

PATIENT HISTORY

This clinic specializes in acupuncture and herbal care. We ask you to fill out this form for either consultation or examination purposes. Examinations are done routinely to determine the nature and extent of the problem. The acupuncturist will explain the level of examination necessary for your type of condition.

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____

ZIP _____ PHONE _____ WORK _____ CELL _____

E-MAIL _____ BIRTHDATE _____ MARITAL STATUS _____

NO.OFCHILDREN _____ OCCUPATION _____

EMPLOYER _____

PRIMARY PHYSICIAN (Name & No.): _____ REFERRED BY _____

EMERGENCY CONTACT (Name & No.): _____

PURPOSE FOR COMING

How did this condition develop? _____

When was the first time you were aware of this condition? _____

What type of service do you desire?

- ____ 1) Temporary relief of symptoms/pain control
- ____ 2) Eradication of tendencies causing condition
- ____ 3) Balanced optimum health—elimination of root cause of problem, if possible
- ____ 4) Maintenance care—regular balancing to keep in good health

Have you ever received treatment for this condition? ____ Yes ____ No

If so, where _____

By Whom: _____

What were the results of treatment? _____

Has the condition been getting ____ better, ____ worse, or ____ staying the same?

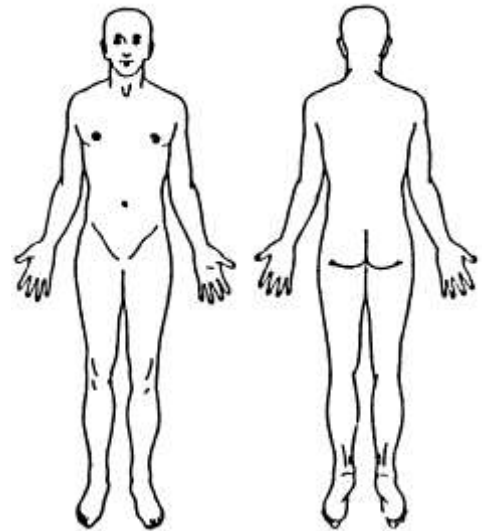
Has this condition affected your ____ home life, ____ work, ____ social life,
 ____ ability to exercise, ____ rest, or ____ sleep?

This is not a detailed history. Please circle all of the conditions below that apply to you.

Tendency to faint, tendency to bruise or discolor easily, tendency to bleed for a long time, hepatitis, AIDS, high blood pressure, heart problems, respiratory problems, treated by acupuncture before, presently using other therapies, past surgeries, taking medications, hungry at present time, exhausted at present time, nervous at present time.

☯ Please note that occasionally some people experience minor bleeding or a tiny bruising from gently piercing the skin. This does not adversely affect your health; on the contrary, it can promote healing.

If you are in pain, please mark the exact location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity that brings on or aggravates the pain. (i.e. sharp abdominal pain, every 30 seconds, for the last two hours when standing or sitting.



PREVENTION HEALING WELLBEING



Current prescriptions medication (i.e. hormones): _____

Over-the-counter: _____

GENERAL HEALTH: (check any that apply)

Chronic Fatigue ____ Irritability ____ Shortness of Breath ____ Headaches ____ Bone Pain ____ Poor Memory ____

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months?

FAMILY MEDICAL HISTORY: (check any that apply)

Breast or other cancers ____ Cardiovascular Disease ____ Osteoporosis ____ Obesity ____ Alcoholism ____

Mental Illness/Depression ____ Alzheimer's ____ Diabetes ____ Arthritis ____ Stroke ____

LIFESTYLE AND DIET:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) ____ Identify the major causes

WHAT YOU EAT: (check any that apply)

Sweets, sodas, ice cream ____ Fried foods ____ Whole grains, legumes, cereals ____ Fruits/vegetables ____

List your 4 favorite foods _____

DO YOU: (check any that apply)

Diet frequently ____ Skip meals ____ How many meals do you eat per day ____ Dine out regularly ____

Use tobacco/smoke cigarettes ____ How many cigarettes per day ____ Exposed to passive smoke ____

Drink coffee ____ No. of cups per day ____ Strong ____ Mild ____ Decaffeinated ____

Eat chocolate ____ Drink alcohol ____ How many oz. per day/week ____ Preference ____

Exercise daily ____ How many times per week/activity ____

DO YOU RESTRICT YOUR INTAKE OR AVOID COMPLETELY: (check any that apply)

Dietary fat ____ Dairy products ____ Animal protein ____ Salt ____ Fiber ____ All animal foods ____

PREVENTION HEALING WELLBEING

The Acupuncture Clinic
www.NasAcupuncture.com (719)634-1669
2020 W. Colorado Ave., Suite B-204, Colorado Springs, CO 80904



MEDICAL HISTORY

Please list any significant illnesses, surgeries, or accidents.

