New Patient Outline of Procedures for Care

Before Your Visit

- Please carefully read the included materials and fill out the Confidential New Patient Information Questionnaire

Step One

- A one-on-one consultation will be done to discuss your health problems and to determine what may be the cause. This consultation will also include an Oriental Medical Examination – including Classical Pulse Diagnosis and Tongue Diagnosis - to determine the precise cause of your problem(s).
- Please bring along any medical reports, x-rays, cat scans etc that relate to your presenting complaint
- Please allow 1 ¼ - 1 ½ hours for this visit

Step Two

- A 15 minute educational session will occur prior to your first treatment to allow you to understand the treatment and therapies being used and allow you to ask any questions
- You will receive your 1st treatment
- Please allow 1 ¼ hours for this visit

Step Three

- You will receive your 2nd and 3rd treatments
- Please allow 1 hour for these visits

Step Four

- At the conclusion of your 3rd treatment, your practitioner will outline your treatment plan detailing your expected number of treatments, duration of care and financial commitments

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Your Acupuncturist will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible

☐ Relief Care ☐ Corrective Care
☐ Whatever your Acupuncturist thinks is appropriate for your condition

PLEASE READ CAREFULLY AND SIGN BELOW:

I understand and agree that all services rendered to me are charged directly to me and that I am directly responsible for payment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I understand that TCR Acupuncture will prepare any necessary reports and forms to assist me in making collections from the insurance company.

I hereby authorize the Acupuncturist to treat my condition as he/she deems appropriate. I also agree that I am responsible for all bills incurred at this office.

Patient’s Signature ___________________________________________ Date ________________

Consent to Treat a Minor ___________________________ Date ________________

Guardian or Spouse’s Signature Authorizing Care ___________________________ Date ________________
Confidential New Patient Information

First Name ___________________________________________ Last Name ___________________________________________
Address ____________________________________________ City & Zip Code ____________________________
Home Phone ____________________________ Work Phone ____________________________ Cell Phone ____________________________
SSN # ____________________________________________ Date of Birth ____________________________
Emergency Contact Name ____________________________________________ Emergency Contact Phone ____________________________
Marital Status ____________________________________________ Occupation ____________________________________________
Referred by ____________________________________________ Primary Care Dr. ____________________________________________

Insurance Information
Health Insurance Co. ____________________________________________ Policy/ID # ____________________________
Name on Card ____________________________________________ Relationship to Patient ____________________________ DOB ____________________________
E-Mail Address: ____________________________________________

Seeking Treatment for
Please list ALL conditions for which you are seeking treatment, in order of significance to you.

<table>
<thead>
<tr>
<th>1. Therapies Tried</th>
<th>How long Yrs/mo.</th>
<th>Did/Does it help?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is currently treating you for this?</td>
<td></td>
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<th>Did/Does it help?</th>
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Additional Information – Please attach further pages if necessary

MEDICATIONS/SUPPLEMENTS/VITAMINS
Please list ALL medications, supplements and vitamins you are taking – please include the dosage
Medications

Supplements

Vitamins

ALLERGIES - Please list ALL known allergies

SURGERIES/HOSPITALIZATIONS - Please list ALL surgeries/hospitalizations, the year they occurred and for what reason

EMOTIONAL/PHYSICAL TRAUMA - Please list ALL emotional and physical traumas (death, divorce, births, car accidents etc)
**PAIN** - indicate on the diagram where you experience pain

Is the pain:
- □ Sharp
- □ Burning
- □ Aching
- □ Cramping
- □ Dull
- □ Moving
- □ Fixed
- □ Other: ______________________

Do the following improve the pain?
- □ Pressure
- □ Cold
- □ Heat
- □ Exercise
- □ Rest

Do the following worsen the pain?
- □ Pressure
- □ Cold
- □ Heat
- □ Other: ______________________

**MEDICAL HISTORY** – please check any tests taken in the last 12 months

- □ Physical
- □ Cholesterol
- □ Blood workup
- □ Thyroid
- □ Colonoscopy
- □ Stress Test
- □ MRI
- □ X-rays
- □ CAT scan
- □ Mammogram
- □ Pap smear
- □ Prostate
- □ HIV/AIDS
- □ Hepatitis A/B/C
- □ Other: ______________________

Significant Results
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Please check any of the following that currently pertain to you:

**Overall Temperature (Yin & Yang)**
The following symptoms indicate an imbalance of Yin and Yang in your body. In Oriental Medicine, Yin is the cool, moist, nourishing aspect of the body. Yang is the hot, dry, invigorating aspect of the body.

