INCLEDON CHIROPRACTIC - FIVE ACTIONS ORIENTAL MEDICINE
6609 WOOLBRIGHT RD. SUITE 414
BOYNTON BEACH, FL 33437
PHONE 561-865-8390

NEW PATIENT INTAKE FORM

Today's Date: _____ Name:_____
Birthdate:_____ Sex:_____ Age:_____ Height:_____ Weight:_____
Address:_____
City, State, Zip Code:_____
Home #:_____ Cell #:_____
Email Address:_____
Work #: _____ Emergency Contact (name & #)_____
Occupation:_____
How did you hear about us?_____
Have you had acupuncture before?_____Chinese herbal medicine?_____
Reason for today's visit: _____
How long have you had this condition?_____
Is it getting worse? _____ Does it bother your sleep/work?_____
What seems to be the initial cause?_____
What makes it worse?_____
Are you under the care of a physician now?_____ If yes, for what?_____
Who is your physician?_____

Health Insurance Information: Please provide card for copying

Name of carrier:_____
Type and # of policy:_____
Primary on policy:_____

PAYMENT IS EXPECTED AT TIME OF YOUR VISIT

HOW WILL YOU BE PAYING FOR TODAY'S VISIT? ___CASH ___CC ___CHECK

___INSURANCE

I understand and agree that health and insurance policies are an arrangement between as insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making the collections from the insurance company and that any amount authorized is to be paid directly to Incledon Chiropractic - Acupuncture & Oriental Medicine and will be creditied to my account upon request. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. **SHOULD I BE REIMBURSED DIRECTLY FROM MY INSURANCE COMPANY, I AGREE TO PRESENT THE EXPLANATION OF BENEFITS AND CHECK TO INCLEDON CHIROPRACTIC - ACUPUNCTURE & ORIENTAL MEDICINE.**

Surgery (list):_____

List Medications and/or Vitamins/Supplements currently taking:

_____
_____

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HIGHLIGHT or CIRCLE Past Medical History and/or Conditions you have currently:

AIDS/HIV	ALCOHOLISM	ALLERGIES	APPENDICITIS	ARTERIOSCLEROSIS
ASTHMA	BIRTH TRAUMA	CANCER	CHICKEN POX	DIABETES EMPHYSEMA
EPILEPSY	GOITER	GOUT	HEART DISEASE	HEPATITIS
HERPES	HIGH/LOW BP	MEASLES/ MUMPS		PACEMAKER
MSPLEURISY		PNEUMONIA		POLIO
RHEUMATIC FEVER		SCARLET FEVER		SEIZURES TB
TYPHOID FEVER		WHOOPING COUGH		STD

HIGHLIGHT OR CRICLE ALL THAT APPLY:

Preference for cold/hot drinks	poor sleep	body heaviness	chills/fever
heavy sleep	cold hands/feet	Recent weight loss/gain	dream-disturbed sleep
poor circulation	sweat easily	Fatigue/lack of strength	night sweats
Cramps	Vertigo/dizziness	bleed/bruise easily	odd taste or none
sores mouth/tongue	frequent sore throat	poor night vision	Glasses
Eye strain/pain glaucoma	dry mouth	swollen glands	Red eyes
cataracts	excess saliva	lumps in throat	Eye floaters
teeth problems	sinus problems	enlarged thyroid	Poor/blurred vision
grind teeth	excess phlegm	nose bleeds	TMJ
facial pain	gum problems	ringing in ears	Poor hearing
earaches	headaches/migraines		

Other head/neck problems:_____

Shortness of breath	difficulty breathing when lying down		tightness in chest
wheezing	labored breathing		Coughing blood
fainting	chest pain		Blood clots (phlebitis)
palpitations	Irregular heartbeat cough		tachycardia

Nausea/Vomiting	diarrhea	intestinal pain or cramping	
constipation	itchy anus	Acid reflux	
Hiccups	laxative use	burning anus	Gas/bloating
Bad breath	black stools	rectal pain	bloody stools hemorrhoids
mucus in stools	anal fissures		

