ACUPUNCTURE NEW PATIENT INTAKE FORM

Dear Patient - Holistic Health is an integrated approach to wellness that treats the whole person, not simply symptoms and disease. The information you provide for us in this Entrance Case History / Patient Intake form will assist us in planning your treatment protocol. In addition to this information, it would be helpful if you would bring in any medical records pertinent to your condition, such as blood test results, CAT scan, MRI, X-Rays or other reports. The information you provide is confidential. Thank you for your cooperation.

ENTRANCE CASE HISTORY

Please write or print clearly

Today's date _____/_____/_____ ☐ Male ☐ Female

Last Name_____ First Name_____ Middle Initial_____

Date of Birth _____/_____/_____ Age_____

Address_____

City_____ State _____ Zip _____

Cell Phone_____ Home Phone_____

Marital Status: □Single □Married □Separated □Divorced □Widowed □Domestic Partner

Occupation_____ Last grade completed_____

eMail_____

Emrgcy Contact / Relationship: _____

Emergency Contact Phone #: _____ home☐ or cell☐

IF UNDER THE AGE OF 18, Parents' / Guardians' Names Requested

Mother's Name_____

Father's Name_____

Guardian's Name(s) _____

Relationship_____

Emergency Contact_____ Phone_____

How did you hear of our center?

□ Referral by whom_____

□ Advertisement which one_____

Please list your major COMPLAINTS and DIAGNOSES in order of importance / severity:

What makes it BETTER or What makes it WORSE? date problem began

1._____ ____/____/____

_____

Better_____Worse_____

2._____ ____/____/____

_____

Better_____Worse_____

3._____ ____/____/____

_____

Better_____Worse_____

4._____ ____/____/____

_____

Better_____Worse_____

5._____ ____/____/____

_____

Better_____Worse_____

- Please list all known allergies_____
- Please list all medications you are taking now_____
  (or attach Universal Medication Form from our website)

  Please list all supplements you are taking now_____

  _____
- Have you had acupuncture before? YES_____ NO_____ WHEN_____

X Signature_____ Date _____

All of the above information, to the best of my knowledge has been filled out correctly.

Name_____ Age_____ Sex_____ Date: _____ Pt Tx #_____

Subjective Chief Complaint_____

_____

Secondary Complaint_____

_____

Indicate onset, frequency, duration and severity of each_____

_____

_____

_____

OFFICE USE:

Emotions

Head & Face

Eyes & Ears

Pain

Appetite

Digestion

Stool

Thirst

Urination

Energy

Sweat

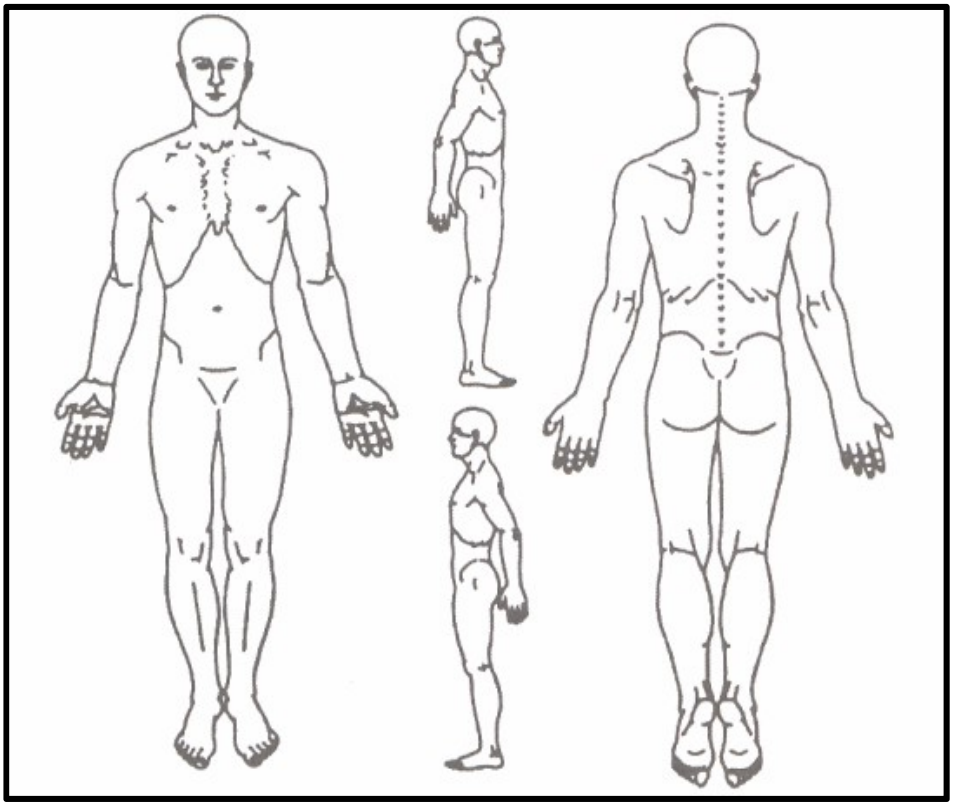
Body Temp

Sleep

Menses

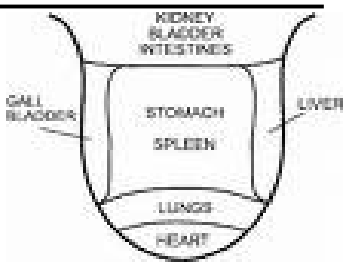
Please indicate areas of pain / discomfort