- □ Cold hands
- □ Cold feet
- □ Sweaty hands
- □ Hot body temperature (sensation)
- □ Afternoon flushes
- □ Heat in the hands, feet & chest
- □ Thirsty
- □ Lack of perspiration

- □ Cold fingers
- □ Cold toes
- □ Sweaty feet
- □ Cold body temperature (sensation)
- □ Night sweats
- □ Hot flashes any time of the day
- □ Perspire easily
- □ Take water to bed

**Overall Energy (Lung, Kidney function)**

- □ Shortness of breath
- □ General weakness
- □ Low energy

- □ Difficulty keeping eyes open in the daytime
- □ Easily catch colds
- □ Feel worst after exercise

**Overall Blood (Liver, Spleen, Heart function)**

- □ Dizziness

- □ See floating black spots

**Heart Function**
The following symptoms are indicators of heart malfunction. The heart governs the blood and blood vessels, manifests on the complexion, governs the emotions, and affects speech and taste controls and perspiration.

- □ Palpitations
- □ Sores on the tip of the tongue
- □ Mental confusion
- □ Frequent dreams
- □ Drink coffee (# cups per day : _______)

- □ Anxiety
- □ Restlessness
- □ Chest pain traveling to the shoulder
- □ Wake unrefreshed
Lung Function
The following symptoms are indicators of lung malfunction. The lungs govern breathing, control the movement of energy, control the immune system, regulate water passages, control the skin and open the nose, throat and sinuses.

- Nasal Discharge (Color: __________)  
- Cough
- Nose Bleeds  
- Sinus Congestion
- Dry mouth  
- Dry throat
- Dry nose  
- Dry skin
- Allergies (To what: ____________________________)
- Alternating fever and chills  
- Sneezing
- Headache (Location: __________)  
- Overall achy feeling in the body
- Stiff neck  
- Stiff shoulders
- Sore throat  
- Difficulty breathing
- Smoke cigarettes (# per day: _______)
- Sadness
- Melancholy

Spleen Function
The following symptoms are indicators of spleen malfunction. The spleen assists in breaking food down into usable nutrients and then transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body.

- Low appetite  
- Abrupt weight gain
- Abrupt weight loss  
- Abdominal bloating
- Abdominal gas  
- Gurgling noise in the stomach
- Fatigue after eating  
- Prolapsed organs (prev. diagnosed, where: ________)
- Easily bruised  
- Hemorrhoids
- Pensive  
- Over-thinking
- Worry

Spleen, Stomach, Large Intestines, Small Intestine Function

- Loose  
- Constipated
- Incomplete stools  
- Diarrhea
- Blood in stools  
- Mucous in stools
- Undigested food in stools

Dampness Trapped in the Body
The following symptoms are indicators of “dampness” which simply refers to fluids that are not metabolized effectively and cause health problems in the body.

- Mental heaviness  
- Mental sluggishness
- Mental fogginess  
- Swollen hands
- Swollen feet  
- Swollen joints
- Chest congestion  
- Nausea
- Snoring  
- General sensation of heaviness in the body

Stomach Function
The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends the energy and is the origin of the body’s fluids.

- Burning sensation after eating  
- Large appetite
- Bad breath  
- Mouth (canker) sores
- Bleeding, swollen or painful gums  
- Heartburn
- Acid regurgitation  
- Ulcer (diagnosed)
- Belching  
- Hiccoughs
- Stomach pain  
- Vomiting
Liver, Gall Bladder Function
The following symptoms are indicators of liver malfunction. **The liver stores the blood, ensures the smooth flow of energy throughout the body, nourishes the tendons and ligaments, manifests in the nails and opens in the eyes. The gall bladder stores bile, which breaks down fats.**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>Alternating diarrhea &amp; constipation</td>
</tr>
<tr>
<td>Tight sensation in chest</td>
<td>Bitter taste in mouth</td>
</tr>
<tr>
<td>Anger easily</td>
<td>Frustration</td>
</tr>
<tr>
<td>Depression</td>
<td>Irritability</td>
</tr>
<tr>
<td>Frequently unable to adapt to stress</td>
<td><strong>(What causes the stress? ____________________________)</strong></td>
</tr>
<tr>
<td>Skin rashes</td>
<td>Headache at the top of the head</td>
</tr>
<tr>
<td>Tingling sensation</td>
<td>Numbness</td>
</tr>
<tr>
<td>Muscle spasms</td>
<td>Muscle twitching</td>
</tr>
<tr>
<td>Muscle cramps</td>
<td>Seizures</td>
</tr>
<tr>
<td>Convulsions</td>
<td>Lump in the throat</td>
</tr>
<tr>
<td>Neck tension</td>
<td>Limited range of motion - neck</td>
</tr>
<tr>
<td>Shoulder tension</td>
<td>Limited range of motion - shoulder</td>
</tr>
<tr>
<td>Hip pain</td>
<td><strong>Drink Alcohol (Type? ________, How much/week? ____)</strong></td>
</tr>
<tr>
<td>High-pitched ringing in ears</td>
<td><strong>Recreational Drugs (Which?________ How often? ____)</strong></td>
</tr>
<tr>
<td>Gall stones (history or current)</td>
<td><strong>Sexually transmitted diseases (Which? ____________)</strong></td>
</tr>
</tbody>
</table>

