NORTHERN INDIANA
ACUPUNCTURE

10319 Dawson's Creek Blvd
Suite E
Fort Wayne, IN 46825
T: 260-800-2140

Date:_____

Patient Name: [Last] _____ [First] _____

Address: [Street/PO Box] _____

[City/State/Zip] _____

Date of Birth: _____ Age: _____ Male _____ Female _____

Phone: (Home) _____ (Cell)_____

Email: _____

Emergency Contact:_____ Phone: _____
Relationship: _____

Occupation: _____ Employer: _____

How were you referred to us? _____ *(friend, family, website, etc)*

Our office will need to call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you, please indicate where it is appropriate to leave messages for you:

Home machine ____ Cell ____ With family members _____ Never leave messages _____

Family Physician: _____

If necessary, may we send your health information and treatment updates to this provider?

Yes_____ No_____

Patient Signature: _____

Date:_____

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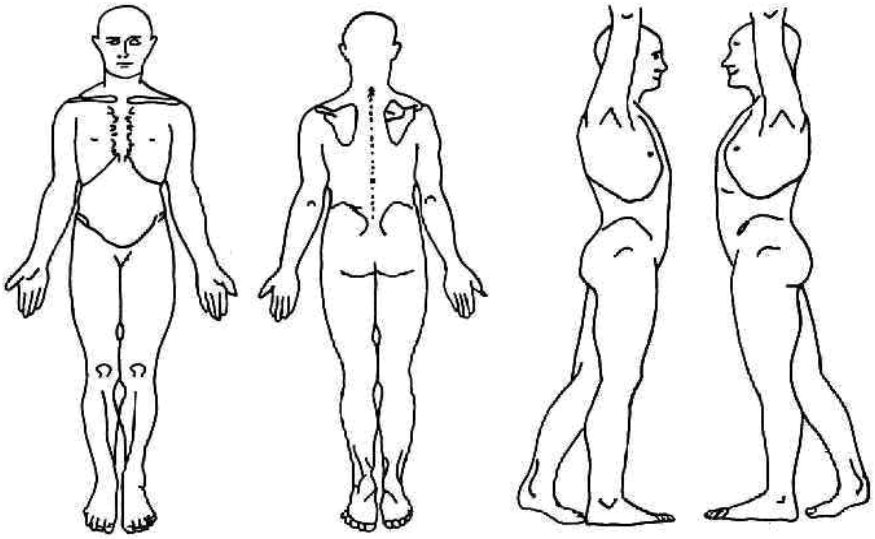
Patient name:_____

PRESENT COMPLAINT_____

CIRCLE ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



1. When did your problem begin? (Specific date if possible)_____

2. Please describe the character of your current pain. You may check one or more answers. ___ Sharp ___Stabbing ___Burning _____Shooting _____Aches _____ Soreness _____Weakness _____Throbbing _____Tingling _____Numbness _____Dull _____ Gripping _____ Constricting _____ Other_____

3. On a Scale from 0-10, with **0 being no pain** and **10 being the worst pain** you have experienced:
What is your current scale of pain? **0** 1 2 3 4 5 6 7 8 9 **10**

4. How often are the complaints present? _ Constant/100% of the time __ 75% ___ 50% ___ 25% of the time

5. Since your problem began is the pain: _____ Increasing _____ Decreasing _____ Not Changing

6. Pain is aggravated by: _____ Walking _____ Sitting _____ Riding in Car _____ Standing _____ Lifting _____Bending _____ Stretching _____ Twisting _____ Other_____

7. Pain is decreased by: _____ Medication _____ Rest _____ Exercise _____ Therapy _____ Other _____

8. Are your complaints affecting your ability to be active? ___No effect ___Some restrictions ___Unable to perform

9. In addition to your complaint/symptoms, have you experienced any of the following with it? ___ dizziness ___ fever/chills ___weight loss ___ interruption of sleep _____change in bowel/bladder control or function?

