Dr. Melissa Georgevitch, DC, MTAA

Back on Track Chiropractic
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ACUPUNCTURE NEW PATIENT FORM

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Email Address: _____

Would you like to be placed on our email list? ☐ Yes ☐ No

Sex: _____ Social Security #: _____

Date of Birth: _____/_____/_____ Age: _____

Occupation: _____

Emergency Contact: _____ Phone #:_____ Relation: _____

Referred by: _____

Physician Name: _____ Phone #: _____

Medications: _____

_____

Vitamins: _____

Acupuncture:

Have you had acupuncture before? ☐ Yes ☐ No

Main reason(s) for currently seeking treatment: _____

_____

How long have you experienced these symptoms? _____

Goals for treatment: _____

History:

Surgeries and Date of Procedure: _____

Significant Trauma: _____

Irritability or low energy between meals: ☐ Yes ☐ No

How many meals per day? _____ Snacks? _____ Ounces of water you drink/day: _____

Caffeinated Drinks/Day _____ Alcohol Drinks/Week? _____

Smoking Status: _____ If current or past, how many packs/day? _____

Exercise: Days per week? _____ Length of Workout? _____ Type: _____

Patient Name: _____ **Date:** _____

Please check the box if you have or had any of these symptoms in the last 6 months

General

- ○ Always Hot/Cold
- ○ Fatigue
- ○ Poor Sleep
- ○ Weight Loss/Gain
- ○ Fever
- ○ Cancer
- ○ Diabetes
- ○ Stress
- ○ Depression

Skin and Hair

- ○ Rashes
- ○ Eczema/Psoriasis
- ○ Skin Discolorations
- ○ Hives/Allergic Reactions
- ○ Loss of Hair
- ○ Itching
- ○ Face Flushing
- ○ Bleed/Bruise Easily
- ○ Night Sweats

Head, Ears, Nose, Throat

- ○ Headaches/Migraines
- ○ Vertigo/ Dizziness
- ○ Eye Strain
- ○ Poor/blurred vision
- ○ Eye Pain
- ○ Ringing in Ears
- ○ Ear aches
- ○ Nosebleeds
- ○ Sinus problems
- ○ Difficulty Swallowing
- ○ Poor Hearing
- ○ Frequent Sore Throat/Colds
- ○ Teeth grinding
- ○ Jaw clicks/locks
- ○ Facial pain
- ○ Decreased mental clarity
- ○ Thyroid dysfunction

Cardiovascular

- ○ Chest Pain
- ○ Cold Hands/Feet
- ○ Shortness of breath
- ○ Irregular heartbeat
- ○ Swelling of hands/feet
- ○ Varicose veins
- ○ Palpitations at rest
- ○ High Blood Pressure
- ○ Low Blood Pressure

Respiratory

- ○ Chronic cough
- ○ Pneumonia
- ○ Bronchitis
- ○ Asthma / Wheezing
- ○ Difficulty breathing
- ○ Other lung conditions:

Gastrointestinal

- ○ Nausea
- ○ Gas
- ○ Indigestion
- ○ Bloating
- ○ Changes in appetite
- ○ Vomiting
- ○ Belching
- ○ Bad breath
- ○ Acid Reflux
- ○ Diarrhea
- ○ Hernia
- ○ Constipation
- ○ Hemorrhoids
- ○ Abdominal Pain/Cramps
- ○ Anemia

Urogenital

- ○ Kidney Stones
- ○ Blood in urine
- ○ Frequent urination
- ○ UTI
- ○ Frequent waking at night to urinate

Musculoskeletal

- ○ Neck Pain
- ○ Shoulder Pain
- ○ Hand/Wrist Pain
- ○ Carpal Tunnel
- ○ Hip Pain
- ○ Knee Pain
- ○ Ankle/Foot Pain
- ○ Back Pain - where:
- ○ Sprains/strains
- ○ Rotator Cuff
- ○ Sciatica
- ○ Tendonitis
- ○ Muscle weakness
- ○ Arthritis

Neuropsychological

- ○ Seizures
- ○ Lack of Coordination
- ○ Anxiety/Panic Attacks
- ○ Loss of Balance
- ○ Poor Memory
- ○ Bad Temper/Irritable
- ○ Concussion
- ○ Numbness
- ○ Tremors

Gynecological/Reproductive

No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Premature Births _____
No. of Abortions _____

Do you practice birth control?
Yes or No

- ○ Painful Menses
- ○ Irregular Menses
- ○ Ovarian Cysts
- ○ Breast lumps
- ○ Fibrocystic Breast Tissue
- ○ Breast Cancer
- ○ Infertility
- ○ Endometriosis

Please read and answer the following questions as accurately as possible.

1.	Have you ever been exposed to Hepatitis?	Yes	No
2.	Have you ever had any form of Hepatitis?	Yes	No
3.	Have you ever been exposed to HIV (AIDS)?	Yes	No
4.	Have you been exposed to any other blood borne disorders?	Yes	No
5.	Do you have AIDS or HIV?	Yes	No
6.	Do you take blood thinners or anticoagulants?	Yes	No
7.	Do you take aspirin on a regular or frequent basis?	Yes	No
8.	Do you have an electrical implant device (pacemaker, defibrillator, etc.)	Yes	No
9.	Do you have any clotting disorders or bleed easily?	Yes	No
10.	Are you pregnant?	Yes	No

Acupuncture Consent

While receiving acupuncture treatment, please feel free to communicate with your practitioner what you are experiencing during the needling process, as this will enable the practitioner to adjust the needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after the needles are withdrawn and generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include, but are not limited to local bruising, mild pain to the area treated, brief generalized fatigue, tingling or numbness.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing (such as athletic clothes).
- Remove all metal and electronic devices during treatment (belts, jewelry, watches, phones, etc.)
- Avoid treatment when excessively fatigued, hungry, full or emotionally upset.
- We are unable to treat patients who are intoxicated and/or are abusing substances.

Everyone responds to treatment differently, therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is experienced until several days go by. Occasionally, some people notice that their pain worsens before it gets better. Let us know how you respond so that your treatment plan can be modified accordingly. In addition, patients are responsible for seeking the advice and treatment of their physician should their symptoms change or if any new condition should arise.

I do hereby authorize and direct Dr. Melissa Georgevitch, DC, MTAA to perform acupuncture and other forms of meridian therapy in my care. I agree that the staff may assist in my care at times as determined by the doctor. I understand that the nature of acupuncture procedure involves the insertion and retention of sterile needles at one or more sites on the body. I have engaged in sufficient discussion of the treatment and possible risks, alternatives, options and likely outcomes to satisfy my understanding of this form of treatment. I state and agree that I understand acupuncture procedures sufficiently to give my informed consent to treatment. Further, I state and agree that in no manner have I been promised a beneficial result from acupuncture treatment nor from any treatment at any time.

By signing this informed consent form, you (the patient) acknowledge that you have read the information above carefully and are giving consent for treatment.

_____	_____	_____
Patient or Guardian Signature	Name	Date