Initial Intake Form

Melanie Mendoza, Licensed Acupuncturist/Herbalist & Massage Therapist
@ The Salt Room, 1804 N. Mills Avenue, Orlando, Fl 32803
W. 407-965-3065 C. 407.488.8830

Today's date ____/____/_____

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential. I will be happy to answer any questions.

General Information

Name_____ Birthdate____/____/_____ Age_____ Gender_____
Address_____ City_____ State_____ Zip_____

Phone numbers (please mark * next to best number):
Home_____ Cell_____ Work_____

E-mail address_____
(email is necessary for us to schedule appointments using our confidential online scheduling system)

Would you like to receive our e-newsletter with supportive health information (only once per season)? ☐ Y ☐ N

Marital Status_____ # of children _____ their age(s)_____
Your Educational level _____ Occupation _____ Hrs per week_____
Employer & location _____ Health Insurance Co._____
How did you hear about us? _____ If via person, name:_____
May we send a thank you card? ☐ Y ☐ N

Emergency Contact

Name_____ Ph_____ Relationship_____

Under 18 ---Responsible Party Information

Name_____ Relationship to Patient_____

Healthcare Providers ---please list those you work with.

Physicians: GP/Primary Care: _____ seeking one? ☐ Y ☐ N
OB-GYN: _____ seeking one? ☐ Y ☐ N
Specialist (describe): _____ seeking one? ☐ Y ☐ N
Chiropractor: _____ seeking one? ☐ Y ☐ N
Massage Therapist:_____ seeking one? ☐ Y ☐ N
Physical Therapist:_____ seeking one? ☐ Y ☐ N
Psychotherapist:_____ seeking one? ☐ Y ☐ N
Personal Trainer:_____ seeking one? ☐ Y ☐ N
Midwife:_____ seeking one? ☐ Y ☐ N
Other:_____

May I contact these providers to ensure coordination of your care? ☐ Y ☐ N

Previous experience with acupuncture? ☐ Y ☐ N With whom and results_____

Health History

Please list your major health concerns in order of importance to you: _____

_____

_____

_____

Check those that apply to your past medical history:

- ☐ Adverse reaction to medical treatment
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Asthma
- ☐ Attempted suicide
- ☐ Birth Trauma
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Immune disorder
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme's disease
- ☐ Lymph nodes removed
- ☐ Mental illness
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease/STD
- ☐
- Other_____

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

_____

_____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).

Date____/_____Event_____Date____/_____ Event_____

Date____/_____Event_____Date____/_____ Event_____

Date____/_____Event_____Date____/_____ Event_____

Family History (List any family physical or mental illnesses and age of death):

Mother_____

Father_____

Grandparents_____

Siblings_____

Children_____

Medications, Herbs, Supplements (List those you are currently taking):

Name_____Reason _____How long and Dose_____

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Lifestyle Habits

Describe your typical daily diet:
Breakfast_____ Lunch_____
Dinner_____ Snacks_____
Special diet_____ 3 worst foods you eat_____

Do you:	Yes	No	
Average 6-8 hours sleep?			What is the major source of joy in your life? _____
Have a supportive relationship?			_____
Have a history of abuse?			_____
Enjoy your work?			What is the major source of stress in your life? _____
Take vacations?			_____
Spend time outside?			_____
Exercise?			Describe exercise: _____
Watch TV?			How many hours weekly?
Read Books?			How many hours weekly
Computer games/browsing?			How many hours weekly
Spiritual/religious practice?			Describe:
Smoke cigarettes?			How much?
Smoke cigarettes in the past?			How many years? How many packs?
Eat out often?			How many meals a week?
Drink coffee?			How many cups a day?
Drink tea?			How many cups a day?
Drink soft drinks?			How many a day?
Use sugar?			How much?
Drink alcohol?			How many drinks a week?
Use recreational drugs?			What and how often?
Have an addiction?			To what and how long?
Been outside the U.S. in past 12 months?			Where?

What are your goals for your health?

