Chiropractic Sports & Wellness PC
Acupuncture Intake Form

Patient Information (Please Print)

Name_____ Date _____ Birth Date _______________

Address_____ City_____ State_____ Zip_____

Gender_____ SS#_____ Ethnicity (please check one) ☐Hispanic **or** ☐Non-Hispanic

Race_____ Preferred Language _____ Height _____ Weight _____

Home Phone(_____)_____ Cell(_____)_____ Cell Provider* _____

Work Phone(_____)_____ E-mail Address_____

Employer _____ Occupation _____ #years _____

Emergency Contact_____ Phone #_____ Relation_____

Whom may we thank for referring you to us? _____ **OR**

How did you find us: Internet?_____ Yellow Page Ad?_____ Other? _____

Please answer the following questions by circling Yes or No

Do you have a tendency to faint?	Yes	No	Have you ever had Hepatitis?	Yes	No
Have you eaten today?	Yes	No	If yes, please circle (We do not treat active Hepatitis)	A B	C
Do you have a pacemaker?	Yes	No	AIDS/HIV Positive?	Yes	No
Do you bleed for a long time?	Yes	No	Pregnant?	Yes	No
Any trouble breathing right now?	Yes	No	Any infections or infectious disease current/past?	Yes	No
Joint Replacement?	Yes	No	What joint?_____		

Have you ever had Acupuncture before? Yes No

Primary Reason for your visit today: _____

How long have you had this condition? _____ Initial Cause? _____Is it getting worse?_____
On a scale of 1 (no problem) to 10 (emergency room), what is the severity of your complaint? _____
Does it affect your sleep, work or daily activities? Please explain how.

_____

What makes it better? _____ What makes it worse? _____

Are you also under a physician's care? Who? If yes, please explain:_____

_____

Physician(s): _____OB/GYN: _____Chiropractor: _____

Other Providers:_____

Health History

Tobacco or Alcohol Use-(please check)

Tobacco Use? ☐Yes ☐No ☐Quit

If yes, type, quantity per day, & how long? _____

Alcohol Use? ☐Yes ☐No

If yes, how many drinks per week?_____

Female Only –

How many children?_____ Pregnant?_____ Taking Birth Control Pills?_____

Nursing? _____ Date of last Menstrual Cycle_____ Date of last Mammogram _____

Please check all that apply to you:

☐____Actinic Keratosis	☐____ COPD	☐____ Migraines	☐____ Fractures
☐____Asthma or Hay Fever	☐____Arthritis	☐____ Parkinson's	☐____Osteoporosis
☐____Pacemaker	☐____ Gout	☐____ M.S.	☐____ Herniated Disc
☐____Chemical Dependency	☐____Chronic Fatigue	☐____ Epilepsy	☐____ Fibromyalgia
☐____Melanoma	☐____ Heart Disease	☐____ Stroke	☐____Rheumatoid
☐____Kidney Stones	☐____ Kidney Disease	☐____ Hepatitis	☐____High Blood Pressure
☐____Tuberculosis	☐____ Diabetes	☐____ Liver Disease	☐____ Back Problems
☐____ Allergies	☐____Prostate Problems	☐____ Emphysema	☐____ High Cholesterol

☐____Cancer(Type)_____

Numbness on inner thighs? YES NO Bladder or bowel problems? YES NO

Any unexplained weight loss? YES NO Pain not improved with rest? YES NO

Do you take immunosuppressants? YES NO Number of Corticosteroid shots that you have received?____

Previous Surgeries and Dates: _____

List ALL Medications you are currently taking: (Please Print)

Allergies (Prescription Drugs and Environmental)	**Current Medication (Exclude Supplements)**

What supplements do you take? _____

What kind of exercise do you do and how much? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office. All outstanding balances are subject to interest and/or late fees.

Patient Signature_____Date_____

AUTHORIZATION FOR ACUPUNCTURE LASER/NEEDLES

I hereby authorize the Doctor to work with my condition through the use of acupuncture to my body, as he or she deems appropriate. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. If the Doctor does accept my case, it does not guarantee nor does it imply a guarantee of being able to cure or prevent any condition illness or injury. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Patient signature_____Date_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures.

- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name(Print):_____Relationship to Patient:_____

Signature _____ Date:_____