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

_____

_____

_____

_____

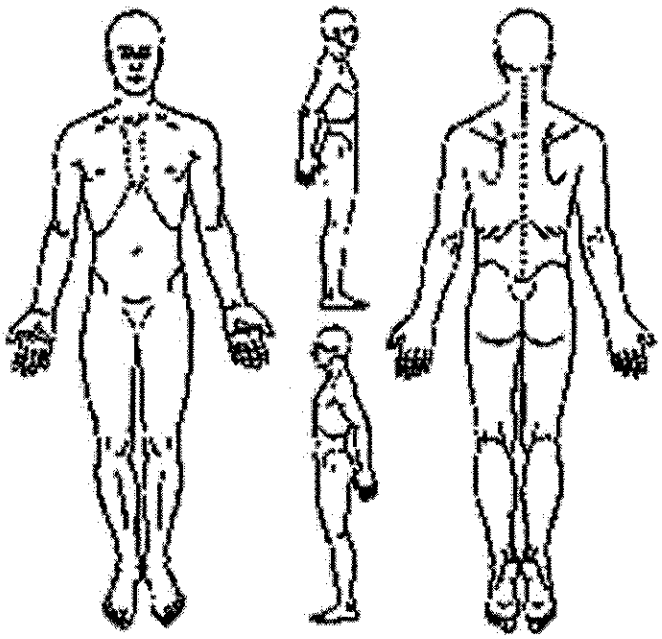
For females: Are you pregnant? NO Possibly YES How far along? _____

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

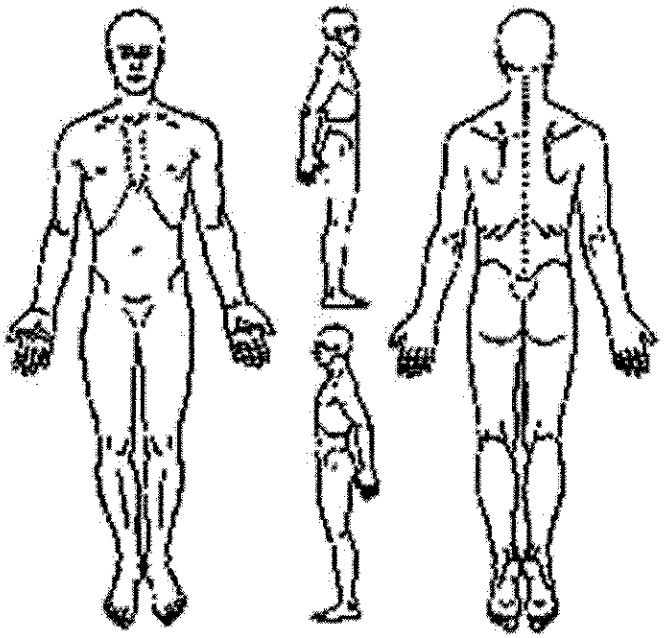
Nature of the Pain
O Constant
O Comes and goes
O Fixed
O Moves
O One side
O Both sides
O Sharp
O Dull
O Burning
O Aching
O Spastic
O Numb



Does the pain get better, or worse with?
O Heat *better worse*
O Cold *better worse*
O Motion *better worse*
O Rest *better worse*
O Pressure *better worse*
O 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
O Constant
O Comes and goes
O Fixed
O Moves
O One side
O Both sides
O Sharp
O Dull
O Burning
O Aching
O Spastic
O Numb



Does the pain get better, or worse with?
O Heat *better worse*
O Cold *better worse*
O Motion *better worse*
O Rest *better worse*
O Pressure *better worse*
O Better in *AM* or *PM*

Do you have any of the following?

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

Is There Family History of:

O Alcoholism
O Allergies
O Asthma
O Bleeding disorders
O Cancer
O Depression
O Diabetes
O Heart disease
O High blood pressure
O Kidney disease
O Mental illness
O Seizures
O Stroke
O Other_____

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?

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

What are your typical sleeping habits?

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

How would you describe your energy levels?

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

Do you have aversion to any of the following?

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

What is your Average Body Temperature?

