Acupuncture Intake Form

Provider: Christopher Woon LAc

Patient Information

Thank you for choosing our practice for chiropractic needs. Please complete this form in ink.
(Please Print)

Name:____________________________ Date:____________ HIC/patient ID#: ________________________
First, Middle Initial, Last

Address: __________________________ City:____________ State:______ Zip Code: _________________

Sex:____________________________ Gender: ____________ Date of Birth: ______________________

Contact Information:

Home Phone:________________Cell Phone: ______________ Work Phone:_____________________

Email: ____

Where Do Your Prefer to Receive Calls? (please circle): Home/Work/Cell/No Preference

Are you comfortable with us leaving a voicemail? Yes/no

Who are you comfortable with sharing appointment information with (**no** medical information - date of appointment and time only):____

Patient employer/School Occupation: ____

Employer/school Address:____________________ City:________ State:____________________

Zip Code:____________ Employer Work Phone: ______________________________________

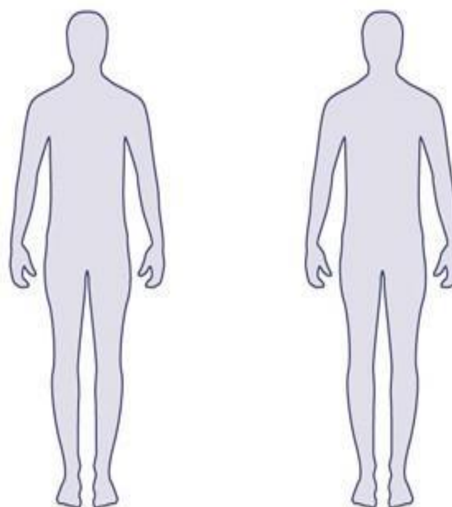
Whom may we thank for referring you to us? ____

Person to contact in case of emergency:______________Phone ______________________________

Doctor's Name:______________________________ Phone:______________________________

Diagnosis by your Doctor:_____________________________

Please circle area of problem



Major Complaints: ______________________________
____
____

Other Complaints: ______________________________
____
____

Pain is (please circle one): minimal / moderate / severe

How long have you had this condition?
____

When? ____

What makes it better? ____

What makes it worse? ____

Is your condition (please circle one): getting worse / constant / comes and goes

Health History: (do you have or have ever had?)

- Arthristis
- Asthma
- Anemia
- Cancer
- Diabetes
- Epilepsy
- Gallstone
- Heart trouble
- Stroke
- High blood pressure
- Kidney or bladder trouble
- Ulcers
- Chronic fatigue
- Jaundice
- Sudden weight loss
- Sudden weight gain
- Other ______________________

____

Medications/Drugs/Herbs you are currently taking: ______________________________

____

List surgeries and operations you have had and the dates: ______________________________

____

Date of last physical examination: ____________ By Whom: ______________

Family History: (has any family member had any of the above?): yes/ no

If yes, which member and what did they have? ______________________________

Energy Levels: high (what time of day)__________ low (what time of day)____________

Stress: (please circle) none, moderate, severe What causes it?______________________

Sweating: (please circle) Sweating at night, rarely sweating, excess sweating

Circulation: Feeling hot or cold? What area? ______________________________

Bleed easily, cold limbs, other: ______________________________

Skin: Dry, itchy, moist/clammy, burning, changing moles or lumps (cysts/tumors), boils, frequent skin rashes, acne, hair loss/thinning, dry scalp or skin, puffy/winkled, hives, bruise easily (black and blue spots) other: ______________________________

Scars: (list all scars from accidents or surgeries)______________________________

Sleeping problems: trouble falling asleep, excess dreaming, restful, other: ____________

How many hours do you sleep at night?______________________________

Head: headaches (what area?) ______________________________

Dizziness, memory loss, loss of balance, other: ______________________________

Eyes (please circle): eye pain, dry eyes, blurred vision, dark under eyes, other: ____________

Nose: frequent nose bleeds, sinus trouble, frequent colds, sinusitis, other: ____________

Throat: sore throat, hoarseness, difficulty swallowing, teeth/gum problems, jaw problems, swollen tongue, other: ______________________________

Chest: hard to breathe, wheezing, shortness of breath, trouble breathing at night, palpitations, mucus, rattles when breathing, pain/pressure in chest, persistent cough, coughing blood, coughing phlegm: sputum color ________ Other: ______________________________

Blood Pressure: high, low, do not know

Bowels: diarrhea, constipation, bloody stools, black stools, mucus in stools, number of bowel movements___ , hemorrhoids, lower bowel gas, stool has foul odor, colon problems, other:

____

Urine: frequent urination, strong smelling urine, hard to urinate, blood in urine, water retention, pain or burning when urinating, frequent infections, other:________________________________

