

Appointment Date: \_\_\_\_\_

### General Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Married Single Partner Divorced Widowed Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Referred By \_\_\_\_\_  
Family Physician \_\_\_\_\_ Contact # \_\_\_\_\_  
Have you had Acupuncture or Oriental medicine before? Yes No  
Are you presently under a doctor's care? Yes No Who and for what? \_\_\_\_\_  
Are there any other therapies which you are involved in? Who and for what? \_\_\_\_\_

### Insurance Information

Insurance Company \_\_\_\_\_ Contact # \_\_\_\_\_  
ID # \_\_\_\_\_ Co-pay \$ \_\_\_\_\_ Visit # \_\_\_\_\_ Referral Yes No Covered % \_\_\_\_\_  
Date called \_\_\_\_\_ Contact Name \_\_\_\_\_ Deductible amount \_\_\_\_\_

### Focus

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

What was the initial cause? \_\_\_\_\_

When did it begin? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How does this problem interfere with your daily activities? ☐ Work ☐ Standing ☐ Sexually ☐ Other  
☐ Sleep ☐ Emotional ☐ Recreation  
☐ Walking ☐ Relationships ☐ Bending  
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this? \_\_\_\_\_

Are you interested in: ☐ Pain Relief ☐ Performance Care ☐ Maintenance Care ☐ Other  
☐ Preventative Care ☐ Holistic Health ☐ Stress Relief  
☐ Oriental Nutrition ☐ Meridian Yoga ☐ Herbal Therapy

What are your health goals? \_\_\_\_\_

List any past or future surgeries. \_\_\_\_\_

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) \_\_\_\_\_

List exercise and sport activities you have been or are currently involved in: \_\_\_\_\_

### Signs/Symptoms

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

### 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 or any family members have or had any of the following conditions:

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

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? \_\_\_\_\_

### Web of Wellness

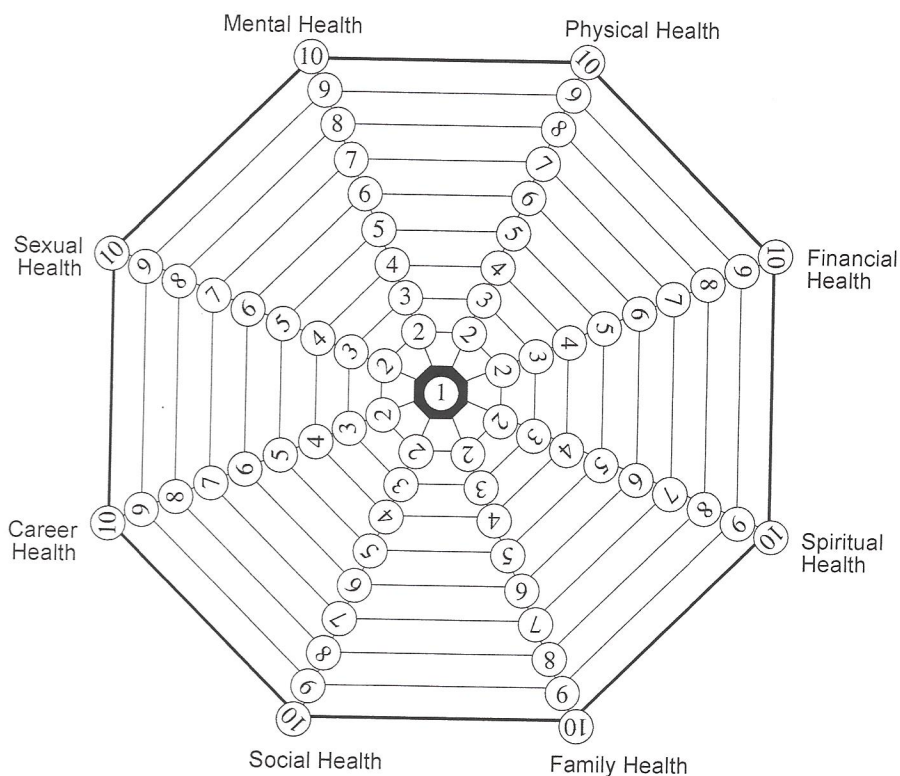
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



### Pain

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

**Pain intensity levels** (please indicate below which best describe)

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

#### Recreation - Can do:

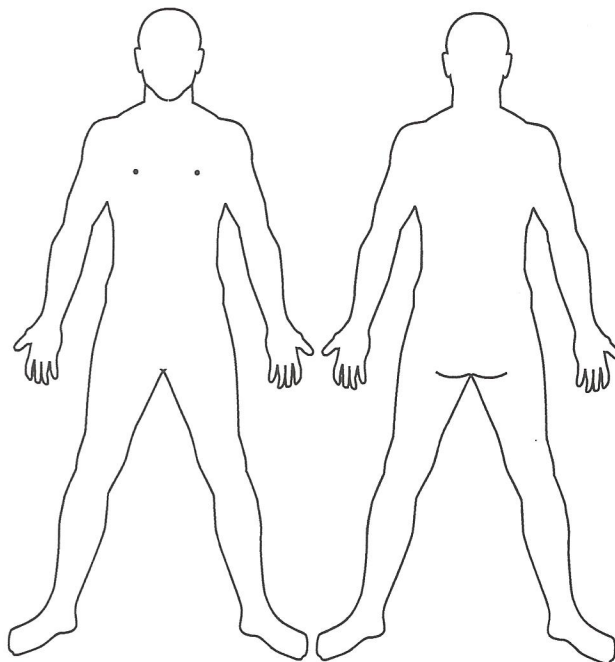
All activities      Some activities      No activities

#### Walking

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

#### Sitting

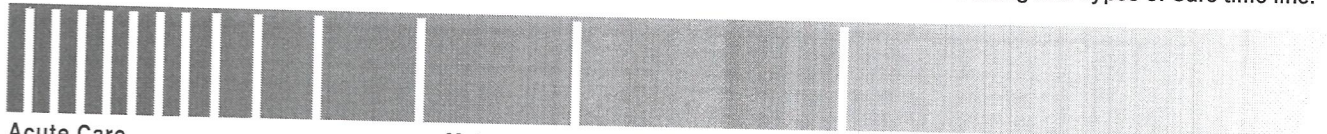
No pain sitting      Some pain while sitting      Cannot sit





## Types of Care

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



### 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 & Preventative 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.

## Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, \_\_\_\_\_ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

(Signature) \_\_\_\_\_ (date) \_\_\_\_\_

## ACUPUNCTURE INSURANCE VERIFICATION

Patient Name:	DOB:
Insurer:	Policy / Plan/ Group #
Insurance Phone#	
Verified By: Name/Employee ID#	
	Claims Billing Address
Call ID#	
Date of Verification:	

<b>POLICY BENEFITS:</b>	<b>Timely Filing Requirement-</b>
Acupuncture Coverage:    Yes        No	MD:                                  LAc:
Referral Needed:            Yes        No	Minors: Yes    No
In or Out of Network Benefits or Limits:	

Deductible Amount: \$	How much met: \$
Deductible Period:	

Acupuncture Diagnosis Requirements : Pain, Nausea, Osteoarthritis etc
Acupuncture Treatment Limits: # of visits, \$ cap, # days etc :

Exams:
Injections:

Physical Medicine and Rehabilitation by Acupuncturist:
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Additional Information: Are there any other limits or provisions on this policy that I have not inquired about?
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MAKE COPY OF PATIENT'S INSURANCE CARD (FRONT AND BACK),

