Eastlake Acupuncture, Inc.
890 Eastlake Parkway #305, Chula Vista, Ca 91914
Office (619) 609-5300 / Fax (619) 550-3269
info@EastlakeAcupuncture.com
www.EastlakeAcupuncture.com

Hello! We are pleased to have you at **Eastlake Acupuncture** and thank you for choosing our clinic to help you achieve your health goals through acupuncture, acupressure, massage and herbal medicine remedies.

The beauty of acupuncture is that its application can be tailored to each individual depending on their specific health needs. On the next pages, you'll find the **'New Patient Intake Form'** that will allow us to gain a better understanding of your specific complaints so we can prepare an individualized treatment just for you. Please **complete the entire questionnaire** to the best of your ability before your first appointment. You may think some of the questions are unrelated to your compliant, but all of your answers will help us better understand and treat you. We keep all patient information strictly confidential.

Important Information For New Patients
If this is your first time seeking acupuncture, you may be nervous when coming in for your first appointment. Below is important information that will help you prepare for your appointment and know what to expect.

What To Wear For Acupuncture
Loose, comfortable clothing is highly recommended for your acupuncture appointments. Depending on your specific treatment protocol, we make ask you to put on a gown, or we may use sheets to access areas of your body where we will insert needles. We value your privacy, and draping will be provided to protect your modesty. We ask that patients **refrain from wearing strong-smelling perfume, cologne**, lotions, oil or cosmetics and **turn off** cell phones and other electronic devices before the treatment.

Needles
Acupuncture involves the placement of thin needles below the surface of the skin to activate the body's natural healing properties. For the majority of our patients, the placement of the needles is not painful. At Eastlake Acupuncture, we only use sterile, disposable needles, which are regulated by the FDA.

Your First Acupuncture Appointment

- We ask that you allow 1 hour for your first appointment. Follow-up appointments will usually last 45 minutes.
- We recommend that you eat before your acupuncture appointment, even if it's just a light snack. It is not a good idea to receive acupuncture on an empty stomach.
- On your first appointment, your acupuncturist will want to learn more about you, your complaint and your medical history. After bringing you into the treatment room, your acupuncturist will ask you a variety of questions and may perform some non-invasive medical tests, such as taking your pulse, and palpating certain areas of your body.
- After your first treatment is complete, the acupuncturist will provide you with treatment recommendations, which will cover treatment frequency and may also incorporate herbal medicine suggestions, nutritional and lifestyle advice or a referral to additional medical practitioners. These recommendations are meant to help you see the best results possible from your treatment and should be taken seriously.

After Your First Appointment

- Everyone responds differently to acupuncture. Some patients feel relaxed afterward, while others feel energized. We recommend that you take a few minutes after your appointment to drink water and rest.
- Keep track of how you feel in the days after your first appointment. When you come in for your second appointment, your acupuncturist will want to know how you felt physically, emotionally and mentally between appointments.
- In some rare cases, patients experience an initial increase in symptoms after their first acupuncture treatment. This type of flair-up usually happens later on the same day as the treatment but then goes away. Overall, acupuncture does not increase painful symptoms.

We welcome all questions from our patients before and after a treatment. Please do not hesitate to call us if you have a question or concern.

CONFIDENTIAL New Patient Intake Form

Patient Name: Last First Middle	Age:	Date of Birth:
Relationship to Patient: □ Self □ Parent □ Child □ Spouse		
Cell Phone Number: ( )	Home Phone Number: ( )	
Home Address: Street Address City State Zip Code		
Employer Name:	Employer Phone Number: ( )	

List the main health problem(s) for which you are seeking treatment:

1. _____

Date of onset of symptom (s): _____ **Severity of Symptoms 1-10 (1 mild/10 severe):** _____

2. _____

Date of onset of symptom (s): _____ **Severity of Symptoms 1-10 (1 mild/10 severe):** _____

Have you had the same symptom(s) or complaint before? yes [ ] no [ ]

Are you taking any prescribed medicines?: yes [ ] no [ ]

CURRENT AND PAST MEDICAL HISTORY (PLEASE CHECK)

AIDS (HIV) ☐ ASTHMA ☐ ARTHRITIS ☐ CANCER ☐ DIABETES ☐

HEPATITIS ☐ HEART DISEASE ☐ HERPES ☐ TUBERCULOSIS ☐

Are you currently Pregnant? □Yes □No

METHOD OF PAYMENT and FINANCIAL POLICY

Check which box applies

□ **Out-of-pocket** Cash/Credit/Debit

New Patients $165, Return Patients $95. Packages available for purchase after the initial treatment. This office does not bill health insurance. Be prepared to pay out of pocket at the time of service, we accept: cash, credit, debit/visa, hsa/fsa only.

□ **HSA/FSA Card** Payment is due at the time of service. **We can provide a superbill (itemized) receipt for all FSA/HSA cards.** Let your practitioner know if you will be requesting a superbill receipt for an FSA/HSA claim. New Patients $165, Return Patients $95.

