Anemia ___ High Blood Pressure ___Heart Trouble ___ Hepatitis ___ HIV/AIDS

___ Covid (if so, number of times): _____ Dates: _____

Other, please list: _____

_____

General Health: (Please select all that apply)

Weight: _____
Height: _____
Blood Pressure: _____
Appetite: ___ Low
___ Moderate ___ High
___ Thirst for water ___ Glasses/Day
___ Coffee ___ Cups/Day
___ Soda ___ Cans/Day
___ Artificial Sweeteners

___ Alcohol ___ Glasses/Day
___ Smoking ___ Cigarettes/Day
___ Marijuana ___ Times/Day
___ Other Drugs: _____
Occupational Hazards: _____
___ Work with chemicals
___ Work involves sitting a lot
___ Physical work

___ Driving a lot
___ Exercise regularly
___ Eat regular meals
___ Get enough sleep
___ Use Sleeping Pills: ___ Qty/Night
___ Stress Level: ___ Mild ___ Moderate
___ High ___ Extreme
Temperature: ___ Often Cold
___ Often Hot ___ Comfortable

Main Complaint(s) in order of importance to you and date of onset:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you been treated for this condition before? ___ Yes ___ No

If so, when and what means of treatment? _____

_____

List any surgeries you've had and the date:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List any medications, OTC prescriptions, herbs you are taking:

1. _____
2. _____
3. _____

Any additional information you would like to add:

_____

_____

_____

Musculoskeletal

___ Muscle pain
___ Muscle cramps/ spasm
___ Painful/swollen joints
___ Hip tightness
___ Cold pain
___ Poor circulation
___ Weak limbs
___ Arthritis
___ Stiffness/Limited range of motion
___ Bursitis
___ Neck pain/stiff neck
___ Shoulder Pain
___ Upper back pain
___ Mid back pain
___ Lower back pain
___ Hip pain
___ Sciatica Pain
___ Numbness/tingling in limbs
___ Burning Sensation
___ Swollen joints
___ Loss of grip
___ Hand or finger pain
___ Wrist pain
___ Elbow pain
___ Knee pain
___ Ankle pain
___ Foot pain
___ Hernia disc
___ Scoliosis

Male

___ Low or no sex drive
___ Excess sexual desire
___ Impotence
___ Infertility
___ Hernia
___ Prostate problem
___ Painful testicles
___ Seminal emission
___ Weak urine system
___ Dribbling urination
___ Urethra discharge

Female

Age started menstrual cycle: _____
Age stopped: _____
Date of last cycle: _____
Date of last PAP test: _____
# of Pregnancies: _____
# of Miscarriages: _____
# of Abortions: _____
Age at menopause: _____
___ Hot Flashes
___ Vaginal Dryness

Length of cycle: _____
Intervals between cycle: _____
Date last period began: _____
Quality of flow:
___ Dark ___ Clots ___Bright
___Excessive __ Irregular Cycles
___ Light scanty bleeding
___ Missed Period
___Lower backache
___ Mood changes

___ Lump in breasts/painful breasts
___ Ovarian Cysts
___ Uterine cysts or tumors
___ Excessive vaginal discharge
___ Vaginal soreness
___ Vaginal itch
___ Vaginal odor
___ Vaginal discharge color: _____
___ Water Retention
Other: _____

Please mark **X** for present condition,
P for past condition.

Liver/ Gallbladder
___ Irritability
___ Anger / Frustration
___ Argumentative / Aggressive
___ Depression
___ Headaches / migraines
___ Red eyes
___ Dry itchy eyes
___ Spots in front of eyes
___ Blurred vision
___ Night blindness
___ Sensitive to sunlight
___ Feeling a lump in throat
___ Clenching of teeth at night
___ Muscle cramping / twitching
___ Joints feel tight / stiff
___ Abdominal pain / rib pain
___ Mood swings
___ Easily stressed
___ Nervous
___ Cold hands / feet
___ Soft / brittle nails
___ Bitter taste in mouth (all day)
___ Difficulty making decisions
___ Craving / avoiding sour foods

Kidney / Urinary Bladder
___ Frequent urination
___ Burning / painful urination
___ Incontinence
___ Incomplete urination
___ Genital discharge
___ Recurrent bladder infection
___ Weakness / Pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual energy
___ Excess sexual desire
___ Short term memory
___ Loss of hair
___ Hearing problems
___ Ringing in ears
___ Ear aches, infection
___ Craving / avoiding salty food

