# Many Lives Chinese Medicine
## Client Intake Form

**Date:**

Name: Date of Birth: Age:

Address: City: Zip:

**Phone(s):**

Home:

Work:

Cell:

Email Address:

Physician: Phone:

Date of last exam: Reason for visit:

Emergency Contact: Phone:

Referred by:

Contact information of referral ( to send thank you):

**Please be respectful of my time and yours. Your time commitment begins at the moment you make an appointment. There are times when a cancellation is, of course, necessary; but please give advanced notice whenever possible. Missed or cancelled appointments without twenty-four (24) hour notice will be charged in full for the missed appointment.**
**If no cancellation arrangements are made, the cost of the appointment will be charged.**

Client Signature: Date:

Confidential

## Woman's Fertility History

Name: ____________________________________

Age when menstruation began: ________________ Duration of menstrual cycle: _____________

Are your menstrual cycles regular? ☐ No ☐ Yes

Days from one period to the next: __________ Date of last menstrual period: _____________

Are you pregnant now: ☐ No ☐ Yes ☐ Don't know (maybe)

Color of blood on day one:
- ☐ Pale red
- ☐ Red
- ☐ Deep red
- ☐ Brown

Color on subsequent days:
- ☐ Pale red
- ☐ Red
- ☐ Deep red
- ☐ Brown

Pain with cycle:
- ☐ Mild
- ☐ Medium
- ☐ Severe

Clotting:
- ☐ Yes
- ☐ No

Blood constitution:
- ☐ Watery
- ☐ Thin
- ☐ Thick

Bleeding:
- ☐ Light
- ☐ Normal
- ☐ Heavy

Before or during your menstrual cycle, do you experience any of the following, and how often?

| | None | Seldom | Mild | Often | Severe |
|---|---|---|---|---|---|
| Breast distention | | | | | |
| Breast tenderness | | | | | |
| Breast lumps | | | | | |
| Better with exercise | | | | | |
| Loose stool | | | | | |
| Acne before or during period | | | | | |
| Mood changes | | | | | |
| Cramping better with heat | | | | | |
| "Bearing-down" sensation | | | | | |
| Food cravings | | | | | |
| Bleeding/spotting between periods | | | | | |
| Low-back pain | | | | | |

### Obstetrical History

How long have you been trying to have a baby: ____________________________

Have you ever been pregnant? ☐ No ☐ Yes

| Date | Current/ prior partner | Live Birth (Y/N) | Miscarry/ Abortion/ Ectopic | Wks. | Fetal heart (Y/N) | D&C (Y/N) | Mode of delivery | Sex | Wt. | Complications/ Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

Name: ______________________________ **Confidential**

Have you ever had an abnormal Pap smear? ☐ No ☐ Yes

Have you ever had a cervical biopsy, operation, cauterization, or conization? ☐ No ☐ Yes

Have you ever had a chlamydial infection? ☐ No ☐ Yes

Have you ever had a venereal disease? ☐ No ☐ Yes

Do you have chronic vaginal discharge? ☐ No ☐ Yes

Do you have any sores on your genitalia? ☐ No ☐ Yes

Do you get yeast infections regularly? ☐ No ☐ Yes

Have you ever had pelvic inflammatory disease? ☐ No ☐ Yes

Were you treated for it? ☐ No ☐ Yes How? ______________________________

Date of last Pap smear: ______________________

Have you ever been diagnosed with any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Uterine fibroids | ☐ No | ☐ Yes | Pelvic adhesions | ☐ No | ☐ Yes |
| Polyps | ☐ No | ☐ Yes | Pelvic abnormality | ☐ No | ☐ Yes |
| Endometriosis | ☐ No | ☐ Yes | PCOS | ☐ No | ☐ Yes |