_____

_____

_____

Please circle your level of commitment to correcting your health issues? (10 = highest level)

1 2 3 4 5 6 7 8 9 10

Tests and Immunizations

Please list the date of your most recent visit:

Chest X-ray _____ Sigmoidoscopy _____ EKG _____ Stool Blood Test _____
Mammogram _____ TB Skin Test _____ Pap Smear _____ Complete Physical _____
GI Series _____ Flu Shot _____ Pneumonia Shot _____ Other _____

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑
If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder

☐ Depression/Stress
☐ Headaches/Migraines
☐ Red/Dry/Itchy Eyes
☐ Visual Problems/Blurred Vision
☐ Dizziness
☐ Gall Stones
☐ Feeling of Lump in Throat
☐ Clenching Teeth at Night
☐ Muscle Cramping/Twitching
☐ Neck/Shoulder Pain/Tightness
☐ Seizures/Tremors
☐ Poor Circulation
☐ Soft/Brittle Nails
☐ Bitter Taste in Mouth
☐ PMS/Menstrual Problems
☐ Tendonitis
☐ Pain Below Ribcage
☐ Do you crave: Sour
☐ Tend to be Irritable/Angry

Heart/Small Intestine

☐ Heart Palpitations
☐ Rapid or Irregular Heartbeat
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Insomnia/Sleep Problems
☐ Vivid Dreams/Nightmares
☐ Easily Startled
☐ Dark Urine
☐ Red Complexion
☐ Do you crave: Bitter
☐ Anxiety/Nervous or Restless

Spleen/Stomach

☐ Body Heaviness
☐ Hard to get up in Morning
☐ Muscles Often Feel Tired
___ Energy Level: 1-10 (low to high)
☐ Edema (☐ Hands ☐ Feet)
☐ Easily Bruising/Bleeding
☐ Bad Breath
☐ Sweet-ish Taste in Mouth
☐ Lack of Taste
☐ Excess or Low Appetite (circle which)
☐ Excess or Lack of Thirst (circle which)
☐ Nausea/Vomiting
☐ Gas/Belching
☐ Hemorrhoids
☐ Organ Prolapse (i.e. uterus)
☐ Chronic Loose Stools
☐ Abdominal Pain
☐ Indigestion/Heartburn
☐ Brain Foggy
☐ Mouth Ulcers
☐ Tendency to Gain Weight
☐ Do you crave: Sweet
☐ Over-thinking/Worry

Lung/Large Intestine

☐ Post Nasal Drip
☐ Sinus Infection / Congestion
☐ Itchy, Red, or Painful Throat
☐ Dry Mouth/Nose/Throat
☐ Skin Rashes/Hives
☐ Snoring
☐ Shortness of Breath
☐ Allergies/Asthma
☐ Low Immunity
☐ Catches Colds Easily
☐ Bronchitis
☐ Black or Bloody Stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis/Spastic Colon
☐ Do you crave: Pungent/ Spicy
☐ Grief/Sadness

Kidney/Urinary Bladder

☐ Urinary Problems (i.e. night-time) _____
☐ Bladder Infection
☐ Incontinence
☐ Weakness / Pain in Low Back
☐ Osteoporosis
☐ Feel Cold or Hot Easily (circle which)
☐ Cold Hands / Feet
☐ Low or Excess Sex Drive (circle which)
☐ Dark Circles under Eyes
☐ Thyroid Problems:

_____

☐ Poor Memory
☐ Hair Loss/Grey Hair
☐ Hearing Problems/Tinnitus
☐ Cavities
☐ Hot Flashes/Night Sweats
☐ Impotence or Premature Ejaculation (circle which)
☐ Do you crave: Salt
☐ Fear

Treatment Terms and Conditions

The following are specific policies that will govern our work together:

Cancellation Policy

In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hrs. notice. We will try to reschedule your appointment for the same week so that you don't miss your treatment. You will be charged the full fee for your session if you do not show up for your appointment or cancel your appointment with less than 24 hours notice (1 full day).

Late Policy

If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then, your appointment will be cancelled and you will be responsible for the full payment of the session.

Phone Calls and Emails

You may phone or email us when necessary and we will respond As Soon As Possible, or within 24 hours. We are generally unavailable on weekends. Except for emergencies, phone and email contacts are limited to 10 minutes of our time. All contacts that require beyond 10 minutes of our time are considered session work and will be billed a flat rate of **$35**.

Confidentiality and Privacy Practices

As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- ☐ You may request restrictions on your disclosures.
- ☐ You may inspect and receive copies of your records within 30 days with a request.
- ☐ You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, announcements and to inform you about our practice and its staff. A more complete description of our privacy practices can be requested.

Fees It is our policy that you pay the entire session fee or co-pay at the time of each session.
If you would like to arrange another payment option, please discuss it with us.
We will provide a minimum of one month's notice of any changes to our fees.

We are partners in your healthcare.

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

Agreement

I have read and understood the clinic's policies. I agree to the all of the above treatment terms and conditions.

Signature: _____ Date: _____

Informed Consent & Disclosure

THE Salt Room
INHALE • EXHALE • STAY WELL

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation/micro-point stimulation, medical qigong, massage therapy, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling/coaching.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring.
Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Frequent, regular treatment is what gives acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her & The Salt Room updated on any changes.

Patient Signature _____ Date _____