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

General Information

- O Anorexia/Bulimia
- O Chronic Fatigue
- O Chicken Pox
- O Chronic Pain
- O Fibromyalgia
- O Hepatitis _____
- O HIV
- O Herpes/Cold Sores
- O Cancer: _____
- O Other: _____
- O Lupus
- O Lyme disease
- O Meningitis
- O Scarlet Fever
- O Mononucleosis
- O Multiple Sclerosis
- O Rheumatoid Disease
- O Rheumatic Fever
- O Mumps
- O Tuberculosis
- O Thyroid Disease
  - o Overactive
  - o underactive
- O Measles
- O Pneumonia
- O Tonsillitis

Head, Eyes, Ears, Nose and Throat

- O Bitter taste
- O Blurred vision
- O Cataracts
- O Concussions
- O Dry mouth / nose
- O Ear aches
- O Excess phlegm
- O Eye pain or strain
- O Facial pain
- O Glasses or contacts
- O Glaucoma
- O Other: _____
- O Grinding of teeth
- O Goiter
- O Gum problems
- O Headaches
- O Hearing aids
- O Itchy eyes
- O Migraines
- O Nose bleeds
- O Poor hearing
- O Red or dry eyes
- O Ringing in ears
  - o High pitch
  - o Low pitch
- O Sinus issues
- O Spots in eyes
- O Swollen glands
- O Teeth issues
- O TMJ Syndrome
- O Trigeminal neuralgia
- O Watery eyes

Respiratory:

- O Asthma/Wheezing
- O Frequent colds
- O Allergies
- O Bronchitis
- O Cough
- O Other: _____
- O Cough + Phlegm
- O Emphysema
- O Heavy Chest
- O Pneumonia
- O COPD
- O Cough + blood
- O Difficult breathing
- O Tight Chest
- O Short of Breath

Cardiovascular:

- O Anemia
- O Arteriosclerosis
- O Easily bruised
- O Poor circulation
- O Blood clots
- O Heart Disease: _____
- O Other: _____
- O Fainting
- O High cholesterol
- O Low blood pressure
- O Palpitations
- O Chest pain
- O High blood pressure
- O Irregular heart beat
- O Pace maker
- O Phlebitis
- O Stroke

Gastrointestinal

- O # Bowel Movements/day___
- O Normal Stool
- O Loose stool
- O Constipation
- O Diarrhea
- O Undigested food in stool
- O Mucous in stool
- O Blood in stool
- O Strong odour
- O Pain before BM
- O Other: _____
- O Pain after BM
- O Heartburn/acid reflux
- O Abdominal pain
- O Appendicitis
- O Bloating
- O Celiac Disease
- O Gas
- O Hiccups
- O Nausea/vomiting
- O Bad breath
- O Rectal pain/itching
- O Hemorrhoids
- O Hernia
- O Liver Disorder
- O Ulcer
  - o H. Pylori Negative
  - o H. Pylori Positive
  - o Not Tested

Genito-Urinary

- O Bed wetting
- O Bladder infections
- O Bloody urine
- O Frequent urination
- O Painful urination
- O Incomplete urination
- O Incontinence
- O Urgent urination
- O Wake to urinate
- O Pale urine
- O Dark urine
- O Cloudy urine
- O Kidney stones
- O Kidney Disease
- O Libido issues
- O Yeast infection
- O Impotence
- O Prostate Disorder
- O Premature ejaculation
- O Nocturnal emissions
- O Other: _____

Gynecological

- O Menopause
- O Oral Birth control pills
- O Intra-Uterine Device IUD
- O Breast lumps
- O Genital burning
- O Genital itching
- O Genital discharge
- O Genital swelling
- O Hysterectomy
- O Endometriosis
- O Fibroids
- O Cysts
- O PMS – headaches
- O PMS – back aches
- O PMS – mood swings
- O # Pregnancies _____
- O # Miscarriages_____

Menstruation Information:

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

Describe the menstrual blood:

- O Pain After
- O Dark Red
- O Bright Red
- O Pale Red
- O Brownish
- O Thin/Watery
- O Very thick
- O Clots?
  - o Size _____
  - o Color _____

Days between periods _____ # days of period_____

Other Information: _____

Skin and Hair

- O Acne
- O Burning skin
- O Dandruff
- O Dermatitis
- O Discolorations
- O Eczema
- O Fungal infection
- O Hair loss
- O Hot flashes
- O Heavy sweating
- O Not able to sweat
- O Hives
- O Itchy/dry skin
- O Psoriasis
- O Rashes
- O Shingles
- O Warts
- O Other: _____

Neuro-Psychological

- O ADD/ADHD
- O Addiction
- O Anxiety
- O Depression
- O Easily stressed
- O Epilepsy
- O Irritability
- O Mental illness
- O numbness
- O "Foggy" feeling
- O Poor coordination
- O Parkinson's Disease
- O Poor memory
- O Seizure
- O Vertigo/Dizziness
- O Other: _____

Musculoskeletal:

- O Osteoarthritis
- O Rheumatoid arthritis
- O Atrophy
- O Body heaviness
- O Joint pain
- O Limited motion
- O Limited use
- O Back pain
- O Muscle pain
- O Muscle cramps
- O Neck pain
- O Rib pain
- O Scoliosis
- O Weight gain
- O Weight loss
- O Broken Bones: _____
- O 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 ***$130 for the initial consultation.***
Established Patients should be prepared to pay ***$90 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 ***$40 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: _____