

Clinic Registration

General Information

FULL NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: Male Female

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME/CELL PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

HEIGHT: _____ WEIGHT: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Do you have insurance coverage that you would like to submit? No Yes Insurance Company Name:

Has the patient had an acupuncture/massage (circle) treatment before? No Yes If so, when and for what condition?

Is the patient presently under a doctor's care? No Yes , Explain:

Are there any other therapies which the patient is receiving services? No Yes, Explain:

Demographics

What is the patient's marital status? (Please check most current status)

-Married or living with significant other
-Divorced/Separated
-Widowed
-Never been married
-Declined to disclose

How much schooling has the patient completed? (Please check one)

-Completed less than high school
-Graduated from High School
-Completed 1-3 years of college
-Graduated from a 2-year Associate degree program or technical school
-Graduated from college
-Completed post-graduate or professional program
-Declined to disclose

Please identify the patient's race, as defined by the federal government. (Please check one)

-Asian or Pacific Islander
-Black/African American
-Hispanic
-American Indian or Alaskan Native
-White
-Other _____
- Declined to disclose

Primary Reason for Visit

Please tell us what the patient's primary reason for seeking care at our office?

On a scale of 0-10 how would you rate your pain? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

What was the initial cause?

When did it begin?

Is it constant or comes and goes?

What makes it better?

What makes it worse?

Sitting Standing Walking Bending Lying Down Stretching Other:

This problem interferes with the patient's following daily activities?

Work Daily routine Emotional Recreation Social life Relationship Sleep

What services has the patient received for this condition?

Is the patient interested in?

Pain Relief Preventative Care Oriental Nutrition Maintenance Care Stress Relief

What are the patient's health goals?

Family Health History: Do/did any members of the patient's immediate family (mother, father, sister, brother) have any serious health conditions?

No

Yes, Please describe your relation to this individual and their condition(s)

Surgical History: Please list any surgeries the patient has had in the past and dates:

Injury History: Please list any auto, workman's compensation, or other injury or trauma with date and descriptions.

Medications, allergies, over the counter drugs or vitamins, or special diets the patient is currently taking: (Include dose, purpose and if prescribed)

Infectious Diseases and Vaccine History:

Please indicate if the patient has had the following diseases and/or vaccinated for these diseases. Up to date all vaccines

| | | | | | | | |
|-------------------------|-----|----|------------|----------------|-----|----|-------------|
| Chicken Pox | Yes | No | Vaccinated | Rotavirus | Yes | No | Vaccinated |
| Diphtheria | Yes | No | Vaccinated | Rubella | Yes | No | Vaccinated |
| Haemophilus Inf. Type B | Yes | No | Vaccinated | STD | Yes | No | Vaccinated. |
| Hepatitis B | Yes | No | Vaccinated | Small Pox | Yes | No | Vaccinated |
| Measles | Yes | No | Vaccinated | Tetanus | Yes | No | Vaccinated |
| Mumps | Yes | No | Vaccinated | Whooping Cough | Yes | No | Vaccinated |
| Polio | Yes | No | Vaccinated | Other: | | | |
| Pneumonococcal | Yes | No | Vaccinated | | | | |

Health History

Please list or check any health problems the patient currently has or has had. Answer to the best of your knowledge.

Chronic or Acute Infectious Diseases

- Hepatitis
- HIV
- Chills
- Fever
- Sore throat
- Low energy/fatigue
- Spontaneous sweating
- Night sweating
- No sweating
- Aversion to heat/cold
- Frequent colds
- Growth disorder

Heart, Lung and Circulation

- Asthma
- High blood pressure
- Previous heart attack
- Chest pain
- Palpitation
- Irregular heartbeat
- Stuffiness in the chest
- Low blood pressure
- Pneumonia
- Bronchitis
- Difficulty breathing
- Shortness of breath
- Swelling of ankles
- Varicose veins

Digestion

- Heartburn
- Constipation
- Diarrhea
- Difficulty swallowing
- Nausea
- Vomiting
- Belching
- Acid reflux
- Poor appetite
- Excessive appetite
- Excess thirst
- Tired after eating
- Mouth or tongue sore
- Stomachaches
- Abdominal pain
- Ulcers
- Gas
- Blood in stools
- Hemorrhoids
- Recent change in number or consistency of bowel movements

Psychosocial

- Depression
- Anxiety
- Violence toward self/others
- Forgetfulness
- Poor memory
- Trouble concentrating
- Stress
- Irritability

