PATIENT INFORMATION

Name _____ **Date of Birth** _____
Last **First** **Middle Initial**

Street Address_____City_____State_____Zip_____

Home Phone: _____ **Work Phone:** _____

Sex: □ M □ F **Marital Status:** □ Single □ Married □ Domestic Partner □ Widowed □ Separated □ Divorced

Name of Spouse: _____ **Names/Ages of Children:**_____

Occupation:_____ **Employer:**_____

Emergency Contact Name:_____ **Phone #:** _____

How did you hear about this practice?_____

MEDICAL INFORMATION

Primary Care Physician: _____ **Phone #:** _____

Referring Physician: _____ **Phone #:** _____

Other health care practitioners (acupuncturist, chiropractor, counselor, lactation consultant, massage therapist, naturopath, medical specialist, other specialists):

Name	Type of practice	Phone number

REASON FOR VISIT

Please list, in order of priority, your present health concerns, problems or symptoms:

1.

2.

3.

What treatments have you tried for your main complaint(s)?

What factors do you feel are contributing to your main complaint(s)?

PATIENT NAME:_____ **BIRTHDATE:**_____

*Check symptoms you **currently have**, have had in the **past year**, or of which you have a **significant history**.*

GENERAL
- □ Anxiety/Depression
- □ Chills/Fever
- □ Convulsions/Seizures
- □ Dizziness/Vertigo
- □ Fainting
- □ Fatigue
- □ Forgetfulness
- □ Frequent colds
- □ Headache
- □ Night sweats
- □ Poor Coordination
- □ Sweat easily
- □ Sleep difficulties
- □ Tremors
- □ Weight change

SKIN/HAIR
- □ Acne
- □ Bruise easily
- □ Change in moles
- □ Dryness
- □ Hair loss
- □ Hair or nail changes
- □ Hives
- □ Itching
- □ Rash
- □ Sores that won't heal

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- □ Neck
- □ Shoulders
- □ Arms
- □ Hands
- □ Back
- □ Hips
- □ Legs
- □ Feet

EYE/EAR/NOSE/THROAT
- □ Blurred vision □ Glasses
- □ Double vision
- □ Eye pain or discharge
- □ Floaters/Spots in vision
- □ Night blindness
- □ Earache or ear discharge
- □ Hearing loss
- □ Ringing in ears
- □ Nosebleeds
- □ Postnasal drip
- □ Sinus problems
- □ Loss of smell
- □ Bleeding gums
- □ Change in taste
- □ Dentures
- □ Difficulty swallowing
- □ Hoarseness
- □ Recurrent sore throats
- □ Sores on lips or tongue
- □ Teeth problems
- □ TMJ or Jaw clicking

GASTROINTESTINAL
- □ Abdominal pain/cramps
- □ Blood in stool
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Loose stool
- □ Poor appetite
- □ Excessive hunger
- □ Excessive thirst
- □ Gas or bloating
- □ Hemorrhoids
- □ Indigestion/Heartburn
- □ Nausea
- □ Vomiting

RESPIRATORY
- □ Cough
- □ Cough with blood
- □ Difficulty breathing
- □ Phlegm
- □ Shortness of breath
- □ Tightness in chest
- □ Allergies/Hayfever

CARDIOVASCULAR
- □ Blood clots
- □ Chest pain or pressure
- □ Cold hands or feet
- □ Heart murmur
- □ Heart palpitations
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Rapid heart beat
- □ Swelling of hands/feet
- □ Varicose veins

GENITOURINARY
- □ Blood in urine
- □ Burning urination
- □ Difficulty urinating
- □ Frequent urination
- □ Painful urination
- □ Urgency to urinate
- □ Wake to urinate
- □ Lack of bladder control

MEN ONLY:
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sores on penis

WOMEN ONLY:
- □ Abnormal Pap Smear
  Date: _____
- □ Bleeding between periods
- □ Breast Augmentation
- □ Breast lump
- □ Decreased libido
- □ Fibrocystic breasts
- □ Hot flashes
- □ Irregular menses
- □ Menstrual pain
- □ Nipple discharge
- □ PMS
- □ Painful intercourse
- □ Uterine fibroids
- □ Vaginal discharge
- □ Vaginal sores

Are you pregnant? _____

Number of:
- Pregnancies _____
- Live births _____
- Miscarriages _____
- Abortions _____

Total number months of breastfeeding: _____

Current birth control method: _____

Age of first menses? _____
Time btwn menses? _____
Duration of menses? _____
First date of last menstrual period? _____

Date of last Pap: _____

HEALTH HABITS	***Use:*** *Regularly*	*Occasionally*	*Never*	*Past*
I consume alcohol:	□	□	□	□
I use tobacco products:	□	□	□	□
I engage in recreational drug use:	□	□	□	□
I am exposed to toxic materials:	□	□	□	□
I get at least 30 minutes of exercise/day:	□	□	□	□
Type:_____				
I have a spiritual or religious practice:	□	□	□	□
I feel supported at home:	□	□	□	□
I take time for "self-care":	□	□	□	□
I eat refined sugars or processed foods:	□	□	□	□
I have at least 32 oz of water a day:	□	□	□	□
I drink caffeinated beverages:	□	□	□	□

Do you follow a specific diet? If so, describe:

What are your short-term health goals?