Musculoskeletal: pain in neck, shoulder, between shoulders, arms/hands, hip, knee, finger, toes, upper back, mid back, lower back, loss of grip, sore pain, bursitis, swollen knees/elbows, leg cramps at night, weakness in legs, weak ankles, stiff, all-over tingling in feet, muscle spasm/cramp, painful joints, loss of feeling in hands/feet, other:__________________________

____

Neurological: nervousness, depressed, easily angered, easily irritated, frequent crying, worry, anxiety, mood swings, memory loss, confusion, suicidal, poor concentration, tremors, numbness/tingling limbs, poor coordination, muscle weakness, feel weak/shaky, seizures, neuralgia (nerve pain), shingles, other:____

Females:

Pregnant? Yes / no

Last monthly period: ______________________ Last PAP Test:____________________

Forms of birth control: none, pill, other: ____

Age started menstrual cycle:_________________ Age stopped: ______________________

Information about menstruation: color_____, location of pain _______, irregular clotting, heavy periods, light, scanty bleeding, water retention, mood changes, missed periods, low or no sex drive, hot flashes, painful breasts, food cravings, other: _________________________________

Discharge color: yellow, thick, white, odor, itching, liquid, other: __________________________

Number of pregnancies:_____ Number of Deliveries: ___________________________________

Number of Cesareans:___ Operations: cervix, uterus, ovaries, other: _______________________

Males:

Low sex drive, impotence, ejaculation cases pain, premature ejaculation, discharge pain, or burning while urinating, prostate problems, other: ____________________________________

Digestion:

Stomach gas, lower bowel gas, heartburn, nausea, burning/belching, stomach pain, stomach cramps, vomiting, bad breath, sores, in mouth, weight gain, weight loss, bitter/sour taste in mouth, abdominal bloating, how long after eating?____

Food Allergies? Yes / no If yes, to what? ____

____

DO YOU:

Skip breakfast, eat a snack, eat a hearty breakfast

How many meals a day do you eat?

What is the biggest meal of the day?

Do you plan meals according to the "four basic food groups"? yes / no

How many glasses of water do you drink per day?

Do you use alcohol? Yes / no Amount per week Type:

Tobacco? Yes / no Packs per day
how many years

Eat raw fruit or vegetables at least twice per day? Y / N

Always add salt at the table? Y / N

Eat green or yellow veg at least twice per day? Y /N

Eat frequently between meals? Y / N

Eat meat or dairy products 2+ times a day? Y / N

Eat until you are full? Y / N

Chew your food thoroughly before swallowing? Y / N

Eat when you're not hungry?

Eat the same foods almost every day?

Occasionally go on a crash diet? Y / N

Drink juice, milk, or other drinks instead of water when thirsty? Y /N

DO YOU:

Have a tendency to faint? Y / N

Bruise or discolor easily? Y / N

Have or have had hepatitis? Y / N

Have excessive thirst? Y / N

ARE YOU:

Taking any therapies at this time? Y / N

Hungry at present? Y / N

Exhausted at present? Y / N

Nervous at present? Y / N

Allergic to anything? Y / N

Insurance Information:

PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK TO WE CAN RETAIN A COPY FOR OUR RECORDS. IF YOU DO NOT PROVIDE YOUR MOST UP TO DATE INSURANCE, YOUR DATES OF SERVICE WILL BE BILLED TO YOU DIRECTLY. THANK YOU FOR YOUR UNDERSTANDING.

Name of Insurance:____

Name of Insured:______________________ Relationship to Patient:__________________________

Policy Effective Date:_________________________ If you are not the insured, please provide, the insured's date of birth:____

Do you have a secondary insurance (please circle one answer): yes/no

If you answer if yes, please provide the following information:

Name of Secondary Insurance:____

Name of Insured:_________________ Relationship to Patient:_________________________________

Policy Effective Date: ______________________ If you are not the insured, please provide, the insured's date of birth:____

Doctor's Name:____________________________ Phone:______________________________________

Individual treatment sessions are typically 45 minutes to 1 hour in length. It is important you are on time because your treatment time will not be extended beyond the scheduled time as a result of your late arrival. Your appointment time is held exclusively for you. If you are unable to keep your appointment for any reason, you must let us know at least 24 hours before your scheduled appointment time. Otherwise, you will be charged a $50.00 fee for the time reserved for you. Insurance companies will not reimburse you or us for a missed appointment.

The fees for acupuncture codes are as follows, one or more code may be billed per session:

97810 w/o electro stim initial 15 min - $95.00

97811 additional 15 min - $70.00

97813 with electro stim initial 15 min - $100.00

97814 additional 15 min w/ electro stim - $75.00

97026 infrared - $30.00

New Patient:

99203 - $130.00

Established Patient Re-Evaluation:

99211 - $60.00

99212 - $75.00

99213 - $85.00

Cash Rate:

Initial Evaluation - $130.00

Per Appointment - $95.00

Senior Discounts Available:

Initial Evaluation - $118.00

Per Appointment - $86.50

PATIENT SIGNATURE ____