Augusta Acupuncture Clinic

Patient's Name _____ Date _____

How did you hear about us? _____

Have you ever received acupuncture or functional medicine before? (circle) Yes No

MAIN COMPLAINTS (list in order of importance):

1) _____ 2) _____

3) _____ 4) _____

If you have a pain condition, on a scale of 1 to 10, what is it at its worst? _____

How long have you suffered with this problem?

_____

Do you know how this problem may have started? (i.e. earlier accidents, injuries, physical stresses, fall, repetitive motion on the job etc.)

_____

What have you tried doing to resolve this problem that DID NOT work?

_____

_____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific.

_____

_____

What would you do differently if your condition did not affect your life?

_____

_____

On scale of 1-10, what is your commitment to resolving your condition? _____

Do you have any concerns? (i.e. Time, Transportations, Finances, etc.)

_____

INTAKE FORM

Eric Sherrell, DACM, LAc

Today's Date:

How did you hear about our office:

PATIENT INFORMATION			
Patient Name			**Home Phone( )**
Address			**Cell Phone ( )**
City	**State**	**Zip**	**Email Address**
DOB	**Age**	**Sex: M F**	**Marital Status M S W D**
Occupation		**Emergency contact person:** **Emergency contact phone number( )**	

Please list the persons with whom we may inform about your health condition or treatment (Include family, friends and physicians)

Name	**Phone**
Name	**Phone**
Name	**Phone**
If Minor: Legal Guardian's Name(print)	**(signature)**

List any significant traumas, surgeries or other health conditions

·Year: ·Conditions:

·Year: ·Conditions:

·Year: ·Conditions:

·Year: ·Conditions:

Have you had Acupuncture before? Yes No

Who is or was your regular doctor?
Name:

City: State

May We contact them? Yes No

Are you taking any medications? Yes No
(Specify)

Do you have the following condition(s) currently?(Circle)

Pregnancy Bleeding Disorder Pacemaker Cancer Ostomy Shunts Local Infection Communicable disease Artificial Joint

How are your dietary habits? Good Fair Poor

Do you exercise routinely? Yes No

I certify that the above statements are true

Print Name: **Signature of patient**:

Examination Record

Name: Age: Male Female Date: / /

Chief Complaints (What are the chief complaints you would like us to help you with?)

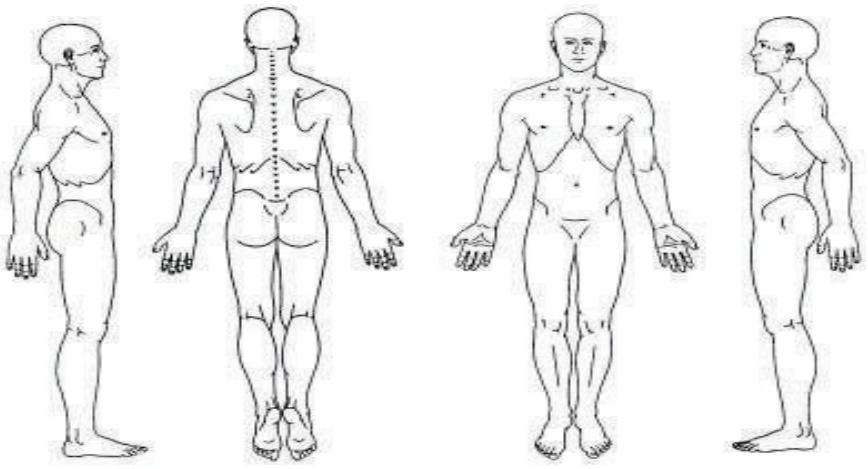
CIRCLE THE APPROPRIATE RESPONSE:

Emotion	Stable Anxious/Fear Worried Depressed Grief Irritable Easy Stressed Exuberant
Energy	**Overall Energy:** Low 1 2 3 4 5 6 7 8 9 10 High
Hot/Cold	**Body:** Hot Cold Warm Even **Hands/Feet:** Hot Cold Warm Even
Thirst	Never Usual Always **Prefers drinking liquids**: Cold Hot
Sweat	Normal Spontaneous Extremities Night Neck Up Whole body
Appetite	Normal Excessive Poor None **Craves:** Sweet Sour Bitter Salt Spicy
Digestion	Normal Bloated Gas Hiccup Reflux Nausea Vomiting Stomache
Stools	Soft Constipation Diarrhea Blood Mucous Incomplete Hemorrhoids Burn/Itch Rectum
Stool Frequency	less than 1 X day 1-2 X day more than 2 X day
Urine	**Color without vitamins:** Clear Light Dark Blood in urine Keydney/Gull Stones Wakes at night
Urine Frequency	**Day Time:** 1-5 X day 5-10X day more than 10 X day **Night Time:** 1-2 times more than 2 times
Urination Flow	Good Scant Incontinent Hesitant Frequent Urgent Pain Burning Night Bedwetting
Genital	**Libido:** Increased Decreased Impotence Premature ejaculation **Vaginal:** Dryness Discharge
Sleep	Restful Interrupted Restless Dreams **Difficult:** falling asleep staying asleep waking up
Neuro	Dizziness Unbalanced Tremors Seizures Spasms Poor Memory Foggy headed Confused
Headache	None Front Top Side Back Whole head Band-type Behind Eyes Sinus Pressure Stabbing
Eyes	Normal Dry Itchy Blurred Spots Red Painful Watery **Corrected vision:** Yes No
Mouth	Grinding teeth TMJ Facial Pain Gum problem Sores Dry Excess saliva
Ears	Normal Poor hearing Deaf Earache Discharge Pressure **Ringing in the Ear:** Low pitch High pitch
Nose	Normal Dry Bleeds Congestion Postnasal drip Sneezing Allergies Difficult breathing Asthma
Throat	Swollen glands Sore Lumps Enlarged thyroid Cough Burning Irritated
Heart	Palpitations Racing Irregular HTN Fainting Low BP Blood clots **Chest:** Tightness Pain
Circulation	Normal Numbness Tingling **Loss of Feeling:** Hands Feet Arms Legs Fingers Toes
Mucous	None Thick Thin Profuse Scanty Nonproductive **Color:** yellow green white clear
Menses	Postmenopausal **Last Menstrual Period:** Cramps Clots Early Heavy Scanty Absent
Menses	**#of day in cycle:** **#of Days Bleeding:** **Blood Color:** Red Dark red Brown Light red
Pregnancy	**#of Pregnancies:** **#of birth:** **#of premature birth:** **#of miscarriages:**
Weight	**Weight Gain/Loss in a year:** lbs

