**Intake Form**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_ Zip:\_\_\_\_\_\_

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Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: M F Other Marital Status: M S W D

Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation and weekly hours you work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where/Who did you hear about us from:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture before: Y N Have you had chiropractic before: Y N

**3 CHIEF COMPLAINTS YOU WOULD LIKE TO FOCUS ON:**

1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY (PLEASE INCLUDE DATES)**

 Allergies:\_\_\_\_\_\_\_\_\_\_\_\_  Rheumatic fever  Other significant illness:

 Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_  Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diabetes  Venereal (STD) disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hepatitis A/B/C  Thyroid disease

 High blood pressure  Birth trauma (prolonged labor,  Accidents or Hospitalizations:

 Heart disease forceps delivery, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Seizures  HIV/AIDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

 High Cholesterol  Cancer  Seizures

 Diabetes  Heart disease  Stroke

 Asthma  High blood pressure  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL (Last 6 Months)**

 Poor appetite  Weight gain  Night sweats

 Insomnia  Weight loss  Fever

 Disturbed sleep  Changes in appetite  Chills

 Localized weakness  Sweating easily  Sudden energy drop

 Anemia  Tremors (time of day?)

 Strong thirst  Bleeding or bruising easily  Poor balance

 Smoke(# of packs/day):  Alcohol consumption(#drinks/day):

**SKIN AND HAIR**

 Rashes  Eczema  Recent moles

 Ulcerations  Pimples  Changes in texture of hair or

 Hives  Dandruff skin

 Itching Hair loss  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD, Neck, EYES, EARS, NOSE, THROAT**

 Dizziness  Color blindness  Recurrent sore throats

 Concussions  Cataracts  Nose bleeds

 Migraines/Headaches  Blurry vision  Grinding teeth

 Glasses  Earaches  Sores on lips or tongue

 Spots in front of eyes  Ringing in ears  Facial pain

 Eye pain  Poor hearing  Teeth problems

 Poor vision  Eye strain  Jaw clicks/TMJ

 Night blindness  Sinus problems  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDIOVASCULAR**

 Hypertension  Swelling of hands/feet  Thrombophlebitis

 Low blood pressure  Fainting  Blood clots

 Chest pain  Cold hands or feet  Difficulty in breathing

 Irregular heartbeat  Myocardial Infarction  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPIRATORY**

 Cough  Bronchitis  Difficulty breathing when

 Coughing up blood  Pain with deep inhalation lying down

 Asthma  Pneumonia  Excessive phlegm (color?)

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIGESTIVE**

 Nausea  Belching  Rectal pain

 Vomiting  Black stools  Hemorrhoids

 Diarrhea  Blood in stools  Abdominal pain or cramps

 Constipation  Indigestion  Chronic laxative use

 Gas  IBS  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENITOURINARY**

 Pain on urination  Decrease in flow  Impotence

 Frequent/Urgent urination  Incontinence  Sores on genitals

 Blood in urine  Kidney stones  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MUSCULOSKELETAL**

 Neck pain  Back pain  Hand/wrist pains

 Muscle pains  Muscle weakness  Shoulder pains

 Knee pain  Foot/ankle sprain/pain  Hip pain

 Carpal Tunnel  Sciatica  Other Joint/Bone:\_\_\_\_\_\_\_\_\_\_

**NEUROPSYCHOLOGICAL**

 Seizures  Poor memory  Anxiety

 Dizziness  Lack of coordination  Bad temper

 Loss of balance  Concussion  Easily susceptible to stress

 Areas of numbness  Depression  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for emotional problems? Y N

Have you ever considered or attempted suicide? Y N

**GYNECOLOGIC**

 Premenstrual changes  Heavy menstrual flow  Premature births

 Menstrual clots  Light menstrual flow  Miscarriages

 Painful menses  Irregular menses  Abortions

 Unusual menses  Other problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first menses:\_\_\_\_\_ Age at menopause:\_\_\_\_\_ # of pregnancies:\_\_\_\_\_

Length of cycles:\_\_\_\_\_ Duration of bleeding:\_\_\_\_\_ First day of last period:\_\_\_\_\_

Current birth control method?

