

New Patient Intake

Patient Name _____ Date _____

General Information

Address _____ City _____ State _____

Home Phone _____ Occupation _____ Zip _____

Work Phone _____ Mobile Phone _____ SS# _____ Date of Birth _____

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails Yes No

Texts Yes No

Mail Yes No

Emergency Contact _____ Relationship _____ Phone _____

Have you had Acupuncture or Oriental medicine before? Yes No Family Physician _____ Phone _____

What was your experience? Very good Good No change Married Partner Divorced Widowed Single

Are you presently under a doctor's care? Yes No Who and what for? _____

Are there any other therapies which you are involved in? Yes No Who and what for? _____

Insurance Information

Insurance Company _____ Phone _____ Date Called _____

ID # _____ Co-Pay \$ _____ Covered % _____

Visit # _____ Deductible Amount _____

Contact Name _____ Referral Yes No

Focus

What is the 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 Holistic Health Stress Relief Other
 Preventative Care Stretching/Yoga Herbal Therapy
 Oriental Nutrition Maintenance Care

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): _____

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

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

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

Other _____

Male Concerns

Testicle pain Penis pain Penis sores Discharge Premature ejaculation Nocturnal emission Impotence

Other _____

Signs/Symptoms

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

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

No Pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Disturbed Very disturbed Cannot sleep

Work - Can do:

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

Frequency of pain

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

Travel

No problem Moderate pain on trips Severe pain

Recreation - Can do:

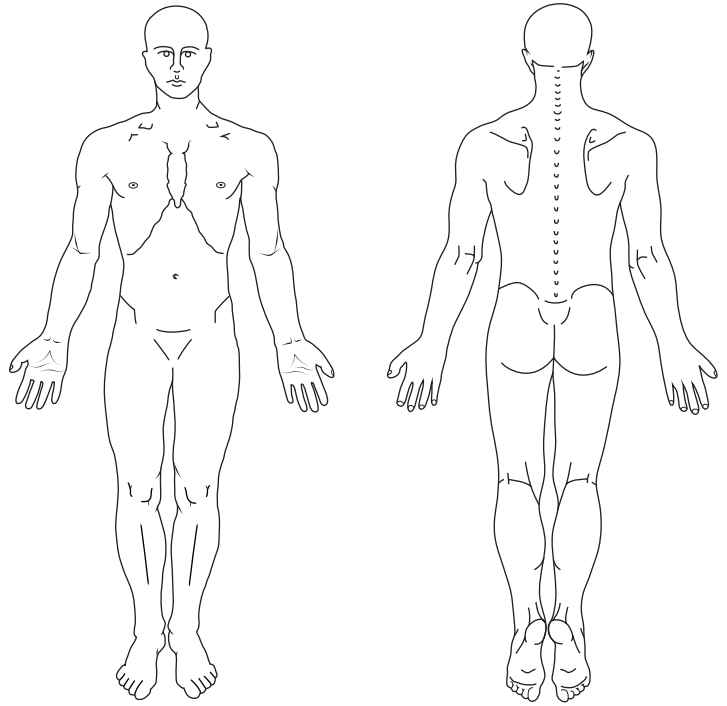
All activities Some activities No activities