What are your long-term health goals?

FAMILY MEDICAL HISTORY

Please check if you or close family members have had any of the following:

Disease	You	Family	Disease	You	Family	Disease	You	Family
Alcoholism			Epilepsy			Neurological Disorder		
Allergies/Hayfever			Fibrocystic breasts			Obesity		
Alzheimers			Fibroids			Osteoporosis		
Anemia			Fibromyalgia			Pacemaker		
Anorexia/Bulimia			Food Intolerance			Pneumonia		
Anxiety			Genetic Disorder			Polio		
Appendicitis			Glaucoma			Prostate Problem		
Arthritis			Gout			Psychiatric Care		
Asthma			Heart Disease			Rheumatic Fever		
Bleeding disorders			Hepatitis			Stroke		
Blood Pressure Issues			Hernia			Suicide Attempt		
Bronchitis			Herpes			Thyroid Problem		
Cancer (type:_____)			High Cholesterol			Tuberculosis		
Cataracts			HIV Positive			Ulcers		
Chemical Dependency			IBS			Ulcerative Colitis		
Chicken Pox			Kidney Disease			UTIs		
Crohn's Disease			Liver Disease			Vaginal Infections		
Chronic Fatigue Syndrome			Lupus			Venereal Disease		
Depression			Measles/Mumps			Varicose Veins		
Diabetes			Migraines			Other:		
Emphysema			Mononucleosis					
Endometriosis			Multiple Sclerosis					

IMMUNIZATIONS

Are you fully vaccinated? _____ If not, which have you avoided?_____

SURGERIES, HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year Type

MEDICATIONS AND SUPPLEMENTS

Name Dosage Reason

ALLERGIES

Please list any known allergies: □ No Known Allergies

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

X _____ _____

Signature of Patient (or Parent/Guardian if Patient is a Minor) *Date*

CONSENT FOR TREATMENT

I, _____(print name), hereby authorize Krystal Silva, ND, L.Ac. to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures: Including but not limited to general physical exams, assessment of mother/infant anatomy, observation of a feeding for evaluation of technique and effectiveness, neurological or musculoskeletal assessments.
Acupuncture: Insertion of special single-use, sterilized needles through the skin into underlying tissues at specific points on the body.
Herbs and Other Natural Medicines: Prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tincture (may contain alcohol), topical creams, pastes, plasters, washes, suppositories or other forms.
Homeopathy: Homeopathic remedies, often highly dilute quantities of naturally occurring substances.
Counseling: Recommendations for management to improve and/or resolve breastfeeding related issues. Lifestyle or psychological counseling.
Dietary Advice, Therapeutic Nutrition, and Exercise Prescriptions: Use of foods, diet plans or nutritional supplements. Recommendations for stretching and exercise.
Physical Medicine: Use of massage, tui na, gua sha, neuro-muscular techniques, energetic modalities, reiki, muscle energy stretching, craniosacral therapy, or visceral manipulation. Hydrotherapy such as hydrocolator, contrast or constitutional hydrotherapy, sitz baths.
Cupping: A technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.
Electromagnetic and Thermal Therapies: Moxabustion (warming or indirect burning of an acupuncture point), microcurrent stimulation, low and high volt electrical muscle stimulation, infrared or ultraviolet therapies.

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue injury from physical manipulations; nausea, loose bowel movements, abdominal cramping, fatigue; and aggravation of pre-existing symptoms.
Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, prevention of disease or its progression; and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: All female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

Please initial:
_____I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, with the understanding that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

_____I understand that Krystal Silva, ND, LAc is providing complementary and adjunctive care. Any change from my primary care physician's recommendations should be discussed with my physician.

_____I understand that the provider may consult with my physician or my child's physician if she deems it necessary. I hereby give authorization to release any information acquired in the evaluation/management of myself and/or my child to our health care providers, referring physician, breastfeeding consultant, or insurance company upon request.

_____ I have received a copy of this provider's Privacy Practices.

_____I understand that payment in full is due at the time of service unless other arrangements have been made prior to my appointment. It is my responsibility to pursue reimbursement for services from my insurance company.

X _____ _____

Signature of Patient (or Parent/Guardian if Patient is a Minor) *Date*