- Easy to anger
- Sadness
- Crying
- Much fear

Skeleton and Joint Problems

- S=Sharp Pain/stabbing
- D=Dull Pain
- N=Numbness
- T=Tingling
- R=Refers pain
- A=Aching pain
- B=Burning pain
- Head
- Neck
- Shoulder
- Upper back
- Arm
- Hand/finger
- Lower back
- Hips
- Leg
- Knee
- Feet/toe
- Stiffness
- Numbness
-
- Arthritis
- Rheumatoid arthritis
- Fibromyalgia
- General weakness
- Swelling of joints

Genitourinary

- Difficult or painful urination
- Kidney stones
- Cloudy urine
- Dark or scanty urine
- Dilute urine
- Scant urine
- Burning urination
- Frequent urination
- Nighttime urination
- Poor bladder control
- Urgency to urinate

Nervous system

- Headaches
- Migraine
- Dizziness
- Multiple sclerosis
- Parkinson's
- Fainting
- Seizures
- Convulsions
- Paralysis
- Tics
- Tremors
- Balance issues
- Recent clumsiness
- Vertigo

Eyes, ears, nose and throat

- Loss of vision or hearing
- Ringing in ear
- Severe dental problems
- Vision problems
- Ear problems
- Ear infections
- Nasal obstruction
- Nasal discharge
- Allergies
- Sinus problems
- Nosebleeds
- TMJ
- Teeth grinding
- Teeth problems
- Cough
- Itchy or scratch throat
- Sore or painful throat
- Strep throat
- Vision see halos

Skin

- Rashes
- Sores
- Moles that have changed
- Dry skin
- Itchiness
- Rashes/hives
- Eczema
- Bruises easily
- Acne
- Brittle nails
- Dry or brittle hair

Chronic immune system deficiencies

- Cold
- Sinusitis
- Bronchitis
- Cancer
- Diabetes

Sleep

- Insomnia
- Difficult falling asleep
- Waking at night
- Waking early
- Excessive or vivid dreams
- Night terrors
- Sweating at night

Exercise and Body weight

- Exercise regularly
- Exercise excessively
- Underweight
- Normal weight
- Over weight

Eating and Health habits

- Vegetarian
- Health diet
- Craves fried foods
- Craves sour foods

- Craves sweet food
- Craves salty food
- Prefer warm/cold
- Food allergies
- Drink alcohol
- Drink coffee
- Drink pop/soda
- High Stress level
- Exercises regularly

Female health

- Heavy period
- Light period
- Long period
- Short period
- No period
- Irregular periods
- Bleed between period
- Painful periods
- Vaginal pain
- Painful sexual intercourse
- Pain during ovulation
- Premenstrual symptoms
- Vaginal discharge
- Vaginal itching
- Vaginal sores
- Urinary tract infection
- Candida/yeast infection
- Use of contraceptive
- Prolapse uterus/bladder
- Low sexual energy
- High sexual energy
- C-section delivery of children
- Difficult labors
- Premenopausal
- Menopause
- Pregnant/Trying to get pregnant
- Age of first menstrual period:
- Date of last menstrual period:
- Days of cycle:
- Length of period:
- Number of pregnancies:
- Number of miscarriages:
- Number of abortions:
- Number of children:

Male Health

- Impotence
- Hernia
- Genital pain
- Genital itching
- Genital sores
- Low sexual energy
- High sexual energy
- Gout/foot fungus

Blue Cross and Blue Shield Financial Disclosure

As your Acupuncturist, I want to provide you with the best care possible. While your policy covers some acupuncture services, there may be others that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, I want to reassure you that I will only recommend care that I believe will benefit your health. Federal Policy coverage notice: under federal law Licensed Acupuncturist are not recognized in policies covered under federal laws and rules and may not be a covered provider and services provided at this clinic would not be covered.

Acupuncture services typically covered by Blue Cross and Blue Shield state policies include:

1. Chronic Pain as defined as duration of at least six months when the following criteria have been met, prior to beginning of acupuncture treatment
A comprehensive history and physical evaluation of the patient has been completed to document etiology of the pain and
Conservative forms of multidisciplinary therapy (for example, pharmacologic therapy, physical therapy, psychotherapy) have been tried and have failed to alleviate the pain.
2. Prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.

I have read and fully understand all of the information above.

Printed Name (First, Middle, Last): _____

Signature: _____ Date: ____/____/____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Bonnie M. Abel Bolash, M.Ac., L.Ac. or legal representative for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due in full at the time of service. I also give permission to release any medical records related to the service dates submitted or other records requested to substantiate the claim for reimbursement. In the event that services that were covered were then at a later date determined to not be a covered service I agree to pay for those services rendered.

Signature of Responsible Party: _____ Date: ____/____/____

BCBS Policy Holder Name: _____ DOB: ____/____/____

BCBS Policy Number: _____ Group: _____

Do Not Bill my Insurance: _____
Signature Date