Walking

Can walk fine Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Pain Key

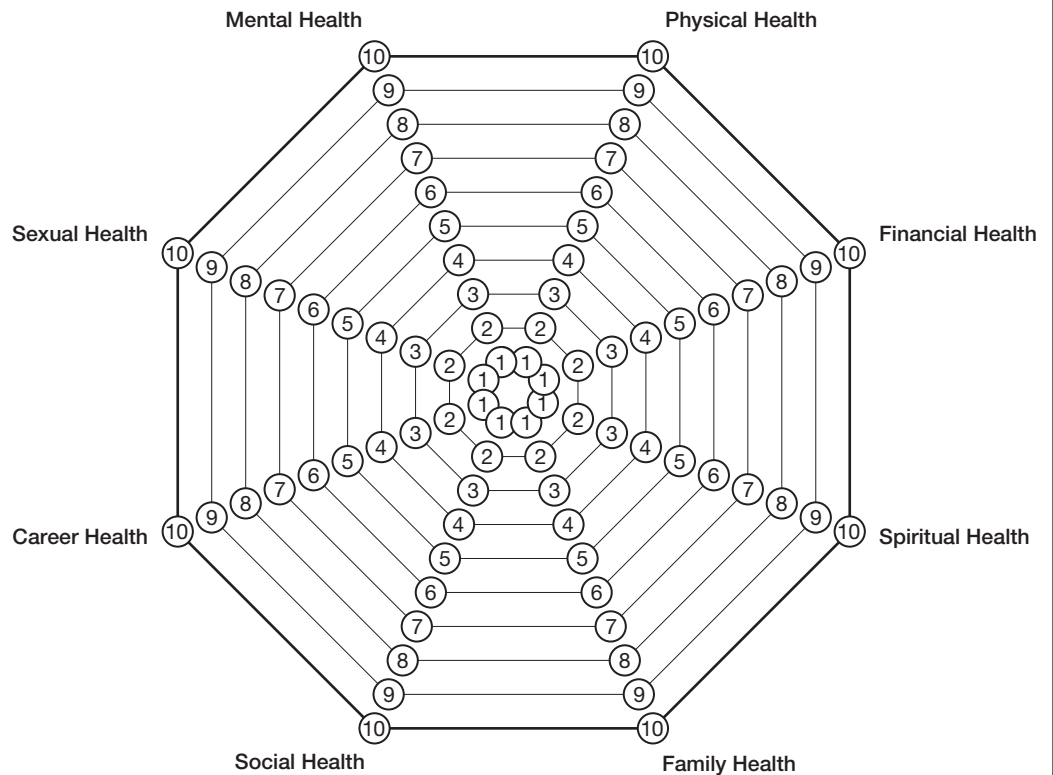
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

Web of Wellness

Health and wellness are 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 to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

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 healing modality 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 _____

Late Cancellation & Missed Appointment Agreement

Please provide 24 hours advance notice of any changes or cancellations.

Appointments that are missed/rescheduled/cancelled with less than 24 hours notice will be billed \$50.

Signature: _____ Date: _____

Insurance Information

Coverage is not guaranteed and needs to be verified with your health plan. Although acupuncture is generally a covered service, it is only covered for certain conditions.

PLEASE READ AND SIGN:

In the event that my insurance coverage expires or denies payment, I understand that I am personally, fully responsible for all fees incurred. I agree to release any medical information my insurance company, adjuster, or the attorney involved in my case may need in order to process payment. I assign some benefits to be paid to the above named provider.

Signature _____ Date _____

Insurance and Payment Information - FOR YOU TO KEEP, PLEASE READ

We want you to experience your time here with minimal effort. The following information will help you become familiar with the insurance process, including billing, co-pays, contracted rates and statements from Acupuncture Healthcare of Leominster.

If you have any questions about your statements please contact David S. Goldstein, Lic. Ac., Dipl. O.M. at david@acuhealthma.com or call 978-728-3809.

YOUR PART:

- Confirm that your insurance covers Acupuncture, and if you need to obtain any physician referral or prescription prior to your first appointment.
- Confirm that your insurance plan covers the condition(s) or diagnosis for which you would like to be seen; most plans only cover certain conditions.
- Confirm the number of appointments your insurance plan allows. Keep track of this number.
- Please know the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay. Our office does not guarantee that your insurance will pay.

CO-PAYS: If you have a co-pay (indicated on your card) it must be paid at the time of your appointment. We accept Cash, Check and Credit Cards. Any co-pays not collected at the time of service will be billed to the address you provide.

BILLING: We process claims and payments in-house. Claims are sent to your insurance company every week and are usually processed by the insurance company within 9-30 days. Since we are contracted with your plan, we agree to be paid the contracted rate, which is a set amount. Your financial obligation is the co-pay, or co-insurance (a percentage), or deductible. If you are paying towards your deductible, you are only responsible for the contracted rate. Codes billed: There are only a select number of codes that we use for acupuncture. On your first visit you will see a first office visit code (99201-99203) and the standard two codes used for a typical acupuncture treatment, 97810/97811 or 97813/97814 plus 97140/97026. On some return visits you may see 99212/99213 which indicates a new condition or further evaluation.

PAYMENTS: You may pay your balance with Cash, Check or Credit Card. Payment is expected at the time of your appointment unless other arrangements have been made. We can provide you with a receipt summary of your visits for your FSA plan.