Jacqueline N. O'Neill, MSTOM, L.Ac.
Collaborative Care | 3723-25 N. Southport Ave. | Chicago, IL 60613
Tel: 773 | 576-3925; Web: www.collaborativecarechicago.com

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in assessment and treatment. All information is strictly confidential.

GENERAL PATIENT INFORMATION

Date: ____________________

First Name: ____________________________ Last Name:____

Street Address: _____________________________________Suite/Apt.# ____________________________

City: ________________________________State:____________________Zip:______________________

Home Phone: _________________________Work Phone: _______________________________________

Email: ______________________________________

Date of Birth: _________________________Place of Birth: _____________________________________

Guardian (if under 18 years of age): ____

Emergency Contact: ____

Emergency Contact Phone#:_________________________________Relationship:____________________

Occupation: ___________________________Employer: ____

If you were referred to Collaborative Care, name of referrer? ____________________________________

Primary Physician Name: ____________________________Phone: _______________________________

Gender: ☐ M ☐ F Height: _____'_____" Weight: ___________

Marital Status: __________________

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes ☐ No ☐

List the primary conditions you would like us to help you with, in order of significance:

____

____

____

How long ago did these problem(s) begin, please be specific:

What previous medical workups, diagnosis and treatment have you had for this problem? How have these been helpful or unhelpful?

Please list any allergies to drugs or medications:

What medications or supplements are you currently taking?

Medication	Dosage	Duration of Use

List your history of any illnesses, surgeries, or injuries (please include the YEAR, ILLNESS, TREATMENT and OUTCOME):

ILLNESSES

SURGERIES

____

____

____

____

INJURIES / TRAUMA

____

____

____

____

FAMILY HISTORY

- ☐ Allergies
- ☐ Emotional Difficulties
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Seizure Disorders
- ☐ Thyroid Problems
- ☐ Heart Problems
- ☐ Tuberculosis
- ☐ Hypertension/ High BP
- ☐ Stroke
- ☐ Cancer

CHECK ANY CONDITIONS OR SYMPTOMS **YOU PRESENTLY HAVE** OR **HAVE HAD IN THE PAST.**

SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT
Cough			**Pneumonia**		
Cough with blood			**Sputum/phlegm**		
Shortness of breath			**Asthma**		
Bronchitis			**Lack of perspiration**		
Seasonal allergies			**Excessive perspiration**		
Chronic colds			**Nose bleeds**		
Sinus congestion			**Nasal polyps**		
Sinus infections			**Loss of smell**		

SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT
Irregular Heartbeat			**Chest pains**		
Poor circulation			**Heart attack**		
Dizziness			**Low blood pressure**		
Palpitations			**High blood pressure**		
Fainting spells			***If high blood pressure, treatment and outcome?***		
Indigestion			**Abdominal cramping**		
Nausea			**Diarrhea**		
Vomiting			**Constipation**		
Vomiting w/ blood			**Laxative use/product**		
Gas			**Alternating Diarrhea and Constipation**		
Bloating			**Rectal pain**		
Belching			**Hemorrhoids**		
Acid regurgitation			**Blood in stool**		
Poor appetite			**Bowel movements every # days?**		
Excessive appetite			**Number of bowel movements / day?**		
Frequent urination			**Burning on urination**		
Excessive urination			**Difficulty urinating**		
Nighttime urination			**Painful urination**		
Unable to hold urine			**Blood in urine**		
Kidney stones			**Sexually transmitted diseases**		
Bladder infections					

SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT
Muscle pain			**Joint pain**		
Muscle weakness			***Where is joint paint?***		
Muscle spasms			**Neck pain**		
Back pain (lower)			**Knee pain**		
Back pain (middle)			**Numbness**		
Back pain (upper)			***If numbness, where?***		
Pain goes down the legs					

Wear glasses			**Eye tiredness / strain**		
Blurred vision			**Seeing spots**		
Double vision			**Sensitivity to light**		
Cataracts			**Eye dryness**		
Glaucoma			**Eye redness**		
Eyes feel swollen			**Eye itchiness**		
Pressure in the eye			**Eye tearing**		
Eye pain					

Hearing difficulties			**Loss of balance**		
Ringing in the ears			**Ear infections**		
Ear pain					

SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT
Sore throats			**Sore gums**		
Mouth dryness			**Bleeding gums**		
Bad taste in mouth			**Sore tongue**		
Halitosis			**Numbness in the tongue**		
Mouth sores / ulcerations			**Grinding teeth**		

Changes in the skin color			**Dandruff**		
Skin bruising			**Eczema**		
Skin rashes			**Psoriasis**		
Skin acne			**Skin ulcerations**		

Sudden weight loss			**Sudden weight gain**		
Diabetes			**Thyroid disorder**		

Anxiety			**Problems with alcohol or drug use**		
Depression			**Psychological crisis**		
Irritability			**Emotional difficulties**		
Hot tempered			***Psychoactive medications**		

SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT
Stress			**If *Psychoactive medications, please list:**		

Fevers			Seizures		
Chills			Concussion		
General Chilliness			Headache		
Cold hands/feet			Shaking/tremors		
Cold Intolerance			Cysts/Tumors		
Heat Intolerance			Edema/water retention		
General warmth			Night Sweating		
Fatigue			Insomnia		
Anemia			Nightmares		
Poor memory					

HABITS/GENERAL HEALTH

Smoking: How many packs/day? ______________________

Alcohol: How many drinks per day? ___________________ How many drinks per week? ____________

NUTRITION
What do you typically eat for the following:

Breakfast: ____

Lunch: ____

Dinner: ____

EXERCISE

What is your daily activity level related to your occupation:

- ☐ Sedentary i.e mostly sitting
- ☐ somewhat active
- ☐ moderately active
- ☐ very active (moving around or up most of the time)
- ☐ heavy duty (lifting, moving thingd etc.)

What kind of physical activity level (exercise, sports) do you participate in?

____

____

____

How often per week?

____

____

How long each time?

____

____

Miscellaneous:

How much water do you drink per day? ____________________________

How many caffeine containing products (coffee, tea, carbonated pop) do you drink per day?

____

____

Snacks on a typical day: ________________________________

____

____

MALE PATIENTS: PLEASE COMPLETE THE FOLLOWING SECTION.

Please check any conditions or symptoms that you presently have or had in the past:

CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT
Prostate enlargement			Premature ejaculation		
Prostatitis			Impotence		

Thank you for completing our new patient intake form!

Please bring your completed form with you on your first visit.

Don't forget to sign and date the following Patient Informed Consent letter.

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PATIENT INFORMED CONSENT

1. I hereby voluntarily consent to be treated by acupuncture and or Chinese Herbs administered by Jacqueline O'Neill, hereinafter referred to as "Practitioner".

2. I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve body function and/or relieve pain.

3. I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

4. I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese herbs.

5. I understand that I may stop treatment at any time.

6. I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic channels of the same name.

7. I acknowledge the fact that Jacqueline O'Neill is not and does not profess to be a western-trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does the Practitioner give any substances by injection.

8. I acknowledge that Jacqueline O'Neill has completed a minimum of three years training In Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the state of Illinois.

9. The clinical data gathered in practice, without names, may be used for statistical research and teaching purposes.

Signature: ___________________________________ Date: _______________________