



Jacqueline N. O'Neill, MSTOM, L.Ac.
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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

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hypertension/ High BP |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> 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			<i>If high blood pressure, treatment and outcome?</i>		
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			<i>Where is joint pain?</i>		
Muscle spasms			Neck pain		
Back pain (lower)			Knee pain		
Back pain (middle)			Numbness		
Back pain (upper)			<i>If numbness, where?</i>		
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		
Ringling 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: _____

FEMALE PATIENTS: PLEASE COMPLETE THE FOLLOWING SECTION.

Are you pregnant? Y N Not sure

Please list history of pregnancy and dates (year). Note if full term (**FT**), premature (**P**), miscarriage (**MC**), abortions (**A**), whether vaginal (**V**) or Cesarean section (**C**). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)

Menstruation

Age of onset: _____ Last Menstrual Period (first day of) _____

Date of last Pap exam: _____ Result _____

Length between periods _____

Regularity:

regular irregular usually early usually late varies between early and late
by _____ days by _____ days

How many days of menstrual flow do you usually have? _____

Flow is: even uneven heavy light

Color is: pale/pink red deep red purplish brown

Consistency is: thin thick clotted

Check any of the following symptoms (before, during or after) menstruation:

lower abdominal distention before during after

lower back soreness before during after

cramping before during after

Other: _____

Premenstrual Syndrome (PMS)

irritability bloating mood swings breast tenderness

other: _____

Vaginal Discharge

No Yes

If yes, color and amount: _____

Menopause:

Age of onset: _____

Any difficulties / symptoms? _____

Uterine bleeding (not related to periods)

No Yes

If yes, color and amount: _____

comes on suddenly all the time

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: _____