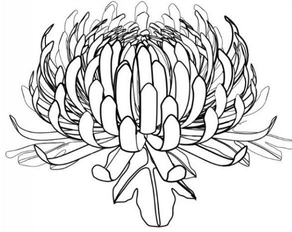


Confidential Acupuncture Intake Form

DATE: ____________________ HOW DID YOU HEAR ABOUT US? ______________________________

PATIENT INFORMATION

Name: ____ Gender: ___________________________

Age: __________ Date of Birth: ____________________

Home Address: ____

____

Home Phone: ______________________ Cell: ______________________ Work Phone: ______________________

Email: ____________________________________

Emergency Contact: ______________________________________ Relationship to Patient: ________________________

Emergency Contact Phone number: __________________________

Primary Care Physician (PCP): ________________________________ PCP Phone: _______________________________

Date of last medical examination: __________________________

Occupation: ____

I. EXPERIENCE WITH ACUPUNCTURE

- Have you received acupuncture treatment before? YES NO
- If yes, for what conditions and what was the outcome?

II. DESCRIPTION OF MAJOR COMPLAINTS

A. What are your main complaints?

1. Primary Complaint: ____
2. Secondary Complaint: ____

B. Please describe your goals, hopes and expectation for your acupuncture treatment:

C. PRIMARY COMPLAINT:

Please answer the following questions focusing on your Primary Complaint ONLY:

1. **Briefly explain history of your Primary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?**

2. **Have you seen a physician (or other primary care provider) for your Primary Complaint? If yes, when and what diagnosis did you receive?**

3. **Other Care: what other therapies are you doing/ have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?**

D. SECONDARY COMPLAINT:

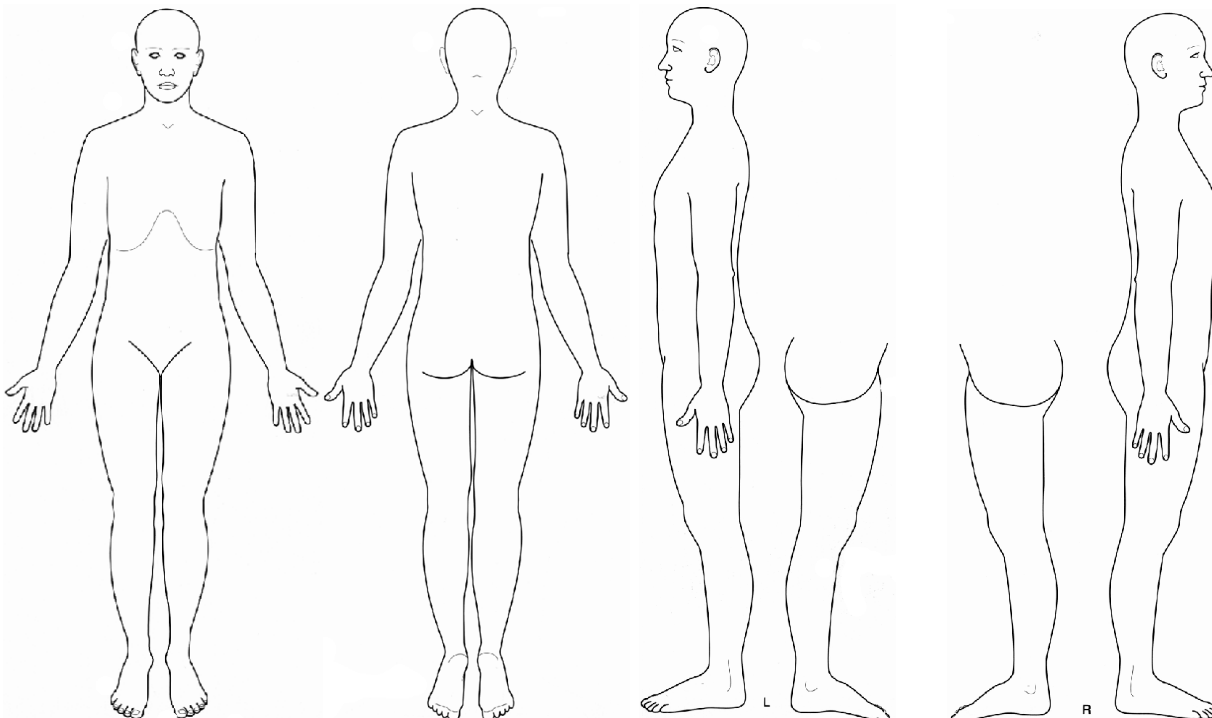
Please answer the following questions focusing on your Secondary Complaint ONLY:

