Community Outreach Acupuncture Program (COAP)

1030 Xenia Avenue, Yellow Springs, OH 45387 937.532.5773

New Patient Intake Form

Please help us to provide you with the best possible care by taking the time to fill out this form as accurately as you can.
All information provided is confidential. Please feel free to ask if you have any questions. Thank you.

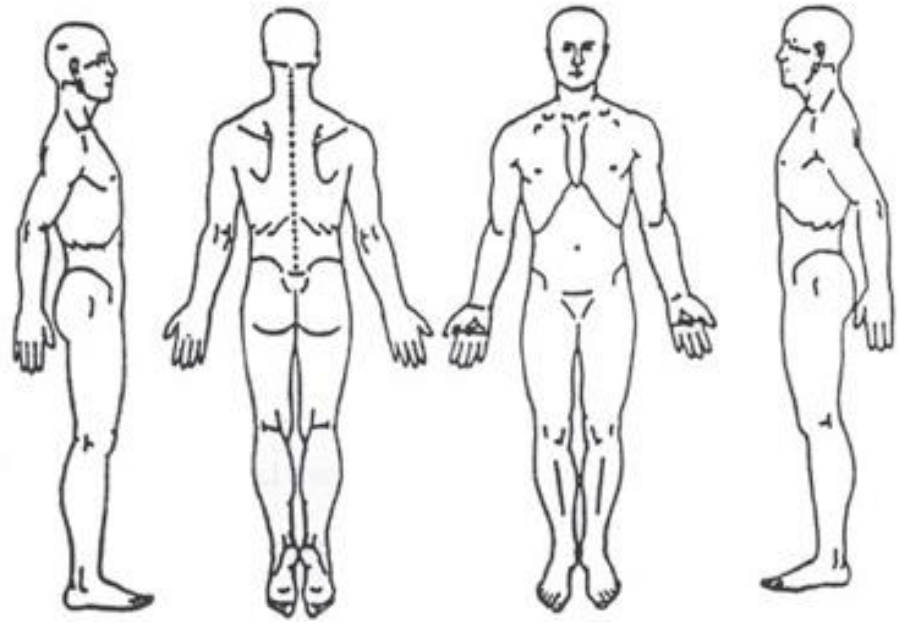
Name _____ Date _____ Gender: F☐ M☐ Married☐ Single☐ Other☐
Date of Birth _____ Age_____ Height _____Weight _____
Address _____ Home Phone (___)_____
City _____ Mobile Phone (___)_____
State _____ Zip Code _____Email _____Work Phone (___)_____
Occupation_____ Employer _____
Emergency Contact _____ Phone _____ Relationship _____

Primary Physician _____ Phone _____ Referred by _____
Main reason you are seeking acupuncture _____
Have you been given a diagnosis for this problem? _____What was the diagnosis? _____
How long have you had this problem? _____
What kinds of treatments have you tried? _____
Have you been treated by acupuncture before?_____

Personal Lifestyle Habits

Coffee/Tea (cups per day) _____ Cigarettes (packs per day) _____
Soda (regular or diet) _____ Alcohol (drinks per week) _____
Exercise (how often) _____ Drug use (recreational) _____
Current Predominant Emotion _____ Stress level: Low:☐ Moderate:☐ High:☐
Best time of year _____ Energy level: Low:☐ Moderate:☐ High:☐

Please indicate on the diagram any type of pain or injury and describe _____
_____
_____



Please describe any medical devices or implants and indicate on the diagram
_____
_____
_____
_____
_____

Past Medical History

Please indicate/describe all that applies if you have experienced in the Past (P) and Currently (C) any of the following:

Significant Illnesses

____ AIDS/HIV
____ Alcoholism
____ Allergies (medications, foods, latex)_____
____ Bleeding disorders_____
____ Cancer _____
____ Diabetes
____ Other _____

General

____ Insomnia/Poor sleep
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Hours of sleep_____
____ Fatigue
____ Peculiar tastes or smell
____ Other _____

Head and Neck

____ Headaches
____ Migraines
____ Other _____

Ears

____ Hearing loss: L_ R_ Both_
____ Ringing: L_R_ Both _
____ Other _____

Eyes

____ Itchy eyes
____ Dry eyes
____ Eye pain
____ Eye strain
____ Other _____

Nose, Throat, and Mouth

____ Sinus problems
____ Sores on lips, tongue, mouth
____ Nosebleed
____ Hoarseness
____ Dental problems
____ Other _____

Skin

____ Rashes
____ Dry skin
____ Itching
____ Bruise easily
____ Other _____

Respiratory

____ Difficulty breathing
____ Asthma
____ Chronic cough
____ Shortness of breath
____ Other _____

Cardiovascular

____ High blood pressure
____ Low blood pressure
____ Chest pain or tightness
____ Palpitation
____ History of heart disease
____ Other _____