Have you taken any medications (other than contraceptives) for gynecological conditions? ☐ No ☐ Yes

| Medication | Reason | How long |
|---|---|---|
| | | |
| | | |
| | | |

Have your cycles changed since they began: ☐ No ☐ Yes

How? ______________________________________________

Do you ovulate on your own? ☐ No ☐ Yes What date? ________________

Are your breasts tender at/during ovulation? ☐ No ☐ Yes

Have you had fertility treatments? ☐ No ☐ Yes

If yes, where & when? ______________________________

By whom? ______________________ What types? ______________________

Have you taken medication to aid ovulation? ☐ No ☐ Yes

What? ________________ When? ______________ How long? ______________

Have your fallopian tubes been evaluated medically? ☐ No ☐ Yes

What were the results? ______________________________

Have you had any tubal operations? ☐ No ☐ Yes

Have you had any hormone laboratory tests performed? ☐ No ☐ Yes

What were the results? ______________________________

Have you taken oral contraceptives? ☐ No ☐ Yes When? __________ How long? ___________

Have you ever had an IUD? ☐ No ☐ Yes When? __________ How long? ___________

Have you ever taken Depo-Provera? ☐ No ☐ Yes When? __________ How long? ___________

How long have you been trying to conceive? ________________________________________

Have you had a diagnosis related to infertility? ☐ No ☐ Yes

What was it? ________________________________________________________

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ No ☐ Yes

If so, with what? ____________________________________________________

Do you use vaginal lubricants? ☐ No ☐ Yes

Are you more than 20% under your ideal body weight? ☐ No ☐ Yes

Are you more than 20% over your ideal body weight? ☐ No ☐ Yes

Is your occupation stressful? ☐ No ☐ Yes

On a scale of 1 to 10, what is your stress level? ______________________________

Do you exercise regularly? ☐ No ☐ Yes

How often? _________________________________________________________

Do you have excessive facial hair? ☐ No ☐ Yes

Do you have excessively oily skin? ☐ No ☐ Yes

Have you experienced excessive loss of hair? ☐ No ☐ Yes

Have you had discharge from your nipples? ☐ No ☐ Yes

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ☐ No ☐ Yes

Have you been exposed to any known environmental toxins or hormones? ☐ No ☐ Yes

Are you presently taking steroids? ☐ No ☐ Yes

Are you presently taking anti-coagulants? ☐ No ☐ Yes

Has your partner been medically evaluated? ☐ No ☐ Yes

What were the results? _______________________________________________

_______________________________________________________________

_______________________________________________________________

**Confidential**

# Many Lives Chinese Medicine

**beth.schiffman@gmail.com** **650.366.4299**

Name: ______________________________________________

Chief complaint: ______________________________________________

Date of onset (when you first noticed the problem): ______________________

How long have you had this condition: ______________________________

Have you had this in the past? ☐ No ☐ Yes When: ______________________

Pain is: ☐ Minimal ☐ Moderate

☐ Slight ☐ Severe Scale of 1 to 10: ______________________

What makes it better? ______________________________________________

What makes it worse? ______________________________________________

Your condition is: ☐ Getting worse ☐ Constant ☐ Comes and goes

Medications/drugs/herbs you are currently taking: ______________________

List surgeries/operations you have undergone, with dates: ______________________

______________________________________________

**Family History**

| | Father | Mother | Sibling | Children | Self |
|---|---|---|---|---|---|
| Arthritis | | | | | |
| Asthma | | | | | |
| Cancer | | | | | |
| Allergies | | | | | |
| Heart trouble | | | | | |
| High blood pressure | | | | | |
| Stroke | | | | | |
| Diabetes | | | | | |

| General | | |
|---|---|---|
| ☐ Chills | ☐ Fatigue | ☐ Aversion to heat/cold |
| ☐ Frequent colds | ☐ Excess thirst | ☐ Low-back pain |
| ☐ Catch colds easily | ☐ Weight loss/gain | ☐ Joint disorders |
| ☐ Allergies | ☐ Dizziness | |

| Energy level | Stress |
|---|---|
| ☐ High (time of day) ________ | ☐ None |
| ☐ Low (time of day) ________ | ☐ Moderate |
| | ☐ Severe |
| | What causes it? ______________________ |

