Acupuncture & Chinese Medical Center

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex ◯F ◯M	Date
Date of birth	Age	Occupation	S. S #
E-mail address	Home phone #	Work phone #	
Address: Street		City State	Zip
In Emergency notify		Marital status ◯S ◯M ◯D ◯W	# of children
Family physician		Chiropractor	
Do you have a health insurance? ◯Yes ◯No		Name of insurance company	
Does your insurance cover acupuncture? ◯Yes ◯No ◯?		Have you ever been treated by acupuncture before? No	
How did you know this clinic ? ◯*Friends/Relatives* _____ ◯*Periodicals* ◯*Direct mails;* ◯*Location or walk by;* ◯*Website* ◯*Referred by* _____ ◯*Yellow Pages;* ◯*Other (please specify)*			

Main problem(s) : You would like us to help you with _____.

When did this problem begin? What are the precipitating factors?

Have you been given a diagnosis for this problem? If so, what?

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?

What kind of treatment have you tried?

What makes this problem worse? What makes this problem better?

Is there anybody in your family with the same/similar problems? Remarks and additional information:

Past medical history (Please include the month/year when the diagnosis was established)

Significant illness: ☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Thyroid Disease ☐ Seizures
☐ Fibromialgia ☐ Arthritis ☐ Tuberculosis ☐ Hypertension ☐ Emotional Imbalance ☐ Anemia
☐ Breathing Problems ☐ Heart Disease ☐ Digestive Disorders ☐ HIV/AIDS Positive ☐ Veneral Disease
☐ Other (pleased specify)

Surgeries: **Hospitalization:**

Significant trauma (auto accidents, sports injuries, etc) :

Allergies: (drugs, chemicals, foods)

Family medical history (Please specify family member) ☐ Cancer ☐ Diabetes ☐ Hepatitis
☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Asthma ☐ Alcoholism ☐ Miscarriage ☐ Other (pleased specify)

Medicines taken within the last two months (including Vitamins, OTC drugs, herbs, etc., and their dosages)

Occupation Do you usually work ◯ indoors ◯ outdoors ?

Occupational stress (chemical, physical, psychological, etc)

Personal Height_____ Weight now_____ One year ago _____

Weight maximum _____@Year _____

Habits Do you smoke ☐ Yes ☐ No What? _____ How many per day?_____ Since when? _____

Please describe any use of drugs for non-medical purposes:

Do you exercise regularly ☐ Yes ☐ No Please describe your exercise program:

How many hours do you sleep in general? When do you usually go to bed?

Diet How much coffee do you drink ? _____cups/day ; Colas _____number/day; Tea _____cups/day.

What kind of alcoholic beverages do you usually drink? _____, average number of drinks/week ? _____

How much water do you drink per day? _____

Are you a vegetarian? ◯ Yes ◯ No ◯ Yes, but not so strict Do you eat a lot of spicy food ? ◯ Yes ◯ No

Remarks and additional information (e.g. diet)

Please describe your average daily diet (Please be as specific as possible):

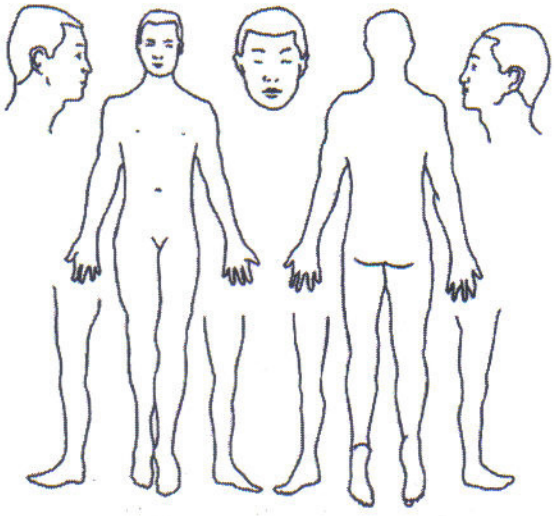
Morning

Afternoon

Evening

Snacks

Indicate painful or distressed areas:



Please check if you have or have had (in the last tree months) any of the following diseases or conditions.