Were you previously treated for this condition? YES NO (If YES): ___ Chiropractor ___M.D. ___ Therapist __ Other Please specify dates and treatment results._____

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MEDICATION LIST

Patient name:_____

Birth date: _____ Sex: M F

ALLERGIES:

Prescription Medications

Name	Dosage	How Often	Reason	Date started

Over-the-counter Medications

Supplements/Herbs/ Homeopathic Remedies

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COMPREHENSIVE MEDICAL HISTORY

Patient Name: _____
Birth date:_____ Age:_____ Sex: M F

Place an **H** if you previously **HAD** the problem and it was concerning. (Example: we've all experienced a fever. Only mark down that you've had a fever if it required hospitalization, was recurring, required other serious intervention, or was associated with a more serious condition.) Place a **P** if you **PRESENTLY** have the problem. **Leave space blank if not applicable**. **This is a confidential part of your medical record and will be kept in this office.*

General

1. _____Fever / Chills
2. _____Night Sweats
3. _____Insomnia or changes in sleep
4. _____Fatigue
5. _____Weight Loss or Gain
6. _____Allergies
7. _____Cancer
8. _____ Warm or cold extremities

Endocrine

9. _____ Diabetes
10. _____ Thyroid Disease
11. _____ Intolerance to heat or cold
12. _____ Increased thirst
13. _____ Other

Eye, Ear, Nose, Throat

14. _____ Glaucoma
15. _____ Sinusitis
16. _____ Poor vision
17. _____ Pain in eye
18. _____ Deafness/Difficulty Hearing
19. _____ Nosebleeds
20. _____ Dental Problems
21. _____ Hoarseness
22. _____ Other

Pulmonary

23. _____ Asthma
24. _____ COPD
25. _____ Tuberculosis
26. _____ Pneumonia
27. _____ Difficulty breathing/ shortness of breath
28. _____ Wheezing
29. _____Chronic cough or phlegm
30. _____ Coughed up blood
31. _____ Other

Gastrointestinal

32. _____ Appendicitis
33. _____ Jaundice, Hepatitis, Cirrhosis
34. _____ Ulcer
35. _____ Gallbladder disease
36. _____ Colon polyps
37. _____ Hemorrhoids
38. _____ Poor appetite
39. _____ Abdominal Pain
40. _____ Black or bloody stool
41. _____ Frequent heartburn
42. _____ Frequent bloating or gas
43. _____ Frequent diarrhea or constipation
44. _____ Frequent nausea or vomiting
45. _____ Difficulty swallowing

Cardiovascular

47. _____ Heart disease
48. _____ High cholesterol or triglycerides
49. _____ High blood pressure
50. _____ Stroke
51. _____ Rheumatic Fever
52. _____ Chest pain
53. _____ Irregular/rapid heartbeat
54. _____ Fainting/lightheadedness
55. _____ Ankle swelling
56. _____ Varicose veins

Blood/Lymph

58. _____ Anemia
59. _____ Bleeding disorder
60. _____ Enlarged lymph nodes

Skin

61. _____ Change in mole
62. _____ Itching or rash

Clinician Comments

Genitourinary

63. _____ Kidney disease or stones
64. _____ Urinary infection
65. _____ Sexually transmitted disease
66. _____ Sexual difficulties
67. _____ Frequent or painful urination
68. _____ Bloody or discolored urine
69. _____ Incontinence
70. _____ Other

Male Specific

71. _____ Prostate disease
72. _____ Testicular pain or swelling
73. _____ Impotence/erectile dysfunction
74. _____ Difficulty urinating
75. _____ Other

Female Specific

76. Date last period began: _____
77. Date of last PAP smear: _____
77. _____ Live births
78. _____ Miscarriage or abortion
79. _____ Menstrual Pain
___ Before ___During ___After
80. _____ Irregular or heavy periods
81. _____ Clots (occasional or frequent)
81. _____ Breast lump/pain/discharge
82. _____ Hot flashes

Neurologic/Emotional

83. _____ Epilepsy/seizures
84. _____ Headache
85. _____ Psychiatric disorder
86. _____ Numbness/tingling
87. _____ Dizziness
88. _____ Tremor or twitching
89. _____ Depression/Anxiety
90. _____ Irritability
91. _____ Sighing/Sadness

Musculoskeletal

94. _____ Fracture or dislocation
95. _____ Arthritis
96. _____ Scoliosis
97. _____ Back pain
98. _____ Swollen/Painful joints
99. _____ Neck stiffness/pain
100. _____ Arm/Wrist/Hand pain
101. _____ Ankle/Foot/Knee pain
102. _____ Hip pain
103. _____ Muscle aches/soreness
104. _____ Muscle weakness

Childhood Disease

105. _____ Measles
106. _____ Mumps
107. _____ Chicken Pox
108. _____ Other

Trauma

109. _____ Motor Vehicle Accident
110. _____ Concussion
111. _____ Other

Hospitalizations/Surgeries

(list dates and reasons)

112. _____
_____
113. _____
_____

Social History

114. _____ Smoking/tobacco use
115. _____ Alcohol use
116. _____ Recreational drug use
117. Are you married/partnered?
____ Yes _____ No
118. Describe your exercise:
_____
_____
119. Describe your diet:
_____
_____
120. What is your occupation?
_____

Family History

122. _____ Kidney Disease
123. _____ Heart disease or stroke
124. _____ High blood pressure
125. _____ Cancer
126. _____ Thyroid disease
127. _____ Diabetes
128. _____ Neurological disease
129. _____ Musculoskeletal disease
130. _____ Psychiatric disease
131. _____ Other

Clinician Comments

Acupuncture specific

132. Do you have a pacemaker or any other device/metal implant? Y or N
133. Are you now, or have you ever been on blood thinners? Y or N
134. Have you ever taken cortisone or other drugs for arthritis? Y or N
135. Do you faint or bleed easily? Y or N

Date of last physical:_____
Have you had acupuncture before? YES NO
For what condition, and what were the results? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient signature:_____ Date: _____

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Informed Consent

Informed consent for your acupuncture treatment is a process and dialogue with your practitioner about the goals, risks, and alternative treatment options, to allow you to participate in and make knowledgeable decisions about your care. It is very important that you as the patient read this document in its entirety. As a patient it is essential that you knowledgeably participate in decisions concerning the nature and course of your care.

Acupuncture Treatment

The acupuncture care you receive will include standard examination and testing procedures. These may include a physical examination, orthopedic and neurological testing, and palpation. In addition, your practitioner may utilize pulse or tongue diagnosis techniques.

Acupuncture involves the insertion of pre-sterilized, disposable needles through the skin into the underlying tissues of specific points on the surface of the body. Treatment within the scope of acupuncture may include, but is not limited to, acupuncture, acupressure, cupping (cups made of glass or other materials placed on the skin with a vacuum created by heat or other device), electrical stimulation (use of electrical device to produce electrical stimulation on the acupuncture needles), tui-na (Chinese massage), gua sha (Chinese dermal friction technique), and nutritional counseling based on traditional Chinese medical theory.

Acupuncture Risks

Acupuncture is generally very safe. Rarely acupuncture may cause discomfort, pain, or minor bruising, blistering, or bleeding. Some patients may experience lightheadedness or drowsiness during or after treatment. Serious side effects are very rare, such as a localized infection at the procedure site or an aggravation of a pre-existing condition. It is your responsibility to **inform your practitioner if you are, or suspect you are pregnant**, as there are specific acupuncture points and modalities that are contraindicated with a pregnant patient.

Single-use, sterile, disposable needles are used in this clinic.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, pain killers, and others
- Hospitalization
- Surgery

If you choose to use any of the above-noted other treatment options, you should be aware that there are benefits and risks of such options and you should discuss these with your primary medical physician.

Risks of Remaining Untreated

Remaining untreated for certain conditions may result in persistent or increasing pain or other symptomatology, increased loss of function, formation of adhesions contributing to a pain reaction further reducing mobility, or worsening of your condition. Over time if you choose to remain untreated, this may complicate future treatment, and make future treatment more difficult and less effective the longer treatment is postponed.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time. I authorize the physician to diagnose and treat me (or my dependent/minor child) and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

Sign: _____

Print name in full:_____

Date: _____

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Patient Financial Policy

Please read thoroughly and feel free to ask any questions.

1. We accept cash, check, credit card, or HSA (Visa, Mastercard, Discover). Payment is due at the time of service.

2. The charge for a returned check is $25. This can be paid by cash, money order, or credit card. This will be applied to your account in addition to the original amount owed.

3. **We do NOT accept insurance.** The patient is responsible for all charges at the time of service. However, if you have an insurance plan that covers out-of-network acupuncture, we would be happy to provide a "superbill" that will contain all of the necessary information regarding your visits. You can then submit this superbill to your insurance company for direct reimbursement. The amount of reimbursement you receive will depend on your insurance plan. Please note that being reimbursed the full fee is extremely rare. Our office is not responsible for any insurance non-payment or underpayment for any reason.

4. Your appointment time is reserved exclusively for you. **Please give our office 24 hours notice for cancelling or rescheduling an appointment.** This allows for other patients to be scheduled into that appointment time. **Failure to notify us 24 hours in advance will be considered a missed appointment and result in a $30 fee.** Your account will be charged and you will need to pay this charge prior to scheduling another appointment.

I acknowledge that I have received and understand fully the financial policy of Northern Indiana Acupuncture. I acknowledge my agreement to abide by these policies with my signature below.

Signed: _____

Date: _____