1. **Briefly explain history of your Secondary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?**

2. **Have you seen a physician (or other primary care provider) for your Secondary Complaint? If yes, when and what diagnosis did you receive?**

3. **Other Care: what other therapies are you doing/ have you done to manage your Secondary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?**

E. On the diagram, please shade in the areas where you feel symptoms associated with your complaints. PLEASE NUMBER THE COMPLAINTS (Primary Complaint = #1; Secondary Complaint = #2):



III. MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1. ______	1. ______
2. ______	2. ______
3. ______	3. ______
4. ______	4. ______
5. ______	5. ______
6. ______	6. ______
7. ______	7. ______
8. ______	8. ______
9. ______	9. ______
10. ______	10. ______

LIST ANY ALLERGIES (to medications, supplements, herbs):

______

IV. PERSONAL MEDICAL HISTORY

1. **BIRTH:** Describe anything significant/traumatic about your birth:

2. **VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

3. **CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

   AGE: ______ ______

   AGE: ______ ______

   AGE: ______ ______

4. **ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

   AGE: ______ ______

   AGE: ______ ______

   AGE: ______ ______

5. **ADULTHOOD ILLNESSES (18 – 35 years):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

   AGE: ______ ______

   AGE: ______ ______

   AGE: ______ ______

6. **ADULTHOOD ILLNESSES (36 & up):** Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

   AGE: ______ ______

   AGE: ______ ______

   AGE: ______ ______

   AGE: ______ ______

   AGE: ______ ______

V. Family Medical History

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

Mother ______________________________

Father ______________________________

Siblings ______________________________

Maternal Grandparents ______________________________

Paternal Grandparents ______________________________

VI. Symptom Overview BY System

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

- A = Acute (under 3 months)
- C = Chronic (over 3 months—experience at some point most days)
- F = Experience frequently (on & off)

Musculoskeletal

- ☐ A C F Joint clicking
- ☐ A C F Limitation of movement
- ☐ A C F Stiffness
- ☐ A C F Spasms or cramps
- ☐ A C F Swelling
- ☐ A C F Weakness
- ☐ A C F Pain: Full body
- ☐ A C F Pain: Facial (e.g. jaw)
- ☐ A C F Pain: Neck
- ☐ A C F Pain: Upper Back
- ☐ A C F Pain: Mid Back
- ☐ A C F Pain: Low Back
- ☐ A C F Pain: Shoulder
- ☐ A C F Pain: Elbow
- ☐ A C F Pain: Wrist
- ☐ A C F Pain: Hand
- ☐ A C F Pain: Hip
- ☐ A C F Pain: Knee
- ☐ A C F Pain: Ankle
- ☐ A C F Pain: Foot
- ☐ A C F OTHER (Please list)

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Eyes, Ears, Nose & Throat

- ☐ A C F Loss of vision
- ☐ A C F Eye pain
- ☐ A C F Tearing or eye dryness
- ☐ A C F Eye discharge
- ☐ A C F Eye redness
- ☐ A C F Ear discharge
- ☐ A C F Ear itching
- ☐ A C F Ear pain &/or infections
- ☐ A C F Loss of hearing
- ☐ A C F Ringing or buzzing in ears
- ☐ A C F Problems with balance (vertigo)
- ☐ A C F Olfaction (sense of smell) impaired
- ☐ A C F Nose obstruction (stuffiness)
- ☐ A C F Nose bleeds
- ☐ A C F Sinus pain, pressure &/or infections
- ☐ A C F OTHER (Please list)

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Respiratory

- ☐ A C F Chest pain &/or tightness
- ☐ A C F Bluish discoloration of skin
- ☐ A C F Cough
- ☐ A C F Coughing up blood (hemoptysis)
- ☐ A C F Shortness of breath (dypsnea)
- ☐ A C F Sore throat
- ☐ A C F Sputum production
- ☐ A C F Voice changes
- ☐ A C F Wheezing
- ☐ A C F OTHER (Please list)

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Cardiovascular

- ☐ A C F Changes in skin temperature & color
- ☐ A C F Chest pain &/or pressure
- ☐ A C F Edema
- ☐ A C F Fainting (syncope)
- ☐ A C F Fatigue
- ☐ A C F Palpitations
- ☐ A C F Skin ulceration
- ☐ A C F Swelling of the ankles &/or legs
- ☐ A C F OTHER (Please list)