| **Sleep problems** | | |
|---|---|---|
| ☐ Trouble falling asleep<br>☐ Trouble staying asleep | ☐ Trouble staying awake<br>☐ Excess dreaming | ☐ Other: ____________________ |
| ☐ How many hours do you sleep each night? ______________________ | | |

| **Sweating** | **Circulation** |
|---|---|
| ☐ Rarely sweat<br>☐ Night sweats<br>☐ Excess sweating<br>☐ Spontaneous sweating | Feelings of: ☐ Hot<br>☐ Cold What area? ________________________________<br><br>Hands and feet get cold easily: ☐ Yes ☐ No |

| **Skin** | | |
|---|---|---|
| ☐ Dry<br>☐ Itchy<br>☐ Moist, clammy<br>☐ Burning<br>☐ Blood not clotting<br>☐ Hives | ☐ Changing moles/lumps (cysts/tumors)<br>☐ Boils<br>☐ Frequent rashes<br>☐ Acne<br>☐ Bruise easily (black-and-blue spots)<br>☐ Hair loss/thinning | ☐ Dry scalp<br>☐ Skin puffy/wrinkled<br>☐ Dark circles under eyes<br>☐ Other: ____________________ |

| **Head & neck** | | |
|---|---|---|
| ☐ Memory loss<br>☐ Eye pain<br>☐ Dry eyes<br>☐ Blurred vision | ☐ Double vision<br>☐ "Floaters" (spots in vision)<br>☐ Loss of balance<br>☐ Burning eyes | ☐ Headaches (list where):<br>______________________________<br>☐ Other: ____________________ |

| **Ears & nose** | | |
|---|---|---|
| ☐ Poor hearing<br>☐ Ear aches<br>☐ Ear discharge/infections | ☐ Ringing/buzzing in ears<br>☐ Frequent nose bleeds<br>☐ Sinus problems | ☐ Congestion/allegeries<br>☐ Frequent colds<br>☐ Other: ____________________ |

| **Chest** | | |
|---|---|---|
| ☐ Trouble breathing<br>☐ Trouble breathing at night<br>☐ Shortness of breath<br>☐ Pain/pressure in chest<br>☐ Palpitations | ☐ Mucous rattle when breathing<br>☐ Wheezing<br>☐ Persistent cough<br>☐ Chest pain<br>☐ Coughing blood | ☐ Swollen ankles<br>☐ Coughing phlegm<br>Color: __________________<br>☐ Other: ____________________ |

| **Genito-urinary** | | |
|---|---|---|
| ☐ Frequent urination<br>☐ Day<br>☐ Night<br>☐ Difficult to urinate | ☐ Strong-smelling urine<br>☐ Pain or burning on urination<br>☐ Blood in urine<br>☐ Frequent infections/dysfunction | ☐ Water retention<br>☐ Abnormal color<br>☐ Other: ____________________ |

| **Neurological** | | |
|---|---|---|
| ☐ Tremors<br>☐ Numbness; where: _________<br>☐ Tingling; where: __________ | ☐ Pain; where: _________________<br>☐ Paralysis; where: _____________<br>☐ Seizures | ☐ Poor coordination<br>☐ Stroke<br>☐ Other: ____________________ |

| Emotional & mental | | |
|---|---|---|
| ☐ Nervousness | ☐ Moody | ☐ Fearful |
| ☐ Depressed | ☐ Mind not clear | ☐ Terrors |
| ☐ Easily angered | ☐ Manic | ☐ Difficulty expressing emotions |
| ☐ Easily irritated | ☐ Obsessive | ☐ Other: ____________________ |
| ☐ Frequent crying | ☐ Compulsive | |
| ☐ Disoriented | ☐ Anxiety | |

