



Many Lives Chinese Medicine Client Intake Form

Date:

Phone:

Name:

Birthdate:

Age:

Address:

City:

Zip:

Email Address:

Emergency Contact:

Phone:

Referred by:

Please be respectful of our time and yours.

Missed or cancelled appointments:

- **There will be NO Appointment Cancellations acknowledged on SUNDAY.**
- **Please give twenty-four (24) hour notice or you will be charged in full for the missed appointment.**

Client Signature:

Date:

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:	Color on subsequent days:	Pain with cycle:
<input type="checkbox"/> Pale red	<input type="checkbox"/> Pale red	<input type="checkbox"/> Mild
<input type="checkbox"/> Red	<input type="checkbox"/> Red	<input type="checkbox"/> Medium
<input type="checkbox"/> Deep red	<input type="checkbox"/> Deep red	<input type="checkbox"/> Severe
<input type="checkbox"/> Brown	<input type="checkbox"/> Brown	

Clotting:	Blood constitution:	Bleeding:
<input type="checkbox"/> Yes	<input type="checkbox"/> Watery	<input type="checkbox"/> Light
<input type="checkbox"/> No	<input type="checkbox"/> Thin	<input type="checkbox"/> Normal
	<input type="checkbox"/> Thick	<input type="checkbox"/> 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 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pelvic adhesions | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Polyps | <input type="checkbox"/> No <input type="checkbox"/> Yes | Pelvic abnormality | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Endometriosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | PCOS | <input type="checkbox"/> No <input type="checkbox"/> 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? _____

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		
<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Aversion to heat/cold
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Excess thirst	<input type="checkbox"/> Low-back pain
<input type="checkbox"/> Catch colds easily	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Joint disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	

Energy level	Stress
<input type="checkbox"/> High (time of day) _____	<input type="checkbox"/> None
<input type="checkbox"/> Low (time of day) _____	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Severe
	What causes it? _____

Sleep problems		
<input type="checkbox"/> Trouble falling asleep	<input type="checkbox"/> Trouble staying awake	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Trouble staying asleep	<input type="checkbox"/> Excess dreaming	
<input type="checkbox"/> How many hours do you sleep each night? _____		

Sweating	Circulation
<input type="checkbox"/> Rarely sweat	Feelings of: <input type="checkbox"/> Hot
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Cold What area? _____
<input type="checkbox"/> Excess sweating	
<input type="checkbox"/> Spontaneous sweating	Hands and feet get cold easily: <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Head & neck		
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Double vision	<input type="checkbox"/> Headaches (list where): _____
<input type="checkbox"/> Eye pain	<input type="checkbox"/> "Floaters" (spots in vision)	
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Burning eyes	

Ears & nose		
<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Ringing/buzzing in ears	<input type="checkbox"/> Congestion/allergies
<input type="checkbox"/> Ear aches	<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Ear discharge/infections	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Other: _____

Chest		
<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Mucous rattle when breathing	<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Trouble breathing at night	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing phlegm
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Persistent cough	Color: _____
<input type="checkbox"/> Pain/pressure in chest	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Coughing blood	

Genito-urinary		
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Strong-smelling urine	<input type="checkbox"/> Water retention
<input type="checkbox"/> Day	<input type="checkbox"/> Pain or burning on urination	<input type="checkbox"/> Abnormal color
<input type="checkbox"/> Night	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Difficult to urinate	<input type="checkbox"/> Frequent infections/dysfunction	

Neurological		
<input type="checkbox"/> Tremors	<input type="checkbox"/> Pain; where: _____	<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Numbness; where: _____	<input type="checkbox"/> Paralysis; where: _____	<input type="checkbox"/> Stroke
<input type="checkbox"/> Tingling; where: _____	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other: _____

Emotional & mental		
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Moody	<input type="checkbox"/> Fearful
<input type="checkbox"/> Depressed	<input type="checkbox"/> Mind not clear	<input type="checkbox"/> Terrors
<input type="checkbox"/> Easily angered	<input type="checkbox"/> Manic	<input type="checkbox"/> Difficulty expressing emotions
<input type="checkbox"/> Easily irritated	<input type="checkbox"/> Obsessive	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Frequent crying	<input type="checkbox"/> Compulsive	
<input type="checkbox"/> Disoriented	<input type="checkbox"/> 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
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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 $\frac{3}{4}$ 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 $\frac{3}{4}$ 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!

Privacy Policy (1/2019)

This notice describes how health care information about you may be used and shared, and how you can get access to this information. Please review this carefully.

We are required by law to inform you of how your health information will be protected, used, or shared by Many Lives Chinese Medicine and its staff. If you have any questions please contact MLCM at 650-366-4299.

MLCM practitioners and staff consider your health information to be private and confidential. All information you provide, and information obtained during the course of treatment is used solely for the purpose of you and your individual treatment.

Your personal health information will only be disclosed between practitioners in order to provide you the best possible care, all MLCM practitioners work as a group.

Your information will only be provided to a third party with your written consent for the purposes of payment, insurance payment, or another practitioner outside of MLCM involved in your care.

Your information can and will be provided without your consent when it is required by law. This includes but is not limited to:

- Cases of suspected abuse or neglect
- Information demanded by legal subpoena
- Public Health authorities where required by law to control disease or injury
- Health and safety of yourself or another person to prevent serious threat

You have the right to request in writing any of the following:

To be informed of any disclosure of your health information

To change or modify your health information

A copy of your health information (fee for copies made)

Confidential communications made with our office (inform us of how to contact you)

Limitation of how your health information is shared or disclosed

You have the right to file a complaint if you believe your health privacy has been violated. U.S. Department of Health and Human Services Office for Civil Rights.

Any Changes made to this policy will be provided to you in writing as soon as possible following changes

Signature _____ Date _____

As part of keeping in touch with our clients, we send out a monthly newsletter which includes recommendations for keeping healthy, new offerings at MLCM and other fun and useful updates. If you would like to opt out of this email, please check the opt out space below. We always respect your privacy, and will never share your information with anyone else. OPT OUT _____