General

☐ Poor appetite ☐ Poor Sleeping ☐ Fatigue ☐ Fevers ☐ Chills

☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite

☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain

☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)

☐ Sudden energy drop (What time of a day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair ☐ Purpura
☐ Change in hair or skin textures ☐ Other?

Musculoskeletal ☐ Joint disorders ☐ Weakness muscles ☐ Pain/soreness in the muscles ☐ Tremors
☐ Difficult walking ☐ Cold hands/feet ☐ Swelling of hands/feet ☐ Back pain ☐ Spinal curvature ☐ Hernia
☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Sprain of joint ☐ Other

Head, eyes, ears, nose, and throat ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens
☐ Eye strain ☐ Eye pain ☐ Color Blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts
☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Facial pain
☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other

Cardiovascular ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other

Respiratory ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty in breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal pain
☐ Hemorrhoids ☐ Abdominal pain/cramp ☐ Gallbladder problems ☐ Parasites ☐ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological ☐ Loss of balance ☐ Lack of coordination ☐ Concussion
☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary ☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgent to urinate
☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection
☐ Pain in genital ☐ Itching of genital ☐ Other

Female ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge
☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods
☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods
_____ number of pregnancies _____ number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ Cesareans _____ Difficult delivery
First date of last period _____ Age of first menses _____ Duration of periods _____days, cycle _____ days
Do you practice birth control ? ☐ Yes ☐ No . If yes, what type and for how long? _____
If you're on birth control pills, what are you taking and for how long? _____

Male ☐ Prostate problems ☐ Discharge ☐ Impotence ☐ Frequent seminal emission
☐ Fertility problem ☐ Ejaculation problems ☐ Painful/swollen testicles ☐ Other

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at the Acupuncture & Chinese Medical Center (ACMC) who now or in the future treat me while employed by, working or associated with or serving as backup for ACMC, including those working at this clinic: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing; modes of manual or physical therapy such as Tuina, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to bleeding, bruising, pneumothroax (punctured lung), puncture of other organs, pain or other strong sensations at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise such judgment during the course of my treatment as the doctor feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at the ACMC clinic.

_____ _____

Patient's name (please print) Patient's signature

_____ _____

Print name of patient's representative (if applicable) Relationship or authority of patient's representative

_____ _____

Date signed Witness

Notification Regarding Evaluation of Patient by Physician

Pursuant to the requirement of section 183.6 (e) of this title and section 6.11, subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture)

I (patient's name),_____ am notifying the ACMC of the following:

Yes☐ No☐ I have been evaluated by a physician, dentist, or nurse practitioner, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

OR

Yes☐ No☐ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is_____, After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Yes_____No_____The acupuncturist has referred me to a physician. It is my responsibility and choice to follow this advice.

_____ _____ _____

Patient Signature (required) Acupuncturist's Signature Date Signed

Acupuncture & Chinese Medical Center

New Patient Information

Welcome to the Acupuncture & Chinese Medical Center. Our clinic is a professional clinic specializing in Oriental medicine which includes acupuncture, herbal consultation and Asian bodywork.

Professional Clinic Appointments

Treatments are by appointment only. In order to better serve you, it is important that we receive twenty-four (24) hour notice if you need to cancel or reschedule an appointment. This enables us to fill the time slot. We reserve the right to charge a current acupuncture treatment fee for appointments canceled with less than twenty-four hours notice or for "no show" appointments.

Payment for Services Rendered

Payment is due at the time of service and May be paid in cash or by check or credit card (Master Card, Visa or Discover only). We reserve the right to charge $25.00 fee for any returned check.

Insurance

We will file insurance claims on your behalf after we have been able to establish with your insurance company that they will honor our claim filing. Until such willingness has been established, it will be necessary for you to pay for your treatment and we will provide you with an insurance receipt which you may use to file your claim. It's your responsibility to pay off unpaid balance related to your treatment.

Please sign and date on the line provided below. Thank you for allowing us to provide you with a quality, low cost alternative to traditional health care.

Patient Signature: _____Date:_____