Are you currently pregnant? Y N Not Sure

**LIST CURRENT MEDICATIONS AND DOSAGE:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER SIGNIFICANT HEALTH INFORMATION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARK AREAS OF PAIN AND DISCOMFORT:**



**PEMA CHEN ACUPUNCTURE**

**INFORMED CONSENT FOR TREATMENT AND PAYMENT POLICY**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have any questions, please do not hesitate to ask. No question is silly or unnecessary in the process of helping you achieve your health & wellness.**

**Your Traditional Chinese Medicine treatment sessions may include:**

**Acupuncture:** Acupuncture needles used here are sterilized and disposed after each use. Needles are never reused. Thin sterile needles inserted into the skin and muscle (with or without electric stimulation)

**Acupressure/Tuina/Massage/Myofacial Release:** Hand and finger pressure to areas of the body.

**Moxibustion**: Mugwort herb that is lit and used directly or indirectly on the patient’s body.

**Cupping:** Small suction cups placed on body regions for muscular tension and a variety of ailments.

**Gua-Sha:** Gentle gliding on the skin with a special tool.

**Warming or Cooling therapy:** Using a hot/cold pack or heat lamp to move the circulation.

**Herbal Medicine and dietary recommendations:** Individual Powders/Pills herbs and food recommendations based on individual needs.

**Risks**

The FDA regulates acupuncture needles as medical devices, and rates them in the category of “safe and effective”. Acupuncture side effects may include mild bruising, swelling, redness; more severe side effects are rare when a trained and licensed practitioner performs acupuncture. Dizziness and fainting are unlikely and are usually brought on by hunger and excessive fear. Cupping and Gua-Sha may intentionally leave red marks that will usually disappear within a week. The energy heat lamp may leave redness and can potentially burn, always let us know if it becomes too hot. As with the introduction of any new substance, herbs and dietary changes can affect your digestive system.

**Pregnancy**: Some herbs and acupuncture points are contra-indicated. If you are or might be pregnant, tell us.

**Patient advisory to consult a physician:**

Acupuncture scope of practice and NYS/NJ Education law, requires that we must advise you to consult a physician regarding your condition. I, the undersigned do affirm that I have been advised by the licensed acupuncturists in this office, to consult a physician regarding the condition for which I am undergoing acupuncture treatment.

**Payment**

If my insurance does not pay for the treatment services, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for PAYMENT. Also, I agree to pay co-payments, deductibles, and/or coinsurances for treatment services as required by my policy.

**Assignment of Benefits**

If using insurance, I authorize the insurance company to make payment to the practitioner for my treatments and services and authorize release of information concerning my (or my child’s) health care, advice and treatment provided only for the purpose of evaluating and administering claims for insurance benefits.

**Appointment Policies**

Please be on time for appointments.

Cancellation Policy: I understand that a full charge will apply for cancellations with less than 24 hours notice.

**Phone calls and messages**

I agree to receive calls, voicemails, and texts for appointment reminders and communication with this office.

**HIPAA Privacy Act** ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you only. Should you have any questions about the privacy of your information at this office, you may ask.

**Your signature indicates that you have read, understand and agree with the above information, and consent to receiving treatment. If you have any questions, feel free to ask at any time and they will be answered.**

SIGNATURE OF PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Patient,

If insurance covers you to receive acupuncture treatments, we have two options available for you (please check one):

* **Option 1) You can pay the full amount for each treatment on the day of treatment and we will help you submit your insurance form to the company.**
* **Option 2) You can receive the treatments without paying, and ask us to wait until we receive the insurance checks for payment.**

If you choose “Option 2”, you are essentially asking us to extend you credit for treatments, because insurance claims take 4-6 weeks to process. We care deeply about our patients and know that some people will have financial difficulty paying for the services up front, that is why we created “Option 2”.

The problem with “Option 2” is that some insurance companies send payment checks to our patients, and a very few number of patients hold the checks for a long time and need us to follow up repeatedly before returning them to Pema Chen Acupuncture. This is not fair to our staff who need to waste time pursuing payments instead of tending to patient care and other necessary functions of the facility. Thus, if you choose option 2, we require that we have a copy of your credit card on hold. Please understand that we will NOT charge you if your insurance fails to pay us, but only if you fail to bring us our insurance checks in a timely matter (within two weeks of receiving them).

 I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print) understand that I will NOT be charged for unauthorized reasons. However, the failure to return insurance checks within two weeks results in the facility’s right to charge my card for the full price of the treatments incurred in order to compensate the office for services rendered.

Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Verification Value Code (CVV):\_\_\_\_\_\_\_\_\_\_\_
(last 3 or 4 digits on the back of credit card)