WELCOME TO OUR OFFICE

We find that communication regarding our office policies will assist us in providing the best of services to you, We would like to answer some of the questions that are most commonly asked. Should you have any questions regarding these guidelines we welcome the opportunity to be of assistance. We look forward to our new association with you.

PAYMENT AT THE TIME SERVICES ARE RENDERED:

Payment is required at the time services are rendered. Co-payment is due and payable at the time of service, unless there is a signed, written financial hardship agreement between physician and patient. We accept cash, credit cards and personal checks. There will be a $25.00 service charge on any returned check.

HEALTH INSURANCE

Check with your Insurance provider to find out if acupuncture is covered under your plan. If Acupuncture is covered please bring your card and we will bill your insurance provider. Alternatively, at the time of payment you will be given a super-bill. It contains all information necessary for successful insurance billing.

REGARDING APPOINTMENTS:

We ask that all our patients be on time. In the event that you arrive late, the time missed will be deducted from your session. Should you need to reschedule an appointment you have made, 24 hours notice is required. If you fail to notify us 24 hours in advance, you will be charged a $45 fee for your missed appointment. A missed appointment is a loss to everyone. For a Monday cancellation, please call on Saturday.

LENGTH OF SESSIONS:

Initial Visits usually last 1:15 hours and follow up visits 1:00 hour. Please download and fill out the intake forms before your appointment or arrive :15 minutes prior to your Initial appointment to fill out paperwork.

PHONE CALLS:

Phone calls are normally withheld during office hours so that each patient receives complete attention. There are set times during the day when the doctor returns calls. Exceptions will be made in an emergency. The first ten minutes of a call are a courtesy. Thereafter there will be a telephone consultation fee.

CONSENT FOR ACUPUNCTURE CARE
I, the undersigned, realize that acupuncture may be considered as an investigative procedure in the United States. I understand the benefits and risks of acupuncture care. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I have read and understand the above guidelines and consent.

Patient signature:_____Date:_____

PATIENT INFORMATION

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION REQUESTED

PATIENT NAME_____DATE _____

HOME ADDRESS_____CITY_____

STATE _____ZIP_____DRIVER'S LICENSE_____

CELL PHONE_____HOME PHONE_____EMAIL_____

EMPLOYER_____OCCUPATION_____

BUS ADDRESS_____CITY_____

STATE_____ZIP_____

DATE OF BIRTH _____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?_____

ADDRESS_____CITY_____

STATE_____ZIP_____RELATIONSHIP _____

HOME PHONE_____ WORK PHONE_____

PERSON RESPONSIBLE FOR PAYMENT_____

IS PATIENT A MINOR?_____ GUARDIAN_____

PERMISSION IS GRANTED TO RENDER TREATMENT, SIGNATURE PARENT OR GUARDIAN:

_____ DATE_____

WHO REFERRED YOU TO US _____

CAN WE TEXT YOU FOR APPOINTMENT REMINDERS? _____YES _____NO

MEDICAL HISTORY

What are your health concerns at this time, both medical and psychological?_____
_____

Indicate the accidents, injuries and hospitalizations you have had:

1. _____Date or Age_____
2. _____Date or Age_____
3. _____Date or Age_____

Have you had the: Measles_____ Mumps_____Chickenpox_____

List any unusual childhood illnesses you may have had. (i.e., rheumatic fever,

pneumonia, etc ..) _____

Family History

In your family is there any history of:

	No	Yes	Family Member
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Hepatitis/Infectious Mono	☐	☐	_____
HIV	☐	☐	_____
Hypertension	☐	☐	_____
Hypoglycemia	☐	☐	_____
Kidney Disease	☐	☐	_____
Mental Illness	☐	☐	_____
Stroke	☐	☐	_____
T.B.	☐	☐	_____
Other	☐	☐	_____

Medication

List any prescribed medication(s) that you are presently taking:

MEDICATION	DOSAGE	REASON
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

What vitamins and/or supplements do you regularly take?

_____

_____

Are you allergic to the following substances?

If yes, please list.

1.Medication **/** drugs_____
2.Food **/** supplements_____
3.Other_____
4.Seasonal_____ Asthma_____ Eczema_____
5.Do you drink coffee or black tea_____if so, how much per day?_____

Do you smoke cigarettes?_____ if so, how many a day?_____

Do you drink alcohol?_____if so, how often?_____

Do you use marijuana or cocaine?_____ if so, which & how much & how often?