Eyes (Liver function)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itchy</td>
<td>Bloodshot</td>
</tr>
<tr>
<td>Hot</td>
<td>Dry</td>
</tr>
<tr>
<td>Watery</td>
<td>Gritty</td>
</tr>
<tr>
<td>Blurry vision</td>
<td>Decreased night vision</td>
</tr>
<tr>
<td>Near-sighted</td>
<td>Far-sighted</td>
</tr>
</tbody>
</table>

Kidney, Urinary Bladder Function
The following symptoms are indicators of kidney or urinary bladder malfunction. **The kidney and adrenal system govern birth/growth/reproduction/development, produce the bone marrow, nourish the brain, control the bones, govern water, open to the ears, manifest the hair, and control the ureter/spermatic duct and lower section of the large intestine. The urinary bladder stores and eliminates impure fluids from the body.**

<table>
<thead>
<tr>
<th>Symptom</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Frequent cavities</td>
<td>Easily broken bones</td>
</tr>
<tr>
<td>Sore knees</td>
<td>Weak knees</td>
</tr>
<tr>
<td>Cold sensation in the knees</td>
<td>Low back pain</td>
</tr>
<tr>
<td>Memory problems</td>
<td>Excessive hair loss</td>
</tr>
<tr>
<td>Low-pitched ringing in ears</td>
<td>Kidney stones</td>
</tr>
<tr>
<td>Bladder infections</td>
<td>Wake during night to urinate twice or more</td>
</tr>
<tr>
<td>Lack of bladder control</td>
<td>Fear</td>
</tr>
<tr>
<td>Easily startled</td>
<td></td>
</tr>
</tbody>
</table>

Urination

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal color</td>
<td>Dark yellow</td>
<td>Clear</td>
</tr>
<tr>
<td>Reddish</td>
<td>Cloudy</td>
<td>Scanty</td>
</tr>
<tr>
<td>Profuse</td>
<td>Strong odor</td>
<td>Burning</td>
</tr>
<tr>
<td>Painful</td>
<td>Discharge</td>
<td>Difficult</td>
</tr>
<tr>
<td>Urgent</td>
<td>Frequent</td>
<td></td>
</tr>
</tbody>
</table>

Libido

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>
Women Only

Menstrual Cycle

Regular Menstrual Cycle □ Yes □ No
Pregnant □ Yes □ No
Number of Pregnancies: ___________ Number of children: ___________
Age of First Menstruation: ___________ Age of Menopause (if applicable): ___________
Average number of days of flow: ___________ Average number of days of entire cycle: ___________

Do you experience:

□ vaginal discharge □ Bleeding between periods

Do you experience any of the following pre-menstrual symptoms?

□ nausea □ vomiting □ food cravings
□ water retention □ breast swelling □ headaches
□ migraines □ breast tenderness □ depression
□ irritability □ breast swelling □ anxiety
□ other emotions: ______________________________
□ dull pain (Where? ____________________________)
□ sharp pain (Where? ____________________________)

Please fill in the following menstrual chart:

<table>
<thead>
<tr>
<th>First day of last menstrual period: __________</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color – normal, bright red, pale, brown, rust, dark, purple, other</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Amount of Flow – normal, heavy, light</td>
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<tr>
<td>Pain/cramps – location, dull, sharp, other</td>
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<tr>
<td>Clots – large, small, black, purple, red, other</td>
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<td></td>
<td></td>
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<tr>
<td>Vomiting – yes, no</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nausea – yes, no</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Men Only

□ Swollen testes □ Testicular Pain □ Impotence
□ Premature ejaculation □ Feeling of coldness/numbness in external genitalia
□ Other: ______________________________

Practitioner Notes:

All please fill out:

Other Comments:  

Patient Signature: 

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