Intake Form

Patient Name:_____ Today's Date:_____

Address:_____City: _____State:_____ Zip:_____

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:_____
☐ Cancer:_____
☐ Diabetes
☐ Hepatitis A/B/C
☐ High blood pressure
☐ Heart disease
☐ Seizures
☐ Rheumatic fever
☐ Surgeries:_____
☐ Venereal (STD) disease
☐ Thyroid disease
☐ Birth trauma (prolonged labor, forceps delivery, etc.)
☐ HIV/AIDS
☐ Other significant illness:
_____
_____
☐ Accidents or Hospitalizations:
_____
_____

FAMILY MEDICAL HISTORY

☐ High Cholesterol
☐ Diabetes
☐ Asthma
☐ Cancer
☐ Heart disease
☐ High blood pressure
☐ Seizures
☐ Stroke
☐ Other:_____

GENERAL (Last 6 Months)

☐ Poor appetite
☐ Insomnia
☐ Disturbed sleep
☐ Localized weakness
☐ Weight gain
☐ Weight loss
☐ Changes in appetite
☐ Sweating easily
☐ Night sweats
☐ Fever
☐ Chills
☐ Sudden energy drop

☐ Anemia
☐ Strong thirst
☐ Smoke(# of packs/day):
☐ Tremors
☐ Bleeding or bruising easily
☐ Alcohol consumption(#drinks/day):
(time of day?)
☐ Poor balance

SKIN AND HAIR

☐ Rashes
☐ Ulcerations
☐ Hives
☐ Itching
☐ Eczema
☐ Pimples
☐ Dandruff
☐ Hair loss
☐ Recent moles
☐ Changes in texture of hair or skin
☐ Other:_____

HEAD, NECK, EYES, EARS, NOSE, THROAT

☐ Dizziness
☐ Concussions
☐ Migraines/Headaches
☐ Glasses
☐ Spots in front of eyes
☐