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:_________________________ Phone_________________________

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?

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

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____________________________________________________________________________________________

____________________________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Date Diagnosed</th>
<th>Date Diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer type:</td>
<td>____________</td>
<td>HIV</td>
</tr>
<tr>
<td>Diabetes</td>
<td>____________</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>____________</td>
<td>Seizures</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>____________</td>
<td>Stroke</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>____________</td>
<td>Thyroid Disease</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>____________</td>
<td>Other ____________</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Family member(s)</th>
<th>Family Member(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (specify type)</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Stroke</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Alcoholism</td>
</tr>
</tbody>
</table>

**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