



White Peony Acupuncture Kim Silsby, L.Ac.
885 N. San Antonio Road, Suite M, Los Altos, CA 94022 650-948-9642

Confidential Intake Form

Name: _____ Date _____

Address: _____

City, State, Zip _____

Which phone # is best to reach you? _____

Email address: _____

Date of birth: _____ Age: _____ Marital Status: _____

Emergency contact, including phone number: _____

How were you referred to White Peony Acupuncture? _____

Fees for services

Initial Consult and Acupuncture in office: \$125

Established client acupuncture in office: \$75

Consult 30/60 minutes, no acupuncture: \$50/\$75

Missed appointment fee: \$50

On call Acupuncture at El Camino Hospital: \$195

On call labor/pregnancy acupuncture/consult: \$250

Out of office home visit, new patient: \$155

Out of office home visit, established patient: \$105

You are required to pay the provider for services at each visit.

Receipts are available upon request.

I have read and understand my responsibility for payment of services.

Patient Signature

Date:



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Cancellation, rescheduling, and payment policy

I understand that there are times when you will need to cancel and/or reschedule your appointment.

I am happy to accommodate your needs. It is my policy, however, that all cancellations and/or rescheduled appointments take place by phone at least 24 hours prior to the date of your originally scheduled appointment.

A fee of **\$50** will be charged if this policy is not honored.

Thank you for your understanding.

I am requesting that you write in your credit card info here, which will be charged for any missed appointment.

Please sign here to indicate you understand, accept, and consent to this policy:

Patient signature

Date

Credit Card Info: Name on card: _____

Type of card: _____ # _____ exp: _____



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What health/ wellness concerns are you here to address? _____

Please list the **medications, supplements, and herbs** you are currently taking:

Please list known **allergies** to environment, food, supplements, or medications:

Please list the name(s) of your current Medical Doctor(s): _____

Where would you rate your current stress level on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

Where would you rate your energy level on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

When did you last have a history and physical? _____

Is your cholesterol normal, date last checked? _____

What is your blood pressure, date last checked? _____

Do you exercise; what type and frequency? _____

Where do you experience pain? _____

When did the pain begin, and was there an injury or an event which initiated it ?

What is the severity of pain **today?** : 0 1 2 3 4 5 6 7 8 9 10

What is the severity of pain **usually?** 0 1 2 3 4 5 6 7 8 9 10

Please describe any digestion problem _____

Please explain your typical diet: _____

Do you sleep well, how many hours? _____

Ever feel hot at night, or wake up sweaty? _____

Are you generally warmer or cooler than others around you? _____

Does elimination occur daily? _____

Describe your general mood _____

Current weight _____ Height _____

Medical Conditions History

Condition	Yes/ No	<u>Comments</u>
German measles (Rubella)		
Migraine		
Prolonged dizziness		
Glasses/contact lenses		
Thyroid problems		
Pneumonia		
Tuberculosis		
Asthma		
Bronchitis		
Other lung conditions		
Heart attack		
Heart murmur		
Rheumatic fever		
Other heart conditions		
High blood pressure		
Gastric/duodenal ulcer		
Hepatitis		
Cirrhosis		
Intestinal bleeding		
Bleeding tendency		
Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infection		
Other kidney disorders		
Bladder infection		
Rheumatoid arthritis		
Other forms of arthritis		
Lupus erythematosus		
Paralysis		
Neurological disorders		
Thrombophlebitis		
Varicose veins		
Breast tumor (benign)		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Other Cancer		

Please list surgeries you have had and the dates: _____

Female Reproductive History

Menstruation: Age it began: _____ Is your cycle regular? _____

Please circle descriptions that most often apply to your menstrual cycle:

Blood color: pale red, red, deep red, brown **Blood consistency:** watery, thick, thin **Amount:** light, normal, heavy

Date of last menstrual cycle: _____ How many days of bleeding? _____

How many days in between cycles? (ie: 28-30 days, etc.) _____

Do you experience cramps, breast tenderness, mood changes, back pain, acne at any time in your monthly cycle?

How do you typically cope with cramps or pms ie: (heat, pain relievers)? _____

Do you experience specific food cravings before, during, or after your menses? _____

Do you ovulate? ____ On what day in your cycle? _____ How do you check for ovulation? _____

Have you been diagnosed with fibroids, cysts, polyps, PCOS, or endometriosis? _____

Do you experience chronic vaginal discharge? _____

Ever had an abnormal pap? When? _____

Ever had a cervical biopsy, operation, cauterization, or conization? _____

Have you ever tested positive for: Chlamydia, venereal disease, hpv, or herpes II? _____

Did your mother ever take DES while pregnant with you? _____

Lab Results (most recent and prior if known)

FSH _____

LH _____

Estrogen _____

Testosterone _____

Prolactin _____

TSH _____

Progesterone _____

Immunology _____

How long have you been trying to conceive? _____

Are you currently breast-feeding? _____ # of months

Are you currently pregnant? _____ # of weeks

How many?

Date(s)

Inseminations (IUI) _____

In Vitro Fertilizations _____

Pregnancies _____

Births _____

Miscarriages _____

Terminations _____

Male Reproductive History

How long have you and your partner been trying to conceive? _____

Have you been evaluated by a Urologist? _____

If yes, what was the diagnosis? _____

Date(s) of last semen analysis: _____

Have your semen analysis been normal? _____

Have you achieved pregnancy with any partner? _____

Do you smoke cigarettes/cigars/marijuana? _____ # per day _____ # of years _____

Do you drink alcohol? _____ How many drinks per week? _____ # of years _____

Do you regularly use a hot tub? _____ # times per week _____

Lab Results:

Test/Procedure	Date	Result	Comment
Blood Tests			
Testosterone			
Antisperm Antibodies			
DQ Alpha			
Male Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			