Age 0-6:

Age 7 – 12:

Age 13 – 20:

Age 21 – 30:

Age 31 – 40:

Age 41 to present:

FOR MALE PATIENTS ONLY

Sexual Drive:

Increased _____ Decreased _____ Impotent _____ Seminal Emission _____ Premature Ejaculation _____

Hernia _____ Prostate Problems _____ Infertility _____ Sterility _____

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CONSENT FOR TREATMENT

Consent for Acupuncture Care: I, the undersigned am aware of both the benefits and risks of acupuncture treatment and give my consent for treatment. I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment or series of treatments. I further understand that the services from this clinic are alternative approaches of my personal choice to support my optimal health; the services are not intending to change or replace any procedure and medication from my physician. And I am aware of that I may seek a second opinion from another health care professional or may terminate therapy at any time.

Patient/Responsible Party Signature: _____ **Date** _____

It is Agreed with regard to medical care and services the ATTENDING ACUPUNCTURIST will provide services to the patient to the best of his/her skill and knowledge of medical care in the light of circumstances, which is possible and practical. The PATIENT will cooperate fully with the acupuncturist by following his/her instructions.

It is also Agreed: I agree to hold harmless this acupuncturist or to present any issue or concerns of medical malpractice by letter to the acupuncturist and, if taken further, it will be decided by neutral arbitration; and therewith give up my right to jury or court trial should an issue arise. Because of the differences in human consultation and response, I understand that there is no way possible to warrant the outcome of such medical care and service.

Patient/Responsible Party Signature: _____ **Date** _____

I understand that insurance benefits are a contract between the patient and the insurance carrier; I am responsible for paying all charges, including co-payments and deductible at the time of service. I am also aware that if insurance does not cover services, or if the physician does not accept assignment, I am responsible for the charges. I authorize payment of insurance benefits directly to The Acupuncture Clinic. I hereby authorize release of medical information needed to complete insurance company claim inquiries, including release of information to the medical billing firm.

Patient/Responsible Party Signature: _____ **Date** _____

Disclosure Form: By signing below, I acknowledge having read the Disclosure Form and I have had the opportunity to ask questions.

Patient/Responsible Party Signature: _____ **Date** _____

Notice of Privacy Practices: By signing below, I acknowledge having read the Notice of Privacy Practices. (Patient may request a copy of Notice of Privacy Practices for their records.)

Patient/Responsible Party Signature: _____ **Date** _____



FINANCIAL POLICY

Thank you for choosing us as a health care provider. We are committed to your treatment being successful. An understanding of our financial policy is a very important part of your care.

Late Policy: All efforts are made to keep our schedules on time; if you are more than 15 minutes late, every effort will be made to fit you into the schedule; however, there is no guarantee that you will be seen immediately.

Missed Appointments: It is required that patients attend all scheduled appointments. If a patient is unable to keep a scheduled appointment, the patient is required to call and cancel the appointment at least 24 hours in advance. **Failure to cancel an appointment within 24 hours will result in the assessment of a \$25.00 fee.** This fee is due when billed or at the patient's next appointment, whichever comes first.

Payment Policy: Patients are responsible for any and all fees incurred as a result of treatment, regardless of insurance coverage. This includes, but is not limited to, payment of co-payments at the time of service, and full financial responsibility for any balance due after the insurance pays or denies claims submitted. Balances are due upon notification. Balances over thirty (30) days old will accrue a 1.5% interest per month. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account.

If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including, but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs.

Pre-Authorization & Referrals: If your insurance requires referrals or pre-authorization for the coverage of Acupuncture treatment(s), it is your responsibility to request such authorization from your doctor, before your Acupuncture visit.

Payment may be made by cash, checks, Visa or MasterCard.

There is a \$20 fee for any checks returned by the bank.

By signing below, I acknowledge that I have read and understand the Financial Policy:

Patient Signature: _____ Date: _____

As a courtesy, we place Reminder Calls to patients the business day before their appointment. All efforts are made to either speak with patient, or leave a message with Appointment Date & Time. Please indicate if you wish to receive these Reminder Calls and if so, which phone number you wish for us to use:

- Yes**, I wish to receive Appointment Reminder Calls at this phone number: _____
- No**, I do not wish to receive Appointment Reminder Calls

☑ We send out holiday and birthday gift certificate, as well as other promotion notes via E-mail, if you wish to receive these, please **print** your E-mail here _____

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