# *PATIENT HISTORY*

Patient's Name ________________________________________ Date of Birth _________
(last) (first) (middle)

Mailing Address ____________________________________________________________
(number and street) (city) (state) (zip)

Home # (___) ________ Cellular # (___) ________ Work # (___) _________

Employer _____________________________

Email address ___________________________________

In Case of Emergency Contact ________________________ Phone # (___) ____________

Referring Physician ____________________________ Date of Injury _________________

Would you like us to provide appointment reminders? Y/N

How did you hear about ABR Acupuncture? _______________________________________

**► IF PATIENT IS UNDER THE AGE OF 18 ◄**

Mother's Name _____________________________________________ Employer ____________________________
Work # (___) _________________________________

Father's Name _____________________________________________ Employer ____________________________
Work # (___) _________________________________

payments due at the time of the service.

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize ABR Acupuncture information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to Sapphire Physical Therapy.

_______________________________________________ ____________________

**Signature** **Date**

# *RELEASE OF INFORMATION*

ABR Acupuncture
2105-C West Cornwallis Drive
Greensboro, NC 27408
336-209-9842
336-235-4530 Healing Hands Chiropractic
336-235-0754 Fax

Thank you for referring your patient to ABR Acupuncture.

Please forward the medical records regarding this patient so we may provide proper treatment to your patient.

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I authorize the release of and correspondence regarding my (or my dependent's) medical records to ABR Acupuncture.

Date ______________________________________________

Patient Name ______________________________________

Date of Birth ______________________________________

__________________________________________ ________________
**Signature** **Date**

# *NOTICE OF PRIVACY PRACTICES*

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

**Uses and Disclosure of Health Information:**
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

**Uses and Disclosures Based on Your Authorization:**
Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

**Uses and Disclosures Not Requiring your Authorization:**
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

**Patient Rights:**
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

**Please contact us with any questions, concerns, or complaints regarding our privacy practices.**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.**

________________________________________________
Patient Name (please print)

________________________________________________
Parent or Authorized Representative (if applicable)

____________________________________ _______________
**Signature** **Date**

# *PATIENT HISTORY FORM*

*Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

## *History of Present Problem*

Please answer the following questions

What is the main reason for your Acupuncture evaluation and treatment today?
______________________________________________________________________________
______________________________________________________________________________

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), circle the number that best describes your average pain?
0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
days ago weeks ago months ago years ago
Other
__________________________________________________________________________

Problem **worsens** with:
Movement Inactivity Standing Lying Sitting
Other
__________________________________________________________________________

Problem **improves** with:
Movement Inactivity Standing Lying Sitting
Rest Medication Heat Ice
Other
______________________________________________________________________________

How frequently are you bothered by this problem?
Constant Occasional/Variable
Oter__________________________________________________________________________

How would you describe your pain?
Dull Sharp Burning
Other
___________________________________________________________________________

Do you have any other symptoms?
Yes No If yes, Please explain
______________________________________________________________________________

Does the problem interfere with daily functions? No Yes, please explain:
_______________________________________________________________________

## *Past Medical & Social History*

List any personal past major illnesses &/or relevant surgeries from the past.

Illness or Surgery _______________________________ Date ____________

_______________________________ ____________

_______________________________ ____________

List all serious illnesses in your family. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart disease, etc.)

______________________________________________________________

______________________________________________________________

______________________________________________________________

Are you on any prescription medications? Yes No (If Yes, List all)

| Name | Dose | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Any over the counter medications? No Yes Please explain ______________________________

Do you have allergies? No Yes Please explain ______________________________

Are you taking any dietary supplements? Yes No (If Yes, List all)

| Name | Dose | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you smoke? No Yes How much?______________

Do you drink alcohol? No Yes How much?______________

How much caffeine do you consume daily? __________________

Do you drink soda/ how much?____________________

How much water do you drink daily?_______________________

Briefly describe your diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you exercise? What types and how often?

## *Review of Systems*

Do you now or have you had any problems related to the following systems? Circle (Y) or (N)
Please explain any yes answer.