Heart Small / Intestine
___ Heart palpitations
___ Chest pain
___ Dizziness
___ Insomnia
___ Poor memory
___ Easily startled
___ Easily sweat
___ Restlessness / agitation
___ Impulsive
___ Anxiety
___ Shortness of breath on exertion
___ Vivid dreams
___ Nightmares
___ Lack of joy in life
___ Laughing for no reason
___ Bitter taste in mouth (am)
___ Craving / avoiding bitter foods

Lung / Large Intestine
___ Dry cough
___ Cough with sputum
___ Sinus problem
___ Poor sense of smell
___ Chronic cough
___ Dry mouth
___ Skin rashes
___ Itchy skin
___ Hives
___ Worry
___ Grief, sadness
___ Shortness of breath
___ Spontaneous sweating
___ Allergies
___ Sore throat
___ Hoarse voice
___ Frequent colds
___ Low physical stamina
___ Craving / avoiding spicy food

Spleen / Stomach
___ Heaviness anywhere in body
___ Fatigue all the time
___ Hard to get up in the morning
___ Afternoon fatigue
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising and bleeding
___ Acne
___ Bad breath
___ Undigested food
___ Low/excessive appetite
___ Frequently snacking
___ Tendency towards hypoglycemia
___ Difficulty digesting oily foods
___ Chemical sensitivities
___ Nausea
___ Vomiting
___ Gas belching
___ Hiccup
___ Bloating
___ Hemorrhoids
___ Constipation / Diarrhea
___ Indigestion / heartburn
___ Ulcers
___ Abdominal pain
___ Over-thinking
___ Poor memory
___ Tendency to become obsessive
___ Bleeding or painful gums
___ Difficulty swallowing
___ Sticky stool
___ Mucous stool
___ Bowel Movements
Frequency: _____
Color:_____
Odor: _____
___ Craving / avoid sweets

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future may treat me while employed, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tul-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling. Sometimes blisters can occur with moxibustion.

I understand sterile disposable needles will be used and may be placed in the external ear and/or body points.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain disease of dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, slight bleeding, temporary discomfort, infections, scarring and hematoma at site of needle. There have been extremely rare Instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risk and complications, and I wish to reply on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

☐ I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Cancellation Policy

- Appointment cancellations must be made at least 48 hours in advance to avoid a $65 cancellation fee.
- "No Show" and cancellations on the day of your appointment are billed the entire charge of the appointment as I am unable to fill that time.

☐ I have read and acknowledge the cancellation policy listed above. By signing below, I am giving consent to charge my card due to last minute cancellations or no-show appointments.

ARE YOU PREGNANT? ___YES ___NO DO YOU HAVE A PACEMAKER? ___YES ___NO

Patient Signature: (If minor, parent or guardian) _____ Date Signed: _____

Print Name: _____ Relationship to Patient: _____

Name of Acupuncturist: ___ Karen Chan L.Ac. _____

Systems Survey Form |

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1.	1	2	3	Acid foods upset
2.	1	2	3	Get chilled often
3.	1	2	3	"Lump" in throat
4.	1	2	3	Dry mouth, eyes, nose
5.	1	2	3	Pulse speeds after meal
6.	1	2	3	Keyed up, fail to calm
7.	1	2	3	Gag occasionally
8.	1	2	3	Unable to relax, startle easily
9.	1	2	3	Extremities cold, clammy
10.	1	2	3	Strong light irritates
11.	1	2	3	Occasionally weak urine flow
12.	1	2	3	Heart pounds after retiring
13.	1	2	3	"Nervous" stomach
14.	1	2	3	Appetite reduced occasionally
15.	1	2	3	Cold sweats often
16.	1	2	3	Get heated easily
17.	1	2	3	Nerve discomfort
18.	1	2	3	Staring, blink little
19.	1	2	3	Sour stomach frequent

____ ____ ____ TOTAL
1 2 3

GROUP 2

20.	1	2	3	Joint stiffness after arising
21.	1	2	3	Muscle, leg, toe cramps at night
22.	1	2	3	"Butterfly" stomach, cramps
23.	1	2	3	Eyes or nose watery
24.	1	2	3	Eyes blink often
25.	1	2	3	Eyelids swollen, puffy
26.	1	2	3	Indigestion soon after meals
27.	1	2	3	Always seem hungry, feel "lightheaded" often
28.	1	2	3	Digestion rapid
29.	1	2	3	Vomit occasionally
30.	1	2	3	Hoarseness frequent
31.	1	2	3	Uneven breathing
32.	1	2	3	Pulse slow
33.	1	2	3	Gagging reflex slow
34.	1	2	3	Difficulty swallowing
35.	1	2	3	Temporary constipation or diarrhea
36.	1	2	3	"Slow starter"
37.	1	2	3	Get "chilled"
38.	1	2	3	Perspire easily
39.	1	2	3	Sensitive to cold
40.	1	2	3	Upper respiratory challenges