**Gastro-intestinal** (check all that apply)

| | Often | Seldom | Severe | Mild | None |
|---|---|---|---|---|---|
| Poor appetite | | | | | |
| Excessive appetite | | | | | |
| Nausea | | | | | |
| Vomiting | | | | | |
| Belching | | | | | |
| Indigestion | | | | | |
| Stomach pain | | | | | |
| Lower-abdominal pain | | | | | |
| Bloody stools | | | | | |
| Black stools | | | | | |
| Mucus in stools | | | | | |
| Stools have foul odor | | | | | |
| Hemorrhoids | | | | | |
| Lower bowel gas | | | | | |
| Colon problems | | | | | |
| Diarrhea | | | | | |
| Constipation | | | | | |

**Lifestyle habits** (please indicate how much, how many, how often)

Cigarettes (packs): ______________________________ Coffee/tea (cups): ____________________________

Alcohol (type/amount per week): ____________________________________________________________________

Prescription drugs: ____________________________________________________________________________

Over-the-counter drugs: ________________________________________________________________________

Recreational drugs: ____________________________________________________________________________

Vitamins/herbs: ________________________________________________________________________________

Dietary restrictions: __________________________________________________________________________

Food cravings: _________________________________________________________________________________

Exercise (type and frequency): _____________________________________________________________________

Briefly describe your diet: __________________________________________________________________________

**Insurance Information**

At Many Lives, we provide insurance billing as a courtesy to our patients. Currently, we accept most PPO insurance plans, and are not currently “in-network” with any of them. Depending on your plan, you may still be covered, but this may result in a lower percentage of your claim being paid. Your financial responsibility depends on your specific health insurance plan.

If we are not able to verify your coverage before your first visit, you are responsible for the full payment at time of service. (Don’t worry) We will issue a refund for your acupuncture charge when we receive payment from your insurance company. When we are able to verify coverage and get an estimate of what they will cover, you will be expected to pay a co-pay at time of service. Amount due at time of service may need to be adjusted once we receive payments from your insurance company.

Please remember, the ultimate financial responsibility for payment lies with the patient, not the insurance company.

**Release of Information**

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release medical information necessary to process your claim:

Your signature below acknowledges that you have read and agreed to these terms.

Signature_____________________________________________ Date______________________

Thank you very much. We look forward to working with you.

# Many Lives Chinese Medicine

## Informed Consent to Treatment

I, ______________________________ consent to acupuncture treatment(s) and other procedures associated with Traditional Chinese Medicine by Beth Schiffman, L.Ac. I have discussed the nature and purpose of my treatment, and understand that methods of treatment may include, but are not limited to acupuncture, herbal medicine, nutritional counseling, moxibustion, cupping and electrical stimulation.

I have been informed that acupuncture utilizes sterile needles and is done in a clean, safe environment; but that it may have side effects, including: bruising, numbness or tingling near acupuncture, dizziness and fainting. Some unusual risks of acupuncture include lung puncture (pneumothorax) and infection. Burns and/or scarring are a potential risk of indirect moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify Beth Schiffman if I am or become pregnant.

Herbs and nutritional supplements (from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs are inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will immediately notify Beth Schiffman of any unanticipated or unpleasant effects associated with the consumption of herbal teas, or patent (pill form) medicines.

By signing below I show that I have read this consent to treatment, and understand the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present and any future conditions for which I seek treatment.

______________________________________________________________

Client Date Practitioner Date

______________________________________________________________

**Directions to Many Lives Chinese Medicine**
**499 Seaport Ct. #101**
**Redwood City CA 94063**
**650-366-4299**

Signage is not well marked

From the North:

101 South
Exit to Seaport Blvd. (Woodside Road)
**Heading East**
Go ¾ mile turn Left on Seaport Ct.
Go to Stop sign, go slight Right
Count 3 light posts (on center strip)
Park. Walk straight, pass the California Overnight box
Door is behind the octagonal planter box!

From the South:

101 north
Exit to Seaport Blvd. (Woodside Road)
**Heading East**
Go ¾ mile turn Left on Seaport Ct.
Go to Stop sign, go slight Right
Count 3 light posts (on center strip)
Park. Walk straight, pass the California Overnight box
Door is behind the octagonal planter box!