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache/migraine | Y | N |

Other ____________________

**Eyes**

| | | |
|---|---|---|
| Blurred Vision | Y | N |
| Double Vision | Y | N |
| Pain | Y | N |

Other ____________________

**Allergic/Immunologic**

| | | |
|---|---|---|
| Seasonal Allergies | Y | N |
| Drug Allergies | Y | N |
| Food Allergies | Y | N |

Other ________________________

**Neurological**

| | | |
|---|---|---|
| Tremors | Y | N |
| Dizzy Spells | Y | N |
| Numbness/tingling | Y | N |

Other ____________________________

**Endocrine**

| | | |
|---|---|---|
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/Sluggish | Y | N |
| Diabetes | Y | N |

Other _______________________

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | Y | N |
| Constipation | Y | N |
| IBS | Y | N |
| Indigestion/heartburn | Y | N |

Other ______________________

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain | Y | N |
| Stroke | Y | N |
| Heart Palpitations | Y | N |
| Heart disease | Y | N |
| High blood pressure | Y | N |

Other _____________________

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | Y | N |
| Boils | Y | N |
| Persistent itch | Y | N |

Other ___________________________________

**Musculoskeletal**

| | | |
|---|---|---|
| Joint Pain | Y | N |
| Neck Pain | Y | N |
| Back Pain | Y | N |
| Muscle Pain | Y | N |

Other ___________________________________

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear Infection | Y | N |
| Ringing in Ears | Y | N |
| Sore Throat | Y | N |
| Sinus Problems | Y | N |

Other ___________________________________

**Genitourinary**

| | | |
|---|---|---|
| Urine Retention | Y | N |
| Painful Urination | Y | N |
| Urinate Frequently | Y | N |
| Incontinence/Leaking | Y | N |

Other ___________________________________

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Y | N |
| Frequent Cough | Y | N |
| Shortness of Breath | Y | N |
| Pneumonia | Y | N |

Other ___________________________________

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |

Other ______________________

**Psychologic**

Have/are you suffered/suffering from depression in the past/ currently? Y N

Do you have any other psychological disorders? Y N

Other _______________________

Do you have any other conditions that may be relevant to your treatment? Y___N ___

If yes, Please explain: ________________________________________

Have you had any recent illnesses within the past 2-3 weeks? (i.e. Colds, flu, bladder/kidney infection.)
Y___ N ___

If yes, Please explain: ________________________________________

Have you noticed any lumps or thickening of skin or muscle anywhere in your body?
Y___ N ___

If yes, Please explain: ________________________________________

Do you have any sores which haven't healed or any changes in size, shape or color of wart or mole?
Y___ N ___

If yes, Please explain: ________________________________________

Do you have any special needs and or considerations?
Y___ N ___

If yes, Please explain: ________________________________________

Have you had any unexplained weight loss or gain in the last month?
Y___ N ___

If yes, Please explain: ________________________________________

Are you pregnant or are you currently trying to become pregnant? Y___ N ___

ABR Acupuncture

# CONSENT TO TREATMENT

I, the undersigned, authorize ABR Acupuncture to perform treatment methods used in this practice which may include, but are not limited to acupuncture, trigger point dry needling, massage therapy, electrical stimulation, cupping, gua sha (scraping), and nutritional counseling.

I understand that acupuncture, trigger point dry needling, massage therapy, electrical stimulation, cupping, gua sha (scraping), are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last for a few days. Unusual risks of treatment include accidental puncture of a lung (pneumothorax), dizziness, fainting, or nerve damage. If a pneumothorax were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Infection is possible, although ABR Acupuncture uses alcohol and sterile disposable needles and maintains a safe and clean environment. Temporary bruising or redness lasting several days is a common side effect of cupping and gua sha.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify ABR Acupuncture should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points that can induce a miscarriage.

I understand that ABR Acupuncture may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with ABR Acupuncture before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his/her judgment in my best interest during the course of treatment, based on the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, A MINIMUM OF 24 HOURS NOTICE IS REQUIRED TO RESCHEDULE OR CANCEL AN APPOINTMENT. UNLESS OTHERWISE AGREED TO IN ADVANCE, THE FULL FEE WILL BE CHARGED FOR THE SESSION MISSED WITHOUT SUCH ADVANCE NOTIFICATION. I UNDERSTAND THAT INSURANCE WILL NOT COVER THE COST OF TREATMENT AND PAYMENT IS DUE AT THE TIME OF SERVICE. Payments through health savings accounts, or flexible spending accounts are welcome.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient's Name (please print)_________________________________________________________________

Patient's Signature_______________________________________________Date________

Parent's Signature signing for a minor______________________________Date________