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Digestive

- ☐ A C F Abdominal distention/bloating
- ☐ A C F Abdominal mass
- ☐ A C F Abdominal pain
- ☐ A C F Acid regurgitation &/or Heartburn
- ☐ A C F Alternating constipation/diarrhea
- ☐ A C F Rectal bleeding
- ☐ A C F Constipation
- ☐ A C F Diarrhea
- ☐ A C F Gas
- ☐ A C F Eating disorder
- ☐ A C F Indigestion
- ☐ A C F Jaundice (yellow tint to skin &/or eyes)
- ☐ A C F Nausea
- ☐ A C F Vomiting
- ☐ A C F OTHER (Please list))

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UROGENITAL

- ☐ A C F Difficulty with urine flow
- ☐ A C F Incontinence
- ☐ A C F Painful urination (dysurea)
- ☐ A C F Rashes
- ☐ A C F Red urine
- ☐ A C F Urinary tract infection (UTI)
- ☐ A C F OTHER (Please list)

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NEUROLOGICAL

- ☐ A C F Changes in consciousness
- ☐ A C F Confusion
- ☐ A C F Difficulty concentrating
- ☐ A C F Dizziness
- ☐ A C F Dysphasia (impaired ability to speak)
- ☐ A C F Gait disturbance
- ☐ A C F Headache
- ☐ A C F Numbness and/or tingling
- ☐ A C F Loss of consciousness
- ☐ A C F Paralysis
- ☐ A C F Post shingles pain
- ☐ A C F Problems coordinating movements
- ☐ A C F Severe forgetfulness
- ☐ A C F Tremor
- ☐ A C F Visual disturbance
- ☐ A C F Weakness
- ☐ A C F OTHER (Please list)

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INTEGUMENTARY (SKIN)

- ☐ A C F Changes in hair
- ☐ A C F Changes in nails
- ☐ A C F Changes in skin color
- ☐ A C F Itching (prurites)
- ☐ A C F Never sweat
- ☐ A C F Rash and/or skin lesion
- ☐ A C F Unusual sweating
- ☐ A C F Wounds that will NOT heal
- ☐ A C F OTHER (Please list)

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PSYCHOLOGICAL

- ☐ A C F Feelings of grief
- ☐ A C F Feeling of sadness
- ☐ A C F Feeling fearful/anxious/nervous
- ☐ A C F Difficulty managing anger
- ☐ A C F Feeling manic
- ☐ A C F Feeling worried or overly pensive
- ☐ A C F Feelings of panic
- ☐ A C F Feeling overwhelmed
- ☐ A C F Extreme mood swings
- ☐ A C F Extreme lack of emotion
- ☐ A C F OTHER (Please list)

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SLEEP

- ☐ A C F Difficulty falling asleep
- ☐ A C F Dream disturbed sleep
- ☐ A C F Wake up & cannot fall back asleep
- ☐ A C F OTHER (Please list)

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MISCELLANEOUS

- ☐ A C F Extremely low energy/fatigue
- ☐ A C F OTHER (Please list)

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FOR WOMEN ONLY

- ☐ A C F Abnormal vaginal bleeding
- ☐ A C F Changes in hair distribution
- ☐ A C F Fertility concerns
- ☐ A C F Irregular menstruation
- ☐ A C F Menopausal symptoms
- ☐ A C F No menses
- ☐ A C F Pain with menses (dysmenorrhea)
- ☐ A C F Pain during or after sexual relations
- ☐ A C F Pelvic pain
- ☐ A C F Premenstrual symptoms
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

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Last menstrual period:____________________

How many days does your period last?_______

How long is your monthly cycle?____________

Are you pregnant OR trying to become pregnant?
YES NO

Have you ever been pregnant? YES NO If yes, how many pregnancies: _________

Births ______

Miscarriages ______

Abortions _____

FOR MEN ONLY

- ☐ A C F Fertility concerns
- ☐ A C F Prostate problems
- ☐ A C F Sexual dysfunction
- ☐ A C F Unusual discharge
- ☐ A C F OTHER (Please list)

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VII. MEDICAL DISEASES/CONDITIONS. **Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.**

- C = Current condition
- P = Past condition, but is now resolved.