____ ____ ____ TOTAL
1 2 3

GROUP 3

41.	1	2	3	Eat when nervous
42.	1	2	3	Excessive appetite
43.	1	2	3	Hungry between meals
44.	1	2	3	Irritable before meals
45.	1	2	3	Get "shaky" if hungry
46.	1	2	3	Fatigue, eating relieves
47.	1	2	3	"Lightheaded" if meals delayed
48.	1	2	3	Heart palpitates if meals missed or delayed
49.	1	2	3	Fatigue in afternoon
50.	1	2	3	Overeating sweets upsets
51.	1	2	3	Awaken after few hours sleep, hard to get back to sleep
52.	1	2	3	Crave candy or coffee in afternoon
53.	1	2	3	Moods of "blues" or melancholy
54.	1	2	3	Craving for sweets or snacks

____ ____ ____ TOTAL
1 2 3

GROUP 4

55.	1	2	3	Hands and feet go to sleep easily, numbness
56.	1	2	3	Sigh frequently, "air hunger"
57.	1	2	3	Aware of "breathing heavily"
58.	1	2	3	High-altitude discomfort
59.	1	2	3	Open windows in closed room
60.	1	2	3	Immune system challenges
61.	1	2	3	Afternoon "yawner"
62.	1	2	3	Get "drowsy" often
63.	1	2	3	Swollen ankles worse at night
64.	1	2	3	Muscle cramps, worse during exercise; get "charley horse"
65.	1	2	3	Difficulty catching breath, especially during exercise
66.	1	2	3	Tightness or pressure in chest, worse on exertion
67.	1	2	3	Skin discolors easily after impact
68.	1	2	3	Tendency to anemia
69.	1	2	3	Noises in head or "ringing in ears"
70.	1	2	3	Fatigue upon exertion

____ ____ ____ TOTAL
1 2 3

GROUP 5

71.	1	2	3	Dizziness
72.	1	2	3	Dry skin
73.	1	2	3	Burning feet
74.	1	2	3	Blurred vision
75.	1	2	3	Itching skin and feet
76.	1	2	3	Hair loss
77.	1	2	3	Occasional skin rashes
78.	1	2	3	Bitter, metallic taste in mouth in morning
79.	1	2	3	Occasional constipation
80.	1	2	3	Worrier, feels insecure
81.	1	2	3	Nausea occasionally after eating
82.	1	2	3	Greasy foods upset
83.	1	2	3	Stools light-colored
84.	1	2	3	Skin peels on foot soles
85.	1	2	3	Discomfort between shoulder blades
86.	1	2	3	Occasional laxative use
87.	1	2	3	Stools alternate from soft to watery
88.	1	2	3	Sneezing attacks
89.	1	2	3	Dreaming, nightmare-type bad dreams
90.	1	2	3	Bad breath (halitosis)
91.	1	2	3	Milk products cause upset
92.	1	2	3	Sensitive to hot weather
93.	1	2	3	Burning or itching anus
94.	1	2	3	Crave sweets

____ ____ ____ TOTAL
1 2 3

GROUP 6

95.	1	2	3	Loss of taste for meat
96.	1	2	3	Lower bowel gas several hours after eating
97.	1	2	3	Burning stomach sensations, eating relieves
98.	1	2	3	Coated tongue
99.	1	2	3	Pass large amounts of foul-smelling gas
100.	1	2	3	Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101.	1	2	3	Watery or loose stool
102.	1	2	3	Gas shortly after eating
103.	1	2	3	Stomach "bloating"

____ ____ ____ TOTAL
1 2 3

GROUP 7A

104.	1	2	3	Difficulty sleeping
105.	1	2	3	On edge
106.	1	2	3	Can't gain weight
107.	1	2	3	Intolerance to heat
108.	1	2	3	Highly emotional
109.	1	2	3	Flush easily
110.	1	2	3	Night sweats
111.	1	2	3	Thin, moist skin
112.	1	2	3	Inward trembling
113.	1	2	3	Heart races
114.	1	2	3	Increased appetite without weight gain
115.	1	2	3	Pulse fast at rest
116.	1	2	3	Eyelids and face twitch
117.	1	2	3	Irritable and restless
118.	1	2	3	Can't work under pressure