By my signature, I acknowledge that I have read, understand, and agree to the financial and office policies stated above.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Patient Name: _____

Height: _____ Weight: _____ lbs Sex: □ Male □ Female Occupation: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Partnered Number of Children: _____

E-mail Address: _____

How did you hear about us: _____

Are you under the care of a physician now? □ Yes □ No If yes, for what? _____

Physician's Name: _____ Physician's Phone: (_____) _____

Have you received Acupuncture therapy before? □ Yes □ No if yes, when? _____

if Yes, How was your experience? _____

Is today's visit because of a Work Injury? □ Yes □ No If yes, Date of Injury: _____

Is today's visit due to an Auto Accident? □ Yes □ No If yes, Date of Accident: _____

Prior attempts to correct problem(s)? *(please include contact with other professionals, meds, types of treatment etc)*

_____

_____

List significant past Hospitalizations, Surgeries or Accidents (car accident, fall etc, include approximate <u>Dates</u>):

_____

_____

Allergies, Food Sensitivities:

_____

<u>EMERGENCY/GUARDIAN CONTACT INFORMATION</u>

Contact Name: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Patient Name: _____

Prescription drugs you are currently taking:

Drug Name: _____ Dosage: _____ For What? _____

Drug Name: _____ Dosage: _____ For What? _____

Vitamins, Supplements, Over-the-Counter Medication you are currently taking:

Name: _____ Dosage: _____ For What? _____

Name: _____ Dosage: _____ For What? _____

Check the Box if any of the following statements is true:

□ I have known Allergies □ I am taking Coumadin/Warfarin □ History of Seizures or Seizure like activity

□ I have a Pacemaker □ I am taking Lithium □ History of Head Trauma

FAMILY MEDICAL HISTORY

(Check the following conditions that have occurred in your blood relatives- grandparents, parents or siblings)

□ Allergies (list)	□ Alcoholism	□ Depression	□ High Blood Pressure	□ Tuberculosis
□ Arteriosclerosis	□ Cancer (type)	□ Diabetes	□ Seizures	□ Obesity
□ Asthma	_____	□ Heart Diseases	□ Stroke	

YOUR PAST MEDICAL HISTORY

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

□ AIDS/HIV	□ Cancer: _____	□ Measles	□ Seizures	□ Herpes (Type: _____)
□ Alcoholism	□ Chicken Pox	□ Multiple Sclerosis	□ Stroke	□ High Blood Pressure
□ Allergies	□ Diabetes (Type: _____)	□ Mumps	□ Thyroid Disorders	□ Venereal disease
□ Appendicitis	□ Emphysema	□ Pacemaker	□ Tuberculosis	□ Rheumatic Fever
□ Arteriosclerosis	□ Gout	□ Pleurisy	□ Typhoid Fever	□ Scarlet Fever
□ Asthma	□ Heart Disease	□ Pneumonia	□ Ulcers	□ Epilepsy
□ Birth Trauma	□ Hepatitis (Type: _____)	□ Psychological Disorder	□ Whooping Cough	□ Goiter

PERSONAL LIFESTYLE HABITS

Cigarettes (packs) _____ Coffee/Tea (cups per day) _____ Alcohol (drinks per week) _____

Recreational drugs: _____ Food cravings: _____

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INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. 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 acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and 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, is in my best interest. I understand that results are not guaranteed.

I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about 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 _____

Patient's Signature _____ Date Signed _____

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____ Print Name of Patient Representative _____

Signature of Patient Representative _____

Relationship or Authority of Patient _____

Name of Acupuncturist: Nadia Ayadi MS LAc, License# 14621

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Patient Responsibility and Office Policies

Thank you for choosing Eastlake Acupuncture Inc, office of Nadia Ayadi MS LAc. I am committed to providing you the very best acupuncture service. Please read the following policies, initial and sign below in the spaces provided.

Cancellations, No Show, Late Arrivals

As an individual healthcare provider, it is the office policy of Nadia Ayadi MS LAc and Eastlake Acupuncture, Inc. to require **24 hours notice for cancellation of any appointment.** If you cancel with less than 24 hours notice or fail to attend a scheduled appointment you will owe a fee of $50 before you can schedule a future appointment, sorry no exceptions.

Running Late: If you are more than 5 minutes late I will need to cancel the appointment upon your late arrival because a full acupuncture treatment will not be possible and tardiness would also affect other patient treatments (tardy appointment = $50.00 fee applies). As an individual healthcare provider I cannot accommodate late arrivals. Please understand that by scheduling an appointment with me you are committing to arriving at my office on that day at that time.

At the 2nd tardy appointment, running late or less than 24 hour notice cancellation you will be immediately dismissed from this practice due to non-compliance. No exceptions.

Initials: _____

Receipt of Notice of Privacy Practices *(located at the front desk)*

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices (In Office). I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

Initials: _____

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF THE OFFICE POLICIES DESCRIBED ABOVE.

Print Patient's Name: _____

Patient Signature: _____ Date: _____

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Directions to Eastlake Acupuncture

From North

805 South
Take the **Telegraph Canyon Rd** Exit (East)
Turn **Right** onto **Telegraph Canyon Rd** (East)
Continue straight for 5.5 miles (approximately 10-15 minutes+ with traffic lights)
(Telegraph Canyon Rd turns into Otay Lakes Rd)
Turn **Left** onto **Eastlake Parkway**
Turn **Left** at **Miller Dr**, into a shopping center
Make **Left into First parking lot** (you will see big medical building on left '**Village Walk Medical Arts Center**').
Park in lot.
Enter building, take elevator to 3rd floor, Suite 305

Toll Road Option- 125 Toll Road ($2.75+, may save up to 10-15 minutes driving time)

125 South, Toll
Take the **Otay Lakes Rd** Exit
Turn **Left** onto **Otay Lakes Rd**
Turn **Left** onto **Eastlake Parkway**
Turn **Left** at **Miller Dr**, into a shopping center
Make **Left into First parking lot** (you will see big medical building on left '**Village Walk Medical Arts Center**').
Park in lot.
Enter building, take elevator to 3rd floor, Suite 305