Acupuncture New Patient Questionnaire

Name _____Today's Date _____

Address_____City_____

State _____ Zip_____E-mail address _____

Phone: Home_____Work_____Cell_____

Birth date _____Age _____Ht _____Wt _____ Gender _____

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)

_____

_____

_____

_____

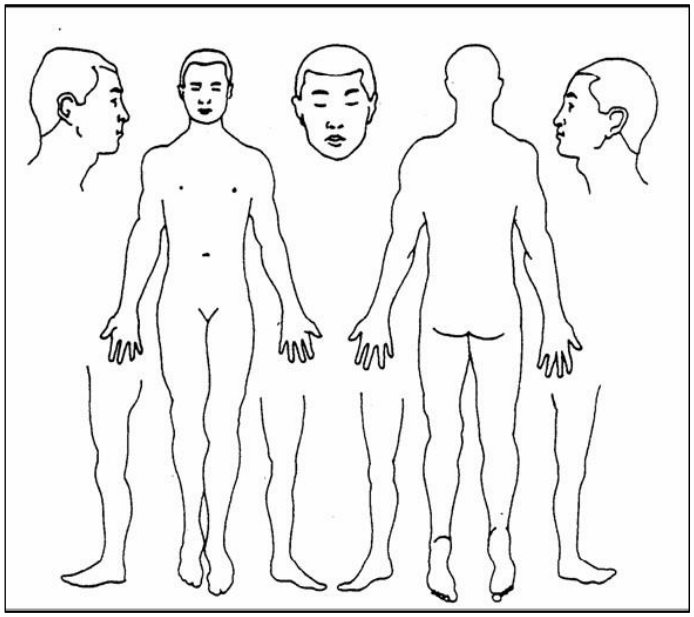
Are you experiencing pain/discomfort in any area of your body? ☐ **Y** ☐ **N**

Please rate your pain level on a scale of 1 to 10 (10 is the worst).

_____

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 $40 missed appointment fee. Exceptions for emergencies will be made on a case by case basis.
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 (Complete only if using insurance. If not using insurance, skip to #4)
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, 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 a licensed acupuncturist at Acupuncture for Balanced Wellness, herein 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 (NCCAOM0 and a Licensed Acupuncturist (L.Ac.) in the State of Illinois.

Signature:_____ **Date:**_____

Angie Ng, L.Ac. Dipl.Ac.
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