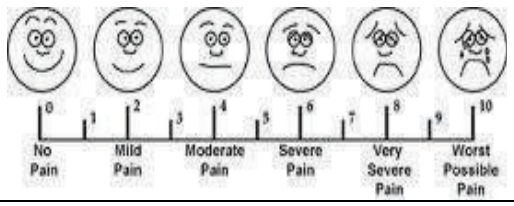
For Patients with Pain Describe: Heavy Empty Aching Distending Stabbing Moving Burning Gripping Pulling

MARK THE AREA WHERE YOU HAVE PAIN.

X = Sharp Pain O = Dull Pain



Pain Scale: ***Please indicate below***



HIPAA Notice

Below is a copy of Augusta Acupuncture Clinic's *Notice of Privacy Practices,* and other pertinent information, which we are required by law to provide to you.

HIPAA (Health Insurance Portability and Accountability Act) was established by Congress to develop national safeguards to protect the confidentiality of patient medical information.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice at your visit.

Please sign the acknowledgement of receipt to indicate that you have received the notices for you and other minor family members and/or dependents who receive care from Augusta Acupuncture Clinic.

This notice is required by law to inform you of how your health information will be protected, how Augusta Acupuncture Clinic may use or disclose your health information, and about your rights regarding your health information.

Each time you visit Augusta Acupuncture Clinic, a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnosis, treatments, and a plan for future care. This information, referred to as your medical record, serves as a:

**Basis for planning your care and treatment*
**A data source for medical research and public health*
**Means of communication among the health professionals that contribute to your care *A source of data for planning facilities, marketing healthcare services and fundraising*
**Legal documents of the care you receive*
**Means by which you or a third-party payer (i.e. health insurance company) can verify that services you received were appropriately billed*
**A tool for education of health professionals*
**A tool with which we can assess and work to improve the care we provide*

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand how others may access and use your health information; and make more informed decisions when authorizing disclosures to others.

Patient: _____ Signature: _____ Date: _____
(or Patient Representative)

Office Signature: _____ Date: _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, injection therapy, moxibustion, cupping, electrical stimulation, Tui-Na(Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Injection therapy might cause bruising or have other side effects such as allergic reactions. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effect of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complication of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Eric Sherrell

PATIENT SIGNATURE: **DATE:**

(Or patient Representative) (Indicate relationship if signing for patient)

Financial Policy Agreement

Your Commitment: In this system of medicine each treatment builds on the previous one. Optimal results are achieved when a patient follows the suggested treatment plan. Understand that acupuncture is a therapeutic process, not a magic cure. Please commit to the treatment plan that has been prescribed by your Acupuncturist. Patients who drop out of care before having a chance to receive the full benefits of acupuncture are never highly satisfied. Continue with your prescribed treatment plan to achieve a new level of health.

Will acupuncture work for me? We only accept patients that we think we can help. We use our Initial Consultation/Exam to determine if you are a good fit for our programs. Our patients enjoy more than an 85% positive outcome rate through regular visits and our highly effective treatment strategies, when you follow our advice.

►Appointments:

- **All appointments require 24 HR notice of Cancellation regardless of situation.**
- **A $45 FEE will be charged PER missed appointment.**
- **Appropriate cancellation notices are: Text message, E-mail, telephone message w/ patient name /date/ time of call provided.**
- **We reserve the right to Discharge You due to missed appointments at any time.**
- **VA Patients will be Discharged on the 2nd NO SHOW or LATE CALL IN, as per VA policy.**

Patient Initial_____

Credit card information is required in case of late cancellation/missed appointment

Type of card:_____Card Number:_____Expiration Date:_____Security Code:___

►Payment:

- **Payment is accepted in the form of Cash, Check, Visa, Mastercard, Discovery, & AMEX and is due before your appointments will be scheduled.**
- **Any unused portion of pre-pay plans are refundable, minus any used services at normal rates.**
- **Herbs, supplements, and all products are NOT REFUNDABLE under any circumstance.**
- **There will be a $25 fee for any returned checks.**

►Insurance:

- **We accept VA Insurance only. We will only start treatments once all of your VA paperwork is fully authorized.**
- **Private Health Insurance: You may call your insurance and check if acupuncture codes are covered, and if so how many acupuncture treatments per year your policy covers. Then we can issue you a superbill one time per month for manual reimbursement by you. We will not call for you.**

►New Patients :

- **For the first 3-6 treatments, please come 15 minutes before your treatment to fill out progress notes, read educational materials, and watch educational videos.**

This will ensure that you will have enough time to get the care that you need. Patient Initial_____

I have read and agree to the above policies. I agree to the release of medical and billing information necessary for treatment, payment, and healthcare operations. I assign benefits payable to Augusta Acupuncture Clinic.

Patient: _____ Date: _____

(or Patient Representative)

Patient Signature: _____

(or Patient Representative)

Office Signature: _____ Date: _____