modernpoint acupuncture & sports medicine

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

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

MENSTRUATION 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:

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

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

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

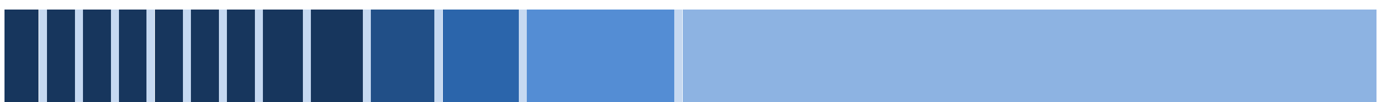
Do you have a low point during the day? ___ Yes ___ No When? ____________________

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)

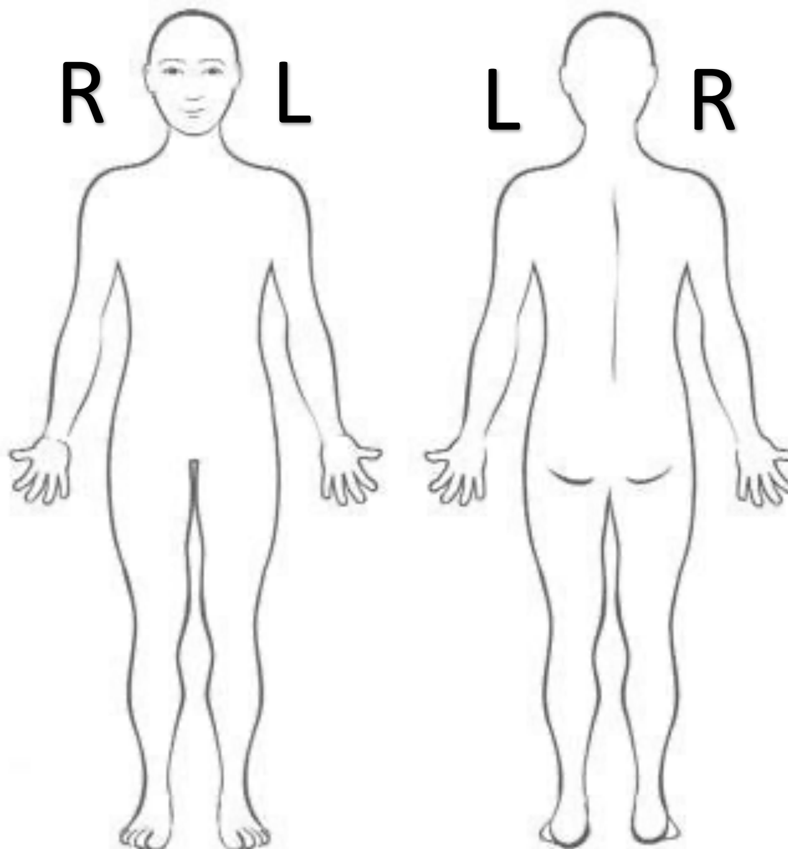
Feeling great! Life is wonderful!

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 Program Agreement

At least a 24-hour notice of cancellation of any appointment is requested by Modern Point Acupuncture. I understand that if I arrive late for a scheduled appointment or do not give 24-hours' notice of a missed appointment the amount of the entire treatment may be deducted from my prepaid acupuncture program, 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 Programs: I consent Modern Point Acupuncture to take payment for and to track the number of visits used for my prepaid acupuncture treatment program. I understand that acupuncture treatment programs 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 program, the regular treatment price (not the discounted program price) is deducted from the total amount paid for the program 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