Neck/shoulder pain	upper/lower back pain	joint pain	limited R.O.M.
Muscle pain	rib pain	limited use	

Rashes/eczema/psoriasis	dandruff	change in skin/hair	Hives
itching	fungal infections	Ulceration's	hair loss
acne	Other:_____		

poor memory	irritability	considered/attempted suicide	Numbness
depression	easily stressed	seeing therapist	
Tics	anxiety	abuse survivor	Other:_____

Pain on urination	blood in urine	venereal disease	
increased/decreased libido	inability to hold urine	Frequent urination	bed wetting
Urgent urination	incomplete urination	wake to urinate	kidney stone
premature ejaculation	Impotence	nocturnal emission	Other:_____

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Gynecology:

Age at start of menses:_____ Menstrual cycle length (e.g., 28-30 days):_____
Duration of menstrual flow:_____ Date last period began:_____

Irregular periods	painful periods (cramps)	PMS
Pass blood clots	Vaginal sores	vaginal odor
vaginal discharge	Breast lumps	# of pregnancies:_____
# of live births:_____		
Premature births	age at menopause:_____	date of last PAP:_____

Other:_____

Patient Signature:_____

Patient or Legal Guardian Patient Name:_____

Date:___/___/___

COMMENTS:_____

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CONSENT TO TREATMENT

By signing below, I voluntarily consent to be treated at Incledon Chiropractic - Five Actions Oriental Medicine. I understand healing is a highly individual process and no guarantees can be made as to my results. **I understand I may refuse or stop any of these treatments at any time.**

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

____**1. Acupuncture:** I understand that acupuncture is performed by the insertion of fine needles through the skin at selected points (acupoints). It balances the flow of vital life energy through out the body, corrects the existing unbalance, restores the body's harmony and functions, and allows the healing to take place and the wellness to be maintained. I am aware that acupuncture may cause pain or discomfort, local bruising, minor bleeding, fatigue, and fainting and occasionally, it can aggravate existing symptoms.

____**2. Chinese Herbs, Homeopathic Remedies, Essential Oils and Nutritional Supplements:** I understand that Chinese herbs, homeopathic remedies, essential oils and nutritional supplements may be recommended to me as a part of my healing program. I understand that if I decide to take them, it is up to me to follow the prescribed instruction. I am aware that these remedies may cause changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of existing symptoms. *Should I experience any problems, which I associate with these remedies, I should stop taking them and call Incledon Chiropractic - Five Actions Oriental Medicine.*

____**3. Moxibustion:** I understand that moxibustion is a special type of heat therapy in which a small wad or stick made of dried moxa (a herb) leaves is applied, while burning slowly and steadily, at selected acupoints near the surface of the body. There are two ways of carrying out moxibustion. Some practitioners prefer to attach a small wad to the end of an acupuncture needle that has been already inserted into the relevant point, light the moxa, and allow the heat to travel down the needle and into the point. Other practitioners like to hold a lit moxa stick with one hand, and wave it around the selected acupoints near the surface of the body. I am aware that moxibustion may cause local burn and pain or discomfort, and sometimes it aggravates existing pain.

____**4. Gua Sha:** I understand that if I receive gua sha as part of my healing program, there is a risk of local bruising, minor bleeding, pain or discomfort, and the possible aggravation of existing symptoms.

____**5. Acupressure/Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage as part of my healing program. I am aware that certain adverse side effects may result. These side effects include but are not limited to: bruising, sore muscles or aches, and the possible aggravation of existing symptoms.

____**6. Electro-Acupuncture:** I understand that electro-acupuncture may be beneficial for my healing and may be recommended and administered to me. I am aware that certain adverse side effects may result. These side effects include but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of existing symptoms.

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____7. MediCupping and Cupping: I understand that if I receive MediCupping and/or Cupping as part of my healing program, there is a risk of local bruising, pain or discomfort and the possible of aggravation of existing symptoms.

