

Acupuncture Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Name: _____ Date of First Visit: _____

Date of Birth: _____ M / F Occupation: _____

Address: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email Address _____ Preferred method of contact: Home Cell E-Mail

Family Doctor: _____ Phone _____

Emergency Contact Name: _____ Phone: _____

How did you hear of us? _____

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: _____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _____

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it

For females: Are you pregnant? NO Possibly YES How far along? _____

Do you have a contagious disease at this time? NO YES: _____

If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

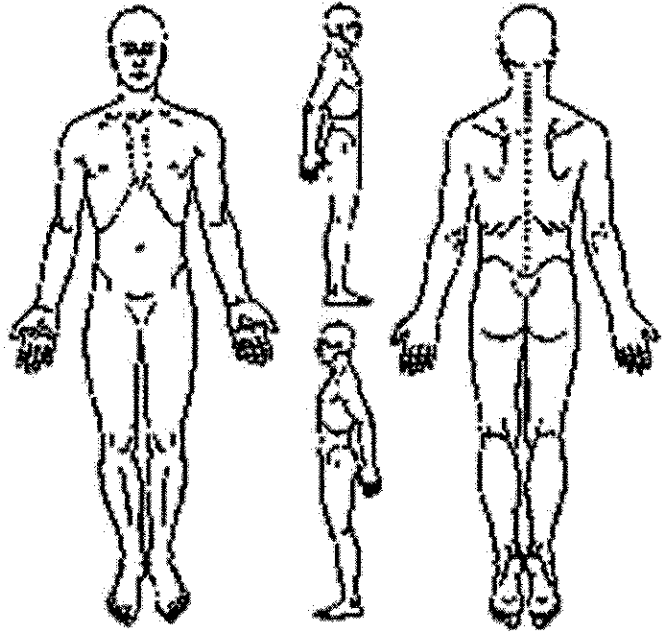
Pain Condition #1 Degree of pain (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain

- Constant
- Comes and goes
- Fixed
- Moves
- One side
- Both sides
- Sharp
- Dull
- Burning
- Aching
- Spastic
- Numb

Does the pain get better, or worse with?

- Heat *better worse*
- Cold *better worse*
- Motion *better worse*
- Rest *better worse*
- Pressure *better worse*
- Better in AM or PM?



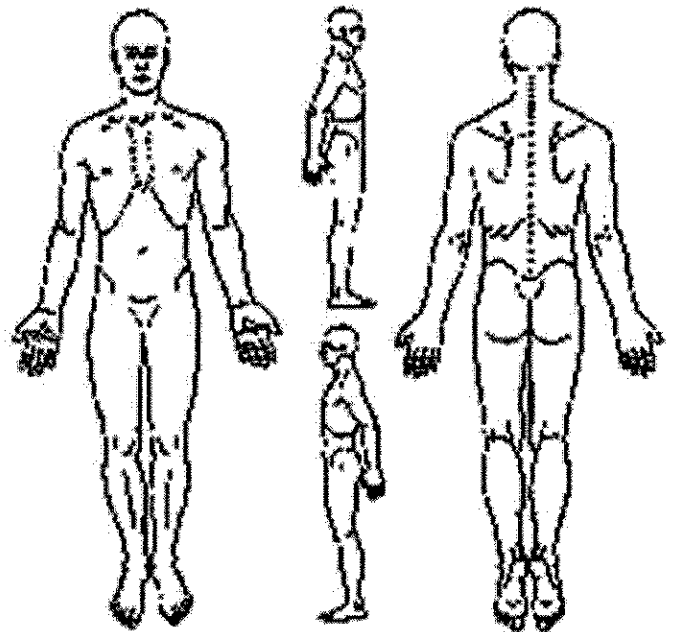
Pain Condition #2 Degree of pain (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain

- Constant
- Comes and goes
- Fixed
- Moves
- One side
- Both sides
- Sharp
- Dull
- Burning
- Aching
- Spastic
- Numb

Does the pain get better, or worse with?

- Heat *better worse*
- Cold *better worse*
- Motion *better worse*
- Rest *better worse*
- Pressure *better worse*
- Better in AM or PM



Do you have any of the following?

- Pacemaker
- Surgical replacements
- Implants
- Other allergy _____
- Hemophilia
- Sensitive skin
- Fear of needles
- Latex allergy
- Nut allergy

Is There Family History of:

- Alcoholism
- Allergies
- Asthma
- Bleeding disorders
- Cancer
- Other _____
- Depression
- Diabetes
- Heart disease
- High blood pressure
- Kidney disease
- Mental illness
- Seizures
- Stroke

How much do you consume per day of:

- Water _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Cigarettes _____
- Generally, do you prefer warm drinks cold drinks room temperature drinks?
- Do you find that you are always thirsty rarely thirsty or thirsty for sips later in the day?

What are your typical eating habits?

- Skip Meal(s) _____
- Eat in a Rush
- Eat When Not Hungry
- Craving specific food(s) _____
- Other: _____
- Eat too Fast
- Cannot eat when Worried/Stressed
- Excess Hunger
- No Desire to Eat
- Eat late at night

What are your typical sleeping habits?

- Hours slept/night _____
- Fall asleep quickly
- Trouble falling asleep
- Difficulty waking up
- Other _____
- Trouble staying asleep
- Deep sleeper
- Light sleeper
- Frequent dreaming
- Disturbing dreams
- Wake at same time every night _____

How would you describe your energy levels?

- High
- Low
- Other _____
- Normal
- Lethargic
- Hyperactive
- Changes from day to day

Do you have aversion to any of the following?

- Cold
- Wind
- Other _____
- Dampness
- Heat
- Loud Noises
- Crowds

What is your Average Body Temperature?

