

ACUPUNCTURE Intake Form

GENERAL INFORMATION

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Work Phone _____ Occupation _____

Email _____

Emergency Contact _____ Contact Number _____

Family Physician _____ Physician Phone _____

Have you had Acupuncture or Dry Needling before? Yes No If Yes, when? ___ / ___ / ___

If Yes, was it performed by a Licensed Acupuncturist, a Chiropractor, or Physical Therapist? (circle answer)

Name of provider _____ Clinic Name _____

Are you presently under a doctor's care? Yes No

Who and for what? _____

Are there any other therapies, which you are involved in? Yes No

Who and for what? _____

FOCUS

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it better? _____

What makes it worse? _____

How does the problem interfere with your daily activities?

Work Sleep Walking Sitting Standing Bending

Stretching Emotional Relationships Social Life Sexually Recreation

Other (list to the right) _____

What have you done about this? _____

Are you interested in?

Pain Relief Performance Care Maintenance Care

Preventative Care Holistic Health Stress Relief

Oriental Nutrition/Diet Herbal Therapy Other

FOCUS (Continued)

What are your health goals? _____

List any past or future surgeries _____

List any significant traumas? When did it occur? (Auto accident, falls, emotional, sexual, etc.) _____

List exercise and sports activities, you have been in or are currently involved in _____

SIGNS/SYMPTOMS

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Dry throat/mouth | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Redness of eyes |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eye pain/strain/tension | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive phlegm color of | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Short temper |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Migraine | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Fever | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Muscle cramps/pain | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Breast lump/pain | <input type="checkbox"/> Gas/belching | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Headache | <input type="checkbox"/> Night sweat | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Teeth/gum problems |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Numbness | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Impotence | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Dark stools | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Irritable | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Poor sleep | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Premature ejaculation | |
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Psoriasis | |

FEMALE CONCERNS

Date of last menstruation? _____ Is your cycle regular? Yes No

Is your cycle painful? Yes No Have you ever been pregnant? Yes No

Birth control? Yes No How long? _____

PMS Clotting Vaginal sores Vaginal pain Discharge

MEDICAL HISTORY

Do you have any allergies? Yes No If so, to what? _____

Do you take medication? Yes No If so, what types and how often? _____

Do you take supplements? Yes No If so, what types and how often? _____

Please indicate if you have or have had any of the following conditions:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Mumps | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Parasites | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Measles | <input type="checkbox"/> Cancer | |

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When? _____

Do you have a low point during the day? Yes No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

TYPES OF CARE

According to your signs and symptoms, please indicate where your current state of health falls along this Types of Care timeline.



ACUTE CARE

(Obvious symptoms and signs)

Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. *Acute Care* helps to ease your initial problem(s) quickly.

MAINTENANCE CARE

(Symptom and signs disappear)

Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

WELLNESS & PREVENTIVE CARE

(You feel great)

Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. *Wellness Care* is your best choice.

PAIN

Pain intensity levels (please indicate below which best describes)

No pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Mildly disturbed Greatly disturbed Cannot sleep

Work – Can do:

Usual work 25% of work 50% of work No work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem on long trips Moderate pain on trips Severe pain on trips

Recreation – Can do:

All activities Some activities No activities

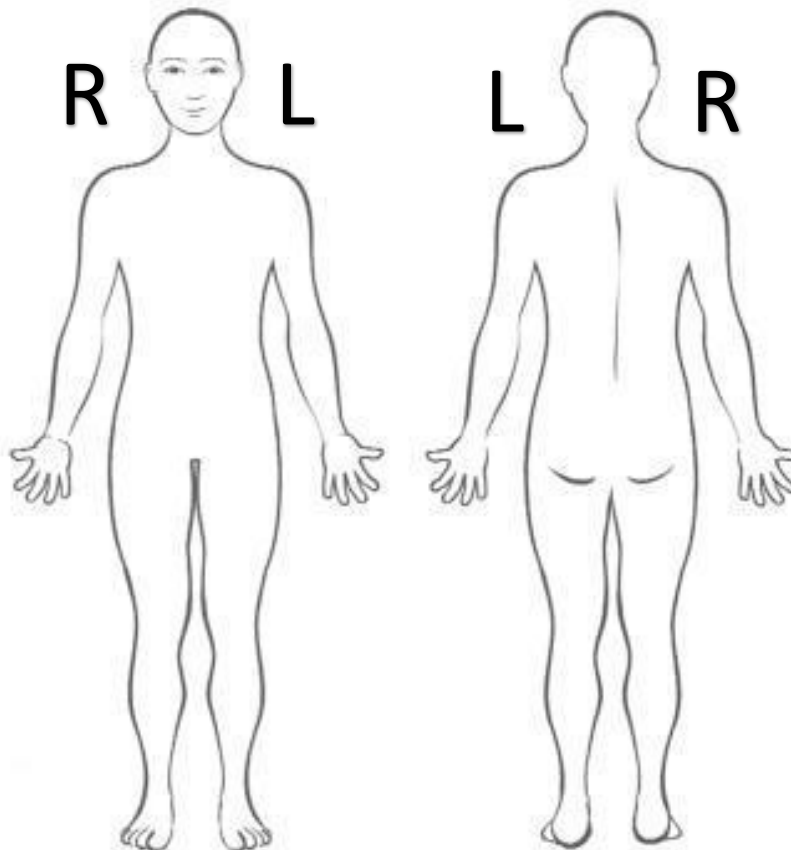
Walking

Can walk any distance Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit

Please indicate areas of pain/tension/tightness/discomfort on the chart below.



GENERAL QUESTIONS

How did you hear about Modern Point Acupuncture? _____

Referred by Someone? _____

Would you like to receive our free monthly newsletter? Yes No

Would you like to receive text message reminders about your appointments?

(Please note that Msg/Data rates may apply.) Yes No

Please send me text message appointment reminders to me at: _____ mobile number.

May we contact you by:

Mobile Phone Yes No

Home Phone Yes No

Work Phone Yes No

Email Yes No

Mail (home address) Yes No

Cancellation Policy and Treatment Package Agreement

At least a 24-hour notice of cancellation of any appointment is requested by Modern Point Acupuncture. I understand that if I arrive more than 15 minutes late for a scheduled appointment or do not give 24-hours' notice of a missed appointment that the amount of the entire treatment may be deducted from my prepaid acupuncture package or I may be charged for the entire amount of the missed appointment. Insurance cannot be billed for missed appointments, the fee is entirely my responsibility. _____ Initial

Modern Point Acupuncture provides an exclusive reservation to me and in exchange, I accept the costs associated with a cancellation on less than 24-hours' notice. Modern Point Acupuncture will not decide if the reason for late cancellation is warranted or not. _____ Initial

Treatment Packages: I consent Modern Point Acupuncture to take payment for and to track the number of visits used for my prepaid acupuncture treatment package. I understand that acupuncture treatment packages are non-transferable, non-refundable*, and expire one year from the date of purchase. This policy is designed for the benefit of both patients and practitioners so that appointments are available to those in need of treatment. _____ Initial

I have read, and I understand the above information:

Patient name printed

Patient Signature

Date

Office signature

Date

*In the rare circumstance that a refund is given for a partially used treatment package, the regular treatment price (not the discounted package treatment price) is deducted from the total amount paid for the package for each treatment used.

Our Clinic Protects Your Health Information and Privacy (HIPAA)

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workers comp and your employer, and other third-party administrators (e.g. requests for medical records, claim payment information).
- In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you – e.g. your name, address, Social Security Number, etc.).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 763-494-9500.

I have read and understand this privacy policy.

X: _____ Date: _____
Patient Signature

Effective Date 3/1/2008