

Acupuncture New Patient Questionnaire

Name _____ Today's Date _____
Address _____ City _____
State _____ Zip _____ E-mail address _____
Phone: Home _____ Work _____ Cell _____
Birth date _____ Age _____ Ht _____ Wt _____ Sex M F
Marital Status _____ No. of Children _____ Occupation _____
Emergency Contact: Name _____ Phone _____
Primary Care Practitioner: _____
Is this your first time getting acupuncture? **Y** **N** How did you hear about us? _____

Goals: What would you most like to achieve with acupuncture treatments?

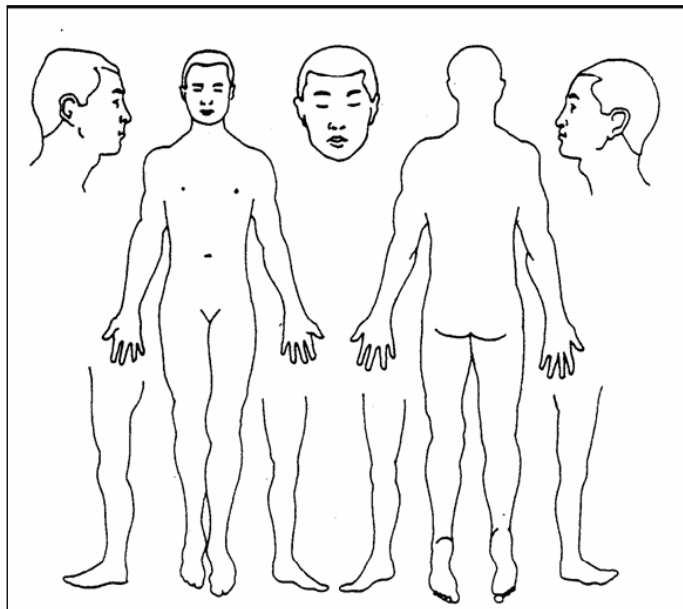
Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

Are you experiencing
pain/discomfort in any area of
your body? **Y** **N**

Please rate your pain level.
1 2 3 4 5 6 7 8 9 10

Use the illustration to indicate
painful or distressed areas.
Indicate the location of the
discomfort by using the symbol
that best describes the feeling:

X X X Sharp/Stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness
T T T Tightness/Spasms



Medical History

Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

	Date Diagnosed		Date Diagnosed
Cancer type: _____	_____	HIV	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Seizures	_____
Hepatitis	_____	Stroke	_____
High Blood Pressure	_____	Thyroid Disease	_____
High Cholesterol	_____	Other _____	_____

Please list any surgeries or major injuries with dates.

List any medications or supplements you have taken in the last 2 months.

Do you have a pacemaker or any metal devices in your body? Y / N

Family History

Indicate close family members with any of the following.

	Family member(s)		Family Member(s)
Cancer (specify type)	_____	High Cholesterol	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Stroke	_____
High Blood Pressure	_____	Alcoholism	_____

Lifestyle Habits

Do you have an exercise routine? Please describe. _____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

Nicotine Use: _____ Alcohol Use (#drinks/week and type): _____

Caffeine Use (#drinks/day and type): _____

Water intake (how much/day): _____

Briefly describe your dietary habits (#meals/day and type of food) _____

Please check all that apply

Energy and Immunity

- ☐ Fatigue
- ☐ Allergies (Specify) _____
- ☐ Anemia
- ☐ Chronic Fatigue Syndrome
- ☐ Thyroid Problems
- ☐ Tendency to Catch Colds

Head, Eye, Ear, Nose, and Throat

- ☐ Eye Dryness
- ☐ Blurry Vision
- ☐ Poor Night Vision
- ☐ Ear Ringing
- ☐ Hearing Difficulties
- ☐ Headaches / Migraines
- ☐ Teeth Grinding / TMJ
- ☐ Sore Throat
- ☐ Chronic Sinus Congestion
- ☐ Dry Mouth
- ☐ Bad Breath
- ☐ Mouth Sores / Bleeding Gums
- ☐ Increase in Thirst

Emotions / Sleep

- ☐ Mood Swings
- ☐ Anxious / Worried
- ☐ Depressed
- ☐ Irritable
- ☐ Difficulty Making Decisions
- ☐ Stressed
- ☐ Insomnia
- ☐ Nightmares
- ☐ Difficulty Falling or Staying Asleep

Respiratory/Cardiovascular

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Chest Pain
- ☐ Palpitations / Fluttering
- ☐ Poor Circulation (Cold hands/feet)
- ☐ Chronic Cough
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Hot/Cold Intolerance