- Hot
- Cold
- Other _____
- Cold Hands & Feet
- Hotter @ Night
- Colder @ night
- 5 Center Heat
- Hot Joints

General Information

- | | | |
|--|---|--|
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Thyroid Disease <ul style="list-style-type: none"> <input type="checkbox"/> Overactive <input type="checkbox"/> underactive |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatoid Disease | |
| <input type="checkbox"/> Herpes/Cold Sores | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cancer: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|--|--|
| <input type="checkbox"/> Bitter taste | <input type="checkbox"/> Grinding of teeth | <input type="checkbox"/> Ringing in ears <ul style="list-style-type: none"> <input type="checkbox"/> High pitch <input type="checkbox"/> Low pitch |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Goiter | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gum problems | |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus issues |
| <input type="checkbox"/> Dry mouth / nose | <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Excess phlegm | <input type="checkbox"/> Migraines | <input type="checkbox"/> Teeth issues |
| <input type="checkbox"/> Eye pain or strain | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> TMJ Syndrome |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> Glasses or contacts | <input type="checkbox"/> Red or dry eyes | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Other: _____ | | |

Respiratory:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Cough + Phlegm | <input type="checkbox"/> Cough + blood |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Difficult breathing |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heavy Chest | <input type="checkbox"/> Tight Chest |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Short of Breath |
| <input type="checkbox"/> Cough | <input type="checkbox"/> COPD | |
| <input type="checkbox"/> Other: _____ | | |

Cardiovascular:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Easily bruised | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Pace maker |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Gastrointestinal

- | | | |
|--|--|--|
| <input type="checkbox"/> # Bowel Movements/day____ | | |
| <input type="checkbox"/> Normal Stool | <input type="checkbox"/> Pain after BM | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Loose stool | <input type="checkbox"/> Heartburn/acid reflux | <input type="checkbox"/> Rectal pain/itching |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Undigested food in stool | <input type="checkbox"/> Bloating | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Ulcer <ul style="list-style-type: none"> <input type="checkbox"/> H. Pylori Negative <input type="checkbox"/> H. Pylori Positive <input type="checkbox"/> Not Tested |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Gas | |
| <input type="checkbox"/> Strong odour | <input type="checkbox"/> Hiccups | |
| <input type="checkbox"/> Pain before BM | <input type="checkbox"/> Nausea/vomiting | |
| <input type="checkbox"/> Other: _____ | | |

Genito-Urinary

- | | | |
|---|---|--|
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Libido issues |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Yeast infection |
| <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Pale urine | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Dark urine | <input type="checkbox"/> Prostate Disorder |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Nocturnal emissions |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Other: _____ | | |

Gynecological

- | | | |
|---|--|---|
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Genital discharge | <input type="checkbox"/> PMS – headaches |
| <input type="checkbox"/> Oral Birth control pills | <input type="checkbox"/> Genital swelling | <input type="checkbox"/> PMS – back aches |
| <input type="checkbox"/> Intra-Uterine Device IUD | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> PMS – mood swings |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> # Pregnancies _____ |
| <input type="checkbox"/> Genital burning | <input type="checkbox"/> Fibroids | <input type="checkbox"/> # Miscarriages _____ |
| <input type="checkbox"/> Genital itching | <input type="checkbox"/> Cysts | |

Menstruation Information:

- Heavy periods
- Light periods
- Irregular periods
- Pain Before
- Pain During

Describe the menstrual blood:

- Pain After
- Dark Red
- Bright Red
- Pale Red
- Brownish

- Thin/Watery
- Very thick
- Clots?
 - Size _____
 - Color _____

Days between periods _____ # days of period _____

Other Information: _____

Skin and Hair

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fungal infection | <input type="checkbox"/> Itchy/dry skin |
| <input type="checkbox"/> Burning skin | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Heavy sweating | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Discolorations | <input type="checkbox"/> Not able to sweat | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | |
| <input type="checkbox"/> Other: _____ | | |

Neuro-Psychological

- | | | |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Irritability | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Depression | <input type="checkbox"/> numbness | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Easily stressed | <input type="checkbox"/> "Foggy" feeling | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Other: _____ | | |

Musculoskeletal:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Limited motion | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Limited use | <input type="checkbox"/> Rib pain |
| <input type="checkbox"/> Atrophy | <input type="checkbox"/> Back pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Body heaviness | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Broken Bones: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information (PHI). The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare options.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may provide treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **Yes No**

May we leave a message on your answering machine at home or on your cell phone? **Yes No**

May we discuss your medical condition with any member of your family? **Yes No**

If YES, please name the members allowed:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Signature of Patient or Legal Guardian: _____

Patient Name (Print): _____

Date: _____ Witness: _____

Financial Policy and Authorization to Bill Insurance

Dear Patient,

There are two billing options available for you. Please select the one that applies to your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Financial Policy and Authorization to Bill Insurance Form.

Private Pay/Uninsured Patients

Patients not covered by any insurance plans or covered by insurance policies that we are unable to bill directly should expect to pay for services billed at our standard rates. All payments will be collected at the time that services are rendered.

New Patients should be prepared to pay up to ***\$125 for the initial consultation.***

Established Patients should be prepared to pay ***\$85 for each follow-up visit.***

Insurance Billing

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. HOODMED will submit my claim for me to my insurance company. Although HOODMED verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. I authorize my insurance benefits to be paid directly to HoodMed. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

NO SHOW POLICY

Patients who miss their appointments without calling and canceling or rescheduling at least 24 hours in advance of the appointment will be assessed a ***\$35 no show fee.***

FORM COMPLETION

Our office charges a flat fee of \$10 for the completion of any forms which require the physician to review your chart and fill out. ***Prepayment is required*** before the form will be completed

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____