____ ____ ____ TOTAL
1 2 3

GROUP 7B

119.	1	2	3	Increase in weight
120.	1	2	3	Decrease in appetite
121.	1	2	3	Fatigue easily
122.	1	2	3	Ringing in ears
123.	1	2	3	Sleepy during day
124.	1	2	3	Sensitive to cold
125.	1	2	3	Dry or scaly skin
126.	1	2	3	Temporary constipation
127.	1	2	3	Mental sluggishness
128.	1	2	3	Hair coarse, falls out
129.	1	2	3	Tension in head upon arising wears off during day
130.	1	2	3	Slow pulse below 65
131.	1	2	3	Changing urinary function
132.	1	2	3	Sounds appear diminished
133.	1	2	3	Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

134.	1	2	3	Failing memory with age
135.	1	2	3	Increased sex drive
136.	1	2	3	Episodes of tension in head
137.	1	2	3	Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

138.	1	2	3	Abnormal thirst
139.	1	2	3	Bloating of abdomen
140.	1	2	3	Weight gain around hips or waist
141.	1	2	3	Sex drive reduced or lacking
142.	1	2	3	Tendency for stomach issues
143.	1	2	3	Immune system challenges
144.	1	2	3	Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

145.	1	2	3	Dizziness
146.	1	2	3	Headaches
147.	1	2	3	Hot flashes
148.	1	2	3	Hair growth on face or body (female)
149.	1	2	3	Sugar in urine (not diabetes)
150.	1	2	3	Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

151.	1	2	3	Weakness, dizziness
152.	1	2	3	Tired throughout day
153.	1	2	3	Nails weak, ridged
154.	1	2	3	Sensitive skin
155.	1	2	3	Stiff joints
156.	1	2	3	Perspiration increase
157.	1	2	3	Bowel discomfort
158.	1	2	3	Poor circulation
159.	1	2	3	Swollen ankles
160.	1	2	3	Crave salt
161.	1	2	3	Areas of skin darkening
162.	1	2	3	Upper respiratory sensitivity
163.	1	2	3	Tiredness
164.	1	2	3	Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

165.	1	2	3	Muscle weakness
166.	1	2	3	Lack of stamina
167.	1	2	3	Drowsiness after eating
168.	1	2	3	Muscular soreness
169.	1	2	3	Heart races
170.	1	2	3	Hyperirritable
171.	1	2	3	Feeling of a band around head
172.	1	2	3	Melancholia (feeling of sadness)
173.	1	2	3	Swelling of ankles
174.	1	2	3	Change in urinary function
175.	1	2	3	Tendency to consume sweets/carbohydrates
176.	1	2	3	Muscle spasms
177.	1	2	3	Blurred vision
178.	1	2	3	Involuntary muscle action
179.	1	2	3	Numbness
180.	1	2	3	Night sweats
181.	1	2	3	Rapid digestion
182.	1	2	3	Sensitivity to noise
183.	1	2	3	Redness of palms of hands and bottom of feet
184.	1	2	3	Visible veins on chest and abdomen
185.	1	2	3	Hemorrhoids
186.	1	2	3	Apprehension (feeling that something bad is going to happen)
187.	1	2	3	Nervousness causing loss of appetite
188.	1	2	3	Nervousness with indigestion
189.	1	2	3	Gastritis
190.	1	2	3	Forgetfulness
191.	1	2	3	Thinning hair

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

192.	1	2	3	Very easily fatigued
193.	1	2	3	Premenstrual tension
194.	1	2	3	Menses more painful than usual
195.	1	2	3	Depressed feelings before menstruation
196.	1	2	3	Painful breasts during menses
197.	1	2	3	Menstruate too frequently
198.	1	2	3	Hysterectomy/ovaries removed
199.	1	2	3	Menopausal hot flashes
200.	1	2	3	Menses scanty or missed
201.	1	2	3	Acne, worse at menses

____ ____ ____ TOTAL
1 2 3

MALE ONLY

202.	1	2	3	Less involved in exercise/social activities
203.	1	2	3	Difficult to postpone urination
204.	1	2	3	Weak urinary stream
205.	1	2	3	Feeling of "blues" or melancholy
206.	1	2	3	Feeling of incomplete bowel evacuation
207.	1	2	3	Lack of energy
208.	1	2	3	Muscles in arms and legs seem softer/smaller
209.	1	2	3	Tire too easily
210.	1	2	3	Avoid activity
211.	1	2	3	Leg nervousness at night
212.	1	2	3	Diminished sex drive

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion
_____ Hydrochloric Acid Point
_____ Enzyme Point
_____ Murphy's Sign

Large Intestine (Palpate)
_____ Ascending
_____ Transverse
_____ Descending

Adrenals
Pass/Fail Pupil Dilation Exam
Postural Hypotension
_____ Supine
_____ Standing

Pass/Fail Zinc Taste Test
Pass/Fail Cuff Test
_____ Cuff Pressure
_____ pH of Saliva
_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.