Gastrointestinal

- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Bloating / Pain
- ☐ Gas
- ☐ Heartburn / Acid Reflux
- ☐ Belching
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Constipation
- ☐ Sudden Weight Change

Kidney/Urinary

- ☐ Painful Urination
- ☐ Frequent Urinary Tract Infections
- ☐ Frequent / Urgent Urination
- ☐ Edema / Swelling

Musculoskeletal

- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps / Weakness
- ☐ Arm Pain
- ☐ Finger Pain / Tingling / Numbness
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg / Knee Pain
- ☐ Foot / Ankle Pain
- ☐ Hip / Pelvic Pain
- ☐ Arthritis

Neurological

- ☐ Vertigo / Dizziness
- ☐ Numbness / Tingling
- ☐ Difficulty Concentrating / Poor Memory

Skin

- ☐ Rashes / Eczema / Hives / Psoriasis
- ☐ Dry Hair or Hair Loss
- ☐ Changes in Skin Color
- ☐ Easy Bruising
- ☐ Acne
- ☐ Dry / Itchy Skin

Female Health

- ☐ Irregular Cycle
- ☐ Heavy Flow
- ☐ Light Flow
- ☐ Clots in Menstrual Blood
- ☐ Menstrual Related Moodiness
- ☐ Menstrual Related Breast Tenderness
- ☐ Menstrual Related Bloating
- ☐ Bleeding Between Cycles
- ☐ Painful Periods (Is pain before, during and/or after period? _____)
- ☐ Hot flashes
- ☐ Vaginal Dryness
- ☐ Breast Lumps / Cysts
- ☐ Uterine Fibroids
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Unusual Vaginal Discharge Odor
- ☐ Frequent Yeast Infections
- ☐ Decreased Libido

Male Health

- ☐ Prostate Enlargement
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Decreased Libido
- ☐ Groin Pain

Acupuncture Patient Payment Policies

We appreciate that you have chosen to receive acupuncture services with Acupuncture for Balanced Wellness and welcome any questions you might have regarding our policies and services.

Outlined below is an overview of our patient payment policies for acupuncture services.

1. **Cancellation / Missed Appointments.** Please call if you need to cancel an appointment at least 24 hours prior to the time scheduled. If your appointment is not cancelled within the 24 hour timeframe or you miss your appointment, you will be charged a \$25 missed appointment fee.
2. **Lateness.** To maintain a high level of service to our patients, we strive to begin appointments on time. If you arrive late to your appointment, we will do our best to treat you in the remaining time allotted.
3. **Insurance.** We may accept insurance for payment for acupuncture services if your insurance policy includes acupuncture benefits. We can also provide an itemized paperwork that you can submit to your insurance company for reimbursement if you wish to pay for services at the time of treatment. We do recommend that you verify your acupuncture insurance benefits by contacting your insurance company, but we can also help you verify benefits at our office.

Assignment and Release (if using insurance)

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Acupuncture for Balanced Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Insured

Relationship to patient

Date

4. **Forms of Payment.** If not using insurance, payment for acupuncture services is expected at the time service is provided. We accept cash, check, Visa, Mastercard, American Express, or Discover for payment.
5. **Flexible Spending Accounts (FSA).** If you have a corporate FSA that covers acupuncture services, we still expect full payment at the time of service. We will provide you with the itemized paperwork necessary for reimbursement. Please check with your human resources representative for details.

By signing below, you acknowledge that you understand the above information and agree to the policies on this form.

Patient's Signature

Date

Patient Informed Consent for Acupuncture

I, _____, hereby voluntarily consent to be treated with acupuncture and other associated forms of therapy which include, but are not limited to, cupping, gua sha, heat therapy, tui na (oriental bodywork), electrical simulation, nutritional counseling, and herbal therapy administered by Angie Ng, hereinafter referred to as Practitioner.

I understand that the acupuncture is performed by the insertion of fine, pre-sterilized, disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain. I acknowledge that although rare, certain side effects may result from acupuncture. These include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or its adjunctive therapies mentioned above. I understand that I may stop treatment at any time. I further understand that the evaluation given to me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination and diagnosis. In the course of the evaluation, there may be reference to the state of various "organs" such as heart, liver, spleen, kidneys, etc., which actually refers to energetic channels of the same name.

I acknowledge the fact that Practitioner is not and does not profess to be a western-trained medical doctor and does not use or advise on the use of medically-prescribed pharmaceuticals or medical treatments, nor does Practitioner give any substances by injection. I acknowledge that Practitioner has completed a minimum of three academic years of training in Acupuncture, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the State of Illinois.

Signature: _____

Date: _____

Witnessed by: _____

Date: _____

Angie Ng, L.Ac. Dipl.Ac.
www.acubalancechicago.com