TH=throbbing **D=dull** **N=numb** **T=tingling** **S=sharp** **A=achy**



OFFICE USE:

Pulse:	Overall Quality:	Tongue Quality
Left:	Right:	
Cun	Cun	
Guan	Guan	
Chi	Chi	



Informed Consent to Receive Treatment

By signing below, I do herby voluntarily consent to be treated by Denise Rusnak, licensed acupuncturist. I understand that acupuncturists practicing in the state of South Carolina are not primary care providers and that regular primary care by a licensed physician is strongly recommended by this clinic's practitioners. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I agree to seek the advice of a primary care physician if my health concerns are not improved after three (3) months of weekly acupuncture treatment.

During the course of treatment, my practitioner may utilize several techniques common to the practice of Chinese Medicine. Each of these techniques will be explained to me prior to treatment and I will have the opportunity to ask any questions. I understand that I must indicate if I am or become pregnant, if I have diabetes, bleeding or bruising disorders or are taking blood thinners or if I am allergic to silicon, latex or vinyl products, as this will affect the course of treatment.

Acupuncture: Acupuncture involves insertion of fine, sterile, disposable needles at specific points found on the body. The needles are left in the body for a period of time during which the patient must lie still to avoid injury. I am aware that certain adverse effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Extremely rare risks include a bent, broken or stuck needle, nerve damage, organ puncture and infection. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: Moxibustion involves the warming of these acupuncture points with a Chinese herb known as Mugwort. The use of moxibustion could result in burn or allergic reaction, although these are rare.

Chinese Herbs and Nutraceuticals: I understand that herbs or nutraceuticals may be recommended to me. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.

Cupping and Gua Sha: I understand that I may receive cupping or gua sha as part of my treatment. This may produce deep redness, discoloration, bruising and on rare occasions, a blister may appear for several days, but will eventually disappear. These are considered a normal and desired effect of cupping and gua sha therapy.

Electro-Stimulation: I understand that I may receive electro-stimulation as part of my treatment. I am aware that certain adverse side effects may result. These may include but are not limited to: electrical shock, pain or discomfort and the possible aggravation of symptoms prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

In general, Chinese Medicine is very safe with few side effects or contraindications. Side effects that may occur are rarely severe. However, we want to ensure that you are fully informed of any that you could experience. We request that you immediately report any concerns you may have.

_____ _____

Signature of Patient or Patient Representative (please indicate relationship if signing for patient)

Date

Denise Rusnak, MSOM, L.Ac.
NCCAOM Board Certified

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Primary Care Acupuncture Center for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at PRIMARY CARE ACUPUNCTURE CENTER may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. PRIMARY CARE ACUPUNCTURE CENTER is not required to agree to the restrictions that I may request. However, if PRIMARY CARE ACUPUNCTURE CENTER agrees to a restriction that I request, the restriction is binding upon PRIMARY CARE ACUPUNCTURE CENTER.

I have the right to revoke this consent, in writing, at any time except to the extent that PRIMARY CARE ACUPUNCTURE CENTER has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand that I have the right to review PRIMARY CARE ACUPUNCTURE CENTER's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of PRIMARY CARE ACUPUNCTURE CENTER. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and PRIMARY CARE ACUPUNCTURE CENTER with respect to my identifiable health information.

PRIMARY CARE ACUPUNCTURE CENTER reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name (and relationship if signing for Patient)

PATIENT'S GUARANTOR BILLING AGREEMENT

I verify that I have reviewed the information on this form, and that it is correct.

I agree to pay the balance in full at the time services are provided.

I acknowledge that I can obtain a copy of the PRIMARY CARE ACUPUNCTURE CENTER's Privacy Practices/Patient's Privacy Rights upon request.

A service charge of $35.00 will be assessed on all returned checks.

RESPONSIBILITY AGREEMENT

I acknowledge and understand that I am financially responsible for all services rendered to me by PRIMARY CARE ACUPUNCTURE CENTER at the time of treatment.

I also understand that if litigation becomes necessary to recoup any balance due to PRIMARY CARE ACUPUNCTURE CENTER, I will be held liable to any attorney's fees and court cost that are applicable.

CANCELLATION POLICY

I acknowledge and understand that I am financially responsible for 100% of the price of services if I give less than 1 hour notice of cancellation or fail to show for my scheduled appointment.

I acknowledge and understand that I am financially responsible for 50% of the price of services if I give less than 24 hours but more than 1 hour notice of cancellation of my scheduled appointment.

_____

Patient/Guarantor Signature

_____

Date