TAYLOR Chiropractic & Oriental Medicine

2190 S. Tamiami Trail, Venice, FL 34293

941-493-2688

Patient Name:_____ Date:_____

Date of Birth:_____ SSN:_____

Address:_____

City:_____ State:_____ Zip: _____

Phone: (H)_____ (W) _____ (C) _____

Email Address: _____

Emergency Contact:_____Phone_____

How did you hear about us?_____

Would you like to check for acupuncture benefits with your insurance company? ☐ Yes ☐ No

If yes, please list your insurance provider and ID# below.

Provider:_____ ID#_____

Do you currently see a pain doctor? ☐ Yes ☐ No If yes, who is it_____

Who is your Primary Care physician? _____

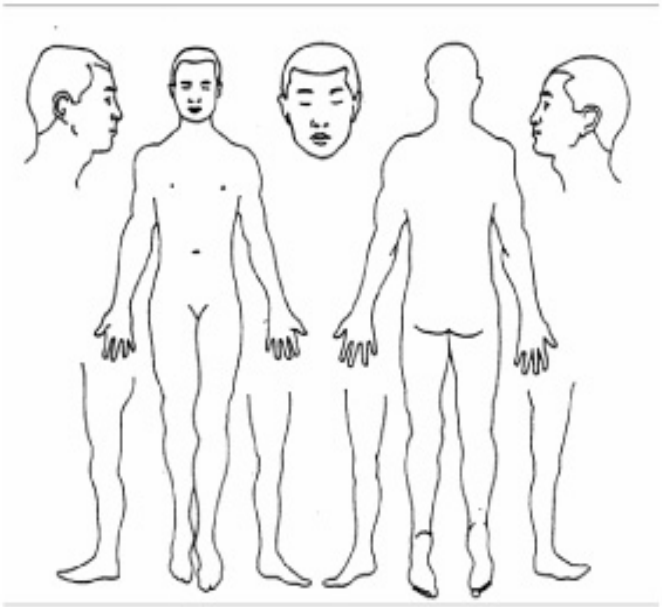
I. **Goals:** What would you most like to achieve through your work with Dr Karen Taylor?

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

II. **Major Symptoms:** Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

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

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain or discomfort in any area of your body? **Yes / No**

If yes, using the models to the right, please indicate the location of the discomfort by **using the symbol that best describes the feeling**

X X X = Sharp/stabbing
P P P = Pins and Needles
D D D = Dull/Aching
N N N = Numbness

For Women:

1. Are you pregnant now? ☐ Yes ☐ No ☐ Unsure
2. Indicate the number of occurrences:
   Live Births_____ Pregnancies _____Miscarriages _____ Abortions_____
3. Age:
   First Period _____ Menopause (if applicable)_____
4. Date:
   Last Pap Smear _____/_____/_____ Last Mammogram ____/_____/_____
5. Any history of an abnormal Pap Smear?? ☐ Yes ☐ No If so, what/when? _____

6. Is your menses cycle regular? ☐ Yes ☐ No
   a. Average number of days of flow _____
   b. The flow is: ☐ Normal ☐ Heavy ☐ Light
   c. The color is: ☐ Normal ☐ Dark ☐ Purple ☐ Light Brown ☐ Brown
7. Do you have the following menstruation related signs/symptoms?

☐ Difficulty with orgasm	☐ Nausea	☐ PMS
☐ Pain with intercourse	☐ Breast Distention	☐ Vaginal discharge
☐ Blood clots	☐ Cramps	☐ Heavy discharge between periods
☐ Bleeding between periods		

For Men:

1. Do you have any bothersome urinary symptoms? ☐ Yes ☐ No

Describe: _____

2. Check all that apply:

☐ Erectile dysfunction	☐ Difficulty with orgasm	☐ Pain or swelling of the testicles	☐ Frequent need to urinate at night
☐ Impotence/erectile dysfunction	☐ Premature ejaculation	☐ Feeling of coldness or numbness in genitalia	☐ Pain/subtly of testicles

3. Do you get up at night to urinate? ☐ Yes ☐ No How often? _____
4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)? _____
5. Have you sought medical intervention for these problems? If so, when?
   _____
   _____
6. What treatments have you tried for these problems and how successful have they been?
   _____
   _____

III. Medical History

Please check all that apply	**Date Diagnosed**		**Date Diagnosed**
Diabetes	____/____/_____	High Cholesterol	____/____/_____
High Blood Pressure	____/____/_____	Low Blood Pressure	____/____/_____
Thyroid Disease	____/____/_____	Seizures	____/____/_____
Cancer	____/____/_____	Hepatitis	____/____/_____
HIV	____/____/_____	Others_____	____/____/_____

IV. Surgical History

_____ Date_____
_____ Date_____
_____ Date_____

V. Family History

Please check all that apply and state how you are related to the family member with that condition

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Glaucoma					

VI. Medications/Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (to chemicals, medications or foods):

_____ _____ _____
_____ _____ _____
_____ _____ _____

VII. Nutrition

1. Do you follow a special diet? ☐ Yes ☐ No If Yes, how would you describe the diet? (for example: vegetarian, low carb, vegan, glutten free, etc.)

   _____

2. What do you eat on a "typical" day?
   a. Breakfast _____
   b. Lunch _____
   c. Dinner _____
   d. Snacks _____
   e. Foods you tend to crave_____
   f. Foods you dislike _____

VIII. Social History

1. How much per day do you use of the following?
   a. Coffee, tea, soft drinks _____
   b. Alcohol _____
   c. Cigarettes, cigars, other tobacco _____
   d. Other drugs _____
2. Have you ever had a problem with alcohol or alcoholism? ☐ Yes ☐ No
3. Have you ever had a problem with dependency on other drugs? ☐ Yes ☐ No
4. If yes, which drug and when?