____8. Other Modalities: I understand that I may receive other modalities (within the scope of practice of licensed acupuncture physicians as permissible by Florida Law), including *but not limited to*: cold laser, auricular (ear) acupuncture or acupressure, dietary counseling and food therapy, aromatherapy, ozone therapy, qi gong, etc. I am aware that certain adverse side effects may result. These may include but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

____***9. YOUR M.D. AND PRESCRIPTION MEDICATIONS:*** I understand that no treatment I receive from Incledon Chiropractic - Five Actions Oriental Medicine should be construed as medical advice to stop seeing my medical doctors or discontinue any therapies or medications they may have prescribed. Although I understand that it is not uncommon for patients to experience beneficial changes in their health that may affect their need for existing therapies, prescription medications and dosages, I am aware that in the course of my treatment it may be necessary to consult more frequently with my prescribing physicians regarding those therapies, medications and dosages. I understand that it is *absolutely necessary* to disclose any and all therapies, prescription medications and dosages I am taking to my acupuncture physician, as these may affect my treatment. I understand that there may be other treatment alternatives for my condition than those offered me by *Incledon Chiropractic - Five Actions Oriental Medicine* including treatment offered by other types of licensed physicians. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient Signature:_____

Patient or Legal Guardian
Patient Name:_____

Date:___/___/___

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GENERAL DISCLAIMER & PATIENT CONSENT FORM

Healing is a highly individual process. The time and number of treatments required for achieving your health and wellness goals varies greatly both among and within individuals. No guarantees can be made as to your results. Payment is for services provided independent of results. The examination and treatment you receive from Incledon Chiropractic - Acupuncture & Oriental Medicine is not intended to replace the examination and treatment you receive from your current western medical doctor. No advice given to you by the Incledon Chiropractic - Five Actions Oriental Medicine staff should be construed as medical advice to stop seeing your medical doctor(s) or to discontinue any therapies or medications they may have prescribed. It is absolutely necessary to disclose any and all therapies and prescription medications you are taking to your acupuncture physician, as they may affect your treatment.

I understand that the healing process is an individual one, and the time and treatments required will vary with each person. Any questions I had have been answered to my satisfaction.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Incledon Chiropractic - Five Actions Oriental Medicine provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Policies.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition treatment upon the execution of this Consent.

This General Disclaimer & Consent Signed By Patient or Representative:_____

Relationship to Patient (if other than patient): _____

Date:____/____/_____

INCLEDON CHIROPRACTIC - FIVE ACTIONS ORIENTAL MEDICINE POLICY

New patients generally run 90 minutes and follow-up patients run up to an hour. This allows time for the acupuncture physician to get to know the each patient and record a detail information on his/her chief complaint.

You must arrive at least 10-15 minutes before your scheduled appointment time. If you are late for your appointment, the acupuncture physician cannot run over into the next appointment and that time you were late is lost. No discounts can be offered for the lost time.

CANCELLATION POLICY

Due to the limited number of acupuncture appointments available and the high demand for these appointments, it has become necessary to implement an Acupuncture & Oriental Medicine Treatment Cancellation Policy.

24-HOUR ADVANCE NOTICE is required for all cancellations so this time can be re booked.

Failure of the patient to notify us of a cancellation with 24-hour advance notice will result in:

1. The patient being responsible for payment of the Acupuncture & Oriental Medicine fee, even though the time was lost (this charge cannot be billed to your insurance).
2. Loss of a patient's ability to schedule further appointments.

In the event that an appointment is missed without advance notice, all future appointments will be automatically deleted until the patient contacts our office and conforms to the above policy. We are not responsible, if before you contact our office, other patients book those time slots.

PATIENTS WILL BE ALLOWED A 1-TIME GRACE FROM THIS POLICY.

A reminder call will be made the day before your appointment to help confirm your appointment. In the event we are unable to reach you, WE WILL LEAVE YOU A MESSAGE AND IT IS REQUIRED THAT YOU CALL US BACK TO CONFIRM THE APPOINTMENT.

Signature: _____
Date: _____/ _____/ _____
Patient or Legal Guardian

Printed Name: _____