Acupuncture Center of Mt. Airy Intake Form

Name_____Today's Date_____

Address_____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Email Address_____

Date of Birth_____Marital Satus: O Single, O Married

Is this your first acupuncture visit?_____

What brings you today?_____

Check all that apply:

O Headache	O Frequent Urination	O Urgent Urination
O Migraines	O Incontinence	O Hypertension
O Diabetes	O Blurred Vision	O Asthma
O Short of Breath	O Palpitations	O Fibromyalgia
O PMS	O Fibroids	O Cancer
O Constipation	O Diarrhea	O Anxiety/Depression
O Arthritis	O Epilepsy	O Acid Reflux

How would you describe your energy level?_____

Gynecological:

What age did menstruation begin?_____

Pregnancies: Y_____N_____Number_____

Number of days in your cycle?_____Number of days of flow?_____

What age did menstruation stop?_____

Pain:

Where_____

_____

_____

History of Surgery:

_____

_____

_____

_____

List all medications including vitamins, herbal supplements and over the counter medications:

_____

_____

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_____

The above information will be treated confidentially. In order to maximize the effectiveness and safety of your treatment please give your feedback at the end of the session. In addition, please alert your practitioner of any changes in the above information as soon as possible.

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I have read the above information and discussed it with my practitioner. I have alerted my practitioner to any physical and emotional conditions that could affect this work. By signing this health screen, I am giving permission for my practitioner to proceed with this and future treatments.

Signature **Date**

Acupuncture Center of Mt. Airy
Phone 443-865-0600
acupamy@comcast.net
www.acupuncturecentermtairy.com
1311 S. Main Street Suite 205
Mt. Airy, MD 21771

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.

b) Payment - To bill you or a third party for payment for services provided to you.

c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you

b) As required by federal, state, or local law

c) If child abuse or neglect is suspected

d) Public health risks (for public health activities to prevent and control spread of disease)

e) Lawsuits and disputes (in response to a court or administrative order)

f) Law enforcement (to help law enforcement officials respond to criminal activities)

g) Coroners, medical examiners and funeral directors

h) Organ or tissue donation facilities if you are an organ donor

i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.

b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request

b) Right to amend information in your health record you believe is inaccurate or incomplete

c) Right to know to whom we have disclosed your health information

d) Right to ask for limits on the health information data we give out about you

e) Right to receive communication from us about your health information in alternate ways

f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Signature of patient or representative Date

_____

Print patient name Patient Birth Date

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I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling. I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking 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 a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. 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 the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process. I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. I understand that my acupuncturist 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 my practitioner 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 or her judgment in my best interest during the course of treatment, based upon 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 sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions. 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 Signature Date