   _____
5. Do you have a known history of any exposure to toxic substances? ☐ Yes ☐ No
6. If so, please list which and when you first noticed symptoms?

   _____

   _____
7. In the past year, how many days have been significantly affected by your health? _____
8. How many days did you feel generally poor? _____
9. How many times were you in the hospital? _____
10. Please describe your current exercise regimen:
    Hours per week: _____ Activities: _____ ☐ No exercise
11. How many hours of sleep do you usually get per night during the week? _____
12. Do you awake feeling rested? ☐ Yes ☐ No Do you sleep well at night? ☐ Yes ☐ No
13. Who would you describe as your source of primary social support? What is their relationship to you? _____

IX. Other Information

Please list and briefly describe the most significant events in your life:

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

Have you been treated for emotional issues? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Do you have any other neurological or psychological problem? ☐ Yes ☐ No _____

Please provide us with any other information that you think is relevant for us to know.

_____

_____

_____

_____

Health: Check all that apply

General

Past	*Current*	*Condition*
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night sweats
☐	☐	Sweat easily
☐	☐	Chills
☐	☐	Localized weakness
☐	☐	Poor coordination
☐	☐	Bleed or bruise easily
☐	☐	Catch cold easily
☐	☐	Change in appetite
☐	☐	Strong thirst
☐	☐	Other_____

Skin & Hair

Past	*Current*	*Condition*
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors, lumps

Back & Neck

Past	*Current*	*Condition*
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Other _____
☐	☐	

Ears

Past	*Current*	*Condition*
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other _____
☐	☐	

Eyes

Past	*Current*	*Condition*
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses/contacts
☐	☐	Eye inflammation
☐	☐	Other _____
☐	☐	

Nose, Throat, Mouth

Past	*Current*	*Condition*
☐	☐	Nose bleeds
☐	☐	Sinus infections
☐	☐	Hay fever or allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing

Cardiovascular

Past	*Current*	*Condition*
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Phlebitis
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands /feet
☐	☐	Fainting
☐	☐	Difficult breathing
☐	☐	Swelling of hands/feet
☐	☐	Other _____

Respiratory

Past	*Current*	*Condition*
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Chronic obstructive
☐	☐	Pulmonary disease
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other _____

Gastro-Intestinal

Past	*Current*	*Condition*
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black
☐	☐	Stools
☐	☐	Bad Breath
☐	☐	Rectal Pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	Other _____

Genito-Urinary

Past	*Current*	*Condition*
☐	☐	Kidney stones
☐	☐	Pain or urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other _____

Male

Past	*Current*	*Condition*
☐	☐	Pain / itching genitals
☐	☐	Genital lesions / discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Other _____

Female

Past	*Current*	*Condition*
☐	☐	Frequent urinary tract infections
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal pap smear
☐	☐	Irregular menstrual periods
☐	☐	Painful menstrual periods
☐	☐	Premenstrual syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Hot flashes
☐	☐	Other _____

Neurological

Past	*Current*	*Condition*
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness/tingling of limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other _____

Psychological

Past	*Current*	*Condition*
☐	☐	Depression
☐	☐	Anxiety / stress
☐	☐	Irritability
☐	☐	Treated for emotional or
☐	☐	Psychological problems
☐	☐	Other _____

Infection Screening

Past	*Current*	*Condition*
☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphilis
☐	☐	Genital warts
☐	☐	Herpes: oral
☐	☐	Herpes: genital

Muscular-Skeletal

Past	*Current*	*Condition*
☐	☐	Stiff neck / shoulders
☐	☐	Low back pain
☐	☐	Back pain
☐	☐	Muscle spasm, twitching, cramps
☐	☐	Sore, cold or weak knees

Taylor Chiropractic & Oriental Medicine

Electronic Health Records Intake Form

******Please Complete This Form In Its Entirety, Enter "N/A" If Something Does Not Apply******

In compliance with requirements for the government EHR Program

Patient Name: _____
First Middle Last

Email Address: _____

DOB: ____/____/_____**Gender (Circle one):** Male / Female **Preferred Language:** _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / Caucasian (White)/ Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
(We realize race & ethnicity can be considered the same question, however, CMS requires providers to report on both)

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Are you currently taking any medications?
Please include regularly used over the counter medications, vitamins and supplements

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Please use the back of this page or attach a separate sheet if more room is needed

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Please use the back of this page or attach a separate sheet if more room is needed

☐ **I choose to decline receipt of my clinical summary after every visit**
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For Office Use Only

☐ **Photo Taken** **Height: _____** **Weight: _____** **Blood Pressure:_____ /_____**

Contact Consent Form

You physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

- LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GAURDIAN
- LEAVE INFORMATION ON AN ANSWERING MACHINE
- LEAVE INFORMATION ON A VOICEMAIL

Please read below and consider carefully whom you want to have access to your medical information.

I _____ give Taylor Chiropractic and Oriental Medicine my permission to leave phone messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

____ May leave message on primary contact phone number
____ May leave message on secondary contact phone number

My medical care may be discussed with the following individuals:
_____
_____
_____

_____ _____
Patient/Guardian Signature Date

INFORMED CONSENT TO ACUPUNCTURE CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effect, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

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

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr Karen Taylor, LAc DOM with Taylor Chiropractic and Oriental Medicine

PATIENT SIGNATURE:	
(Or Patient Representative)	(Indicate relationship if signing for patient)
OFFICE SIGNATURE:	