_____

Do you eat sugar?_____ if so, how often, what kind? _____

Do you exercise?_____ if so, how often? _____

FEMALES ONLY

Are you or might you be pregnant? Yes __ No __ Maybe __

If yes, what month?_____

What method of birth control do you use?_____

Are you experiencing reduced sexual energies?_____Other difficulties?_____

Explain:_____

Do you have regular PAP tests? _____ How regular?_____

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Menstrual Cycle:

____Irregular

____Painful

____Excess of blood

____Lack of blood

____Dark

____Light

____Heavy clotting

____Water retention

____Painful breast

Gynecological History or operations:

___Ovaries _____
___Uterus _____
___Tubes _____
___Vagina _____
___Breast _____
___Other _____

Pregnancy:

___Total number: _____

___Number of abortions: _____

___Number of children: _____

___Number of miscarriages: _____

___Complications: _____

Vaginal Discharge:

___Yellow

___Bad

___White

___Odor

___Liquid

___Other

___Thick

MALES ONLY:

Please check or explain where necessary

____Dribbling/weak stream of urination_____

____Reduced sexual energies_____

____Premature ejaculation_____

____Uncontrolled seminal emission_____

____Difficulty with erection_____

____Pain in genitals_____

____Discharges_____

____Other_____

IN THE LAST SIX MONTHS WHICH OF THE FOLLOWING SYMPTOMS HAVE YOU EXPERIENCED?

	NEVER	SOMETIMES	OFTEN
Belching or Burping	_____	_____	_____
Clammy Hands	_____	_____	_____
Digestion Problems	_____	_____	_____
Excessive Appetite	_____	_____	_____
Feeling of Retention of Food in Stomach	_____	_____	_____
Heartburn	_____	_____	_____
Indigestion	_____	_____	_____
Lack of Appetite	_____	_____	_____
Nausea	_____	_____	_____
Tendency to be "Obsessive" in Work Relationships	_____	_____	_____
Thirsty	_____	_____	_____
Vomiting	_____	_____	_____
Blood in Stool	_____	_____	_____
Blood-tinged sputum	_____	_____	_____
Bronchitis	_____	_____	_____
Chills	_____	_____	_____
Colitis or Diverticulitis	_____	_____	_____
Constipation	_____	_____	_____
Cough	_____	_____	_____
Dry Cough	_____	_____	_____
Cough with Thick Mucus	_____	_____	_____
Cough with Thin Mucus	_____	_____	_____
Decreased Sense of Smell	_____	_____	_____

	NEVER	SOMETIMES	OFTEN
Feeling of "Claustrophobia"	_____	_____	_____
Fever	_____	_____	_____
Frequent Sore Throats	_____	_____	_____
Hemorrhoids	_____	_____	_____
Nasal Problems	_____	_____	_____
Night Sweats	_____	_____	_____
Recent use of Antibiotics	_____	_____	_____
Shortness of Breath	_____	_____	_____
Skin Problems	_____	_____	_____
Sweating without Exercise	_____	_____	_____
Varicose Veins	_____	_____	_____
Blood in Urine	_____	_____	_____
Burning upon Urination	_____	_____	_____
Decreased Sex Drive	_____	_____	_____
Frequent Urination at Night	_____	_____	_____
Frequent Urination Day	_____	_____	_____
Hair Loss	_____	_____	_____
Hearing Impairment	_____	_____	_____
Kidney Stones	_____	_____	_____
Knee problems	_____	_____	_____
Low Back Pain	_____	_____	_____
Painful Urination	_____	_____	_____
Ringing in Ears	_____	_____	_____
Urine Retention	_____	_____	_____
Diarrhea	_____	_____	_____
Angina Pains	_____	_____	_____

	NEVER	SOMETIMES	OFTEN
Anxiety	_____	_____	_____
Cries a Lot	_____	_____	_____
Depression	_____	_____	_____
Dizziness	_____	_____	_____
Fear	_____	_____	_____
Heart Palpitations	_____	_____	_____
Insomnia	_____	_____	_____
Laughing for no Apparent Reason	_____	_____	_____
Nightmares	_____	_____	_____
Poor Memory	_____	_____	_____
Difficulty Digesting Oily Foods	_____	_____	_____
Difficulty Making Plans/Decisions	_____	_____	_____
Easily Angered or Agitated	_____	_____	_____
Eye Problems	_____	_____	_____
Gall Stones	_____	_____	_____
Hepatitis	_____	_____	_____
Jaundice (Yellow Eyes or Skin)	_____	_____	_____
Light Colored Stools	_____	_____	_____
Pain Under Ribs	_____	_____	_____
Soft or Brittle Nails	_____	_____	_____
Spasm or Twitching of Muscles	_____	_____	_____
Burning Feet or Hands at Night	_____	_____	_____
Difficulty to Stop Bleeding	_____	_____	_____
Dry Skin	_____	_____	_____
Easily Bruised	_____	_____	_____
Edema	_____	_____	_____

	NEVER	SOMETIMES	OFTEN
Fatigue	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol Levels	_____	_____	_____
Hot Flashes	_____	_____	_____
Intolerant to Weather Changes	_____	_____	_____
Joint Swelling	_____	_____	_____
Muscle Weakness	_____	_____	_____
Numbness, Tingling	_____	_____	_____
Oily Skin	_____	_____	_____
Paralysis	_____	_____	_____
Sudden Weight Loss	_____	_____	_____
Tendency to Catch Colds Easily	_____	_____	_____
Tendency to Faint Easily	_____	_____	_____
Tendency to be Cold	_____	_____	_____
Abdominal Pain	_____	_____	_____
Chest Pain	_____	_____	_____
Headaches	_____	_____	_____
Sciatic Pain	_____	_____	_____
Other	_____	_____	_____