Gastrointestinal

____ Cravings_____
____ Nausea
____ Vomiting
____ Indigestion
____ Stomach pain
____ Abdominal pain
____ Gallbladder problems
____ Hernia
____ Loose stools
____ Constipation
____ Poor appetite
____ Excessive hunger
____ Hemorrhoids
____ Bowel movements
____ x per day
____ Other _____

Musculoskeletal

____ Joint pain/swelling_____
____ Arthritis
____ Muscle cramps
____ Muscle weakness
____ Muscle soreness
____ Herniated disc
____ Osteoporosis
____ Pain/Injury (see diagram)
____ Other _____

Neurological

____ Concussions
____ Fainting
____ Dizziness
____ Seizures
____ Poor coordination/balance
____ Poor memory
____ Other _____

Mental/Emotional

____ Depression
____ Irritability
____ Panic attacks
____ Difficulty relaxing
____ Difficulty making decisions
____ Sadness
____ Nervousness
____ Frequent worrying
____ Compulsive behaviors
____ PTSD
____ Other _____

Urinary

____ Pain with urination
____ Frequent/urgent urination
____ Incontinence
____ Waking to urinate___ x night
____ Bladder infections
____ Kidney problems
____ Other _____

Male Genital

____ Fertility problems
____ Prostate problems
____ Decreased libido
____ Other _____

Gynecology (Women Only)

____ Fertility problems
____ Currently pregnant
____ Menopause
____ Last menstrual period_____
____ Birth control_____
____ PMS
____ Missed/Irregular periods
____ Menstrual cramps
____ Decreased libido
____ Other _____

Surgeries (type and date)

_____
_____
_____

Trauma, Injuries (type and date)

_____
_____
_____

Medications, Supplements, Vitamins

_____
_____
_____

Other information

_____
_____
_____

Acupuncture Clinic Fees

All payments (cash or check only) are due at time of service.

_____
Signature of Patient or Legal Representative

_____
Date

Community Outreach Acupuncture Program (COAP)

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby voluntarily request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of an acupuncturist to be performed by *practitioners associated with the Community Outreach Acupuncture Program (COAP)*, on me (or on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Gua-Sha, and supplemental techniques.

I understand that acupuncture is a generally safe method of treatment, but that it may have some side effects that include, but are not limited to, unusual dizziness or fainting, temporary bruising, pain or discomfort, soreness, swelling, bleeding, numbness or tingling near the needling sites that may last a few days. Burns, blistering, or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify the acupuncturist if I am or become pregnant or if I am in the process of trying to become pregnant.

While I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, to be in my best interest.

I understand that acupuncture is not a substitute of conventional medical diagnosis and treatment and that I have the opportunity to discuss the nature and purpose of acupuncture and treatments with the practitioner at any time during my care. I understand that there is no implied or stated guarantee of cure or improvement of my condition.

I understand the acupuncturist may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that scheduling an appointment reserves a time specifically for me, and that consequently, a minimum of 24 hour notice is required to reschedule or cancel an appointment. If I do not call or show up, I will be responsible for the missed session fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent for treatment, acknowledge the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Patient's Signature Date

_____ _____

Print Name of Patient's Representative (If Applicable) Relationship to Patient

_____

Signature of Patient's Representative (If Applicable) Date

Community Outreach Acupuncture Program (COAP)

FOR PATIENT REVIEW REGARDING DIAGNOSTIC EXAM
PLEASE SIGN ONE OF THE TWO OPTIONS LISTED BELOW:

Option 1:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

_____

Patient's Signature Date

Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

_____

Patient's Signature Date

_____

Licensed Acupuncturist (L.Ac, L.OM) Signature Date

Community Outreach Acupuncture Program (COAP)

Our Clinic Protects Your Health Information and Privacy

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, workman's comp and your employer, and other third part 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 during regular business hours at 937-532-5773.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name and Relationship to Patient

Community Outreach Acupuncture Program (COAP)

Acknowledgment of Receipt of Privacy Practices

I consent to the use or disclosure of my identifiable health information by *the practitioners associated with the Community Outreach Acupuncture Program (COAP)* for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by *the practitioners associated with COAP* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *The practitioners associated with COAP* is not required to agree to the restrictions that I may request. However, if *the practitioners associated with COAP* agrees to a restriction that I request, the restriction is binding upon *the practitioners associated with COAP*.

I have the right to revoke this consent, in writing, at any time except to the extent that *the practitioners associated with COAP* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices followed by *the practitioners associated with COAP* prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.HealingCareAcupuncture.com. This Notice of Privacy Practices also describes my rights and the duties of *the practitioners associated with COAP* with respect to my identifiable health information.

The practitioners associated with COAP reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name and Relationship to Patient