☐ C P AIDS/HIV
☐ C P Alcoholism &/or substance addiction
☐ C P Allergies (If yes, pls indicate diagnosis & history)

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☐ C P Anemia
☐ C P Asthma
☐ C P Bell's Palsy
☐ C P Blood clotting disorder (If yes, pls indicate diagnosis & history)

____

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☐ C P Bipolar disorder
☐ C P Cancer (If yes, pls indicate diagnosis & history)

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☐ C P Chron's Disease &/or colitis
☐ C P Chronic Fatigue Syndrome (CFIDS)
☐ C P Depression (Major)
☐ C P Diabetes
☐ C P Eczema
☐ C P Endometriosis
☐ C P Fibroids
☐ C P Infertility
☐ C P Lung disease, e.g. COPD (If yes, pls indicate diagnosis & history)

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☐ C P Fibromyalgia
☐ C P Gallstones
☐ C P Heart disease (If yes, pls indicate diagnosis & history)

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☐ C P Hepatitis A / B / C
☐ C P Hernia
☐ C P Herpes
☐ C P Hypertension
☐ C P Hypoglycemia
☐ C P Irritable Bowel Syndrome (IBS)
☐ C P Joint Replacement (If yes, pls indicate diagnosis & history)

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____

☐ C P Kidney Stones and/or Disease (If yes, pls indicate diagnosis & history)

____

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☐ C P Lupus
☐ C P Lyme Disease
☐ C P Lymph node removal
☐ C P Mitral valve prolapse
☐ C P Mood Disorder
☐ C P Mononucleosus
☐ C P Multiple Sclerosis
☐ C P Organ removal or transplant (If yes, pls indicate diagnosis & history)

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☐ C P Osteoarthritis
☐ C P Osteoporosis
☐ C P Pacemaker (heart or stomach)
☐ C P Parkinson's Disease
☐ C P Pelvic Inflammatory Disease
☐ C P Polio
☐ C P Psoriasis
☐ C P PTSD (Post-Traumatic Stress Disorder)
☐ C P Reflux esophagistis (GERD)
☐ C P Rheumatic fever
☐ C P Rheumatoid arthritis
☐ C P Scarlet Fever
☐ C P Schizophrenia
☐ C P Scoliosis
☐ C P Seizures and /or epilepsy
☐ C P Shingles
☐ C P Sleep Disorder
☐ C P Stroke
☐ C P Schizophrenia
☐ C P Thyroid disease (If yes, pls indicate diagnosis & history)

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____

☐ C P Ulcer
☐ C P Trigeminal Neuralgia
☐ C P Tuberculosis
☐ C P Vascular disease (e.g. phlebitis) (If yes, pls indicate diagnosis & history)

____

____

☐ C P OTHER (pls list)

____

____

VIII. LIFESTYLE INFORMATION

A. Stress, Energy Level & Sleep

1. Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

2. Do you have any problems with your energy level? If yes, please briefly describe:

3. Do you have any problems with sleep? If yes, please briefly describe:

4. Do you have any problems with your sexual drive? If yes, please briefly describe:

5. Describe your current level of activity and if applicable, your exercise regimen.

B. Smoking, Alcohol & Drugs

1. Do you smoke tobacco? YES NO If yes, do you believe that this is a problem for you?

2. Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?

3. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO Do you believe that this is a problem for you?

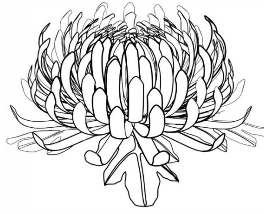
C. Diet and Nutrition

1. If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe that your diet has any impact on your complaints? YES NO

2. Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO

IX. LIFESTYLE COUNSELING OPTION

Would you be interested in developing an acupuncture treatment plan that includes helping you with lifestyle issues?



INFORMED CONSENT: ACUPUNCTURE SERVICES

To All Patients:

Welcome to Mind Body Medicine (MBM) Acupuncture. Please take time to read this page, which provides basic information on acupuncture treatment. While receiving acupuncture treatment, please feel free to communicate with the practitioner whatever you experience during the needling process, as this will enable us to adjust needles and the points selected to maximize your comfort during treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let us know immediately. This is known as needle shock, and while this occurrence is extremely rare, it helps to let the practitioners know if you experience any of these symptoms so that the needles can be removed. These symptoms usually go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time or receiving acupuncture when excessively hungry. Other possible side effects of acupuncture treatment may include slight local bruising or mild pain in the area treated; brief generalized fatigue, tingling or numbness and under extremely rare occasion spontaneous miscarriage or pneumothorax. Moxibustion, the burning of an herb known as mugwort, is a traditional method of acupuncture treatment, which is occasionally used in the clinic and under rare circumstances may put the patient at risk for burns. Moxibustion produces some smoke, which may irritate sensitive or susceptible individuals. Patients who are especially susceptible or sensitive should notify their practitioner. Occasionally, electrical stimulation with mild current may be added to an acupuncture treatment in order to stimulate the needles. Patients with a heart condition or any electrical implants in their body must tell their practitioner prior to treatment.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing.
- We will provide a paper gown during treatment if you want one.
- Maintain good personal hygiene.
- Avoid treatment when excessively hungry.
- We are unable to treat patients who are intoxicated and/or are abusing substances.

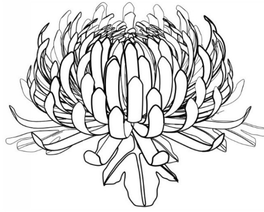
Everyone responds to treatment differently therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly. Depending on your condition and your goals for treatment, we may require a physician referral in order for you to continue treatment in our clinic.

By signing below, I do hereby voluntarily consent to be treated with acupuncture and / or other modalities of Chinese Medicine by Mind Body Medicine Acupuncture. **Clients at Mind Body Medicine Acupuncture are advised to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.** Acupuncturists practicing in New York State are not primary care providers. Please note that if you experience any alarming side effects or concerns after treatment, in addition to calling your practitioner, you must call your primary care provider and or visit the emergency room.

____ ________________________

Signature of Client, I have read and understand the above statement Date

Adam Cantor, MS, LAc
Mind Body Medicine Acupuncture



MINDBODYMEDICINE

SERVICES AND FEES

PRIMARY AND FOLLOW UP VISITS:
A thorough history and evaluation is followed by a full treatment. The plan of treatment will be determined at this time. Please allow one hour for your treatment.

Any appointments missed or cancelled with less than 24 hours notice will incur the full service fee billed to your account. Patients who miss their appointment without 24hrs notification will be charged for the full price of their visit. We understand and appreciate that sometimes it is necessary to re-schedule appointments. Therefore, please give us at least 24hrs notice prior to canceling and we will gladly reschedule your appointment. If you are unable to keep your appointment, please notify us as soon as possible.

Please arrive 5-10min before your scheduled appointment time so you can relax from your commute and change into loose fitting clothing if necessary. Early arrival will also enable you to finish any paperwork you may need to complete prior to treatment. In the event that you are late, we will make every effort to provide you with as complete a treatment as possible; however, please understand we may need to make the treatment shorter than it would have been had you arrived on time. If you arrive more than 20 minutes late for your scheduled appointment, we reserve the right to reschedule you for another time instead of offering treatment. If the appointment is rescheduled due to a late arrival, you will be responsible for 50% of the appointment fee regardless of the reason for being late (this fee will be charged to your account).

I have read the above and agree to pay the fees listed at the time of service. I understand that if I miss an appointment, cancel with less than 24 hours notice or arrive more than 20 minutes late for my appointment I will pay the fees as per this agreement. __________ (Initial)

INSURANCE:
I understand that services rendered to me are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to this office and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service and I agree to be personally responsible for the total charges incurred by me. I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO ADJUDICATE THIS CLAIM. I also understand that should my insurance company send payment to me, I will forward the payment to this office within 5 business days. To avoid any additional cost and inconvenience, should my insurance company forward payment to me, I authorize this office to facilitate payment utilizing the credit card information below. Charges to this card will NOT occur unless checks from the Insurance Carrier are not endorsed and received within 5 days of receipt. ___________ (Initial)

I hereby authorize Mind Body Medicine Acupuncture, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment.
___________ (Initial)

NAME ON CREDIT CARD: __________________________ CREDIT CARD TYPE: ______________________________

CREDIT CARD #: __________________________________ EXPIRATION DATE: ________________________________

CVV #: _______________________________________ BILLING ZIP CODE: ____________________________________

SIGNATURE: ____

**ALL FINANCIAL AND PERSONAL HEALTH INFORMATION (PHI) ARE STORED ACCORDING TO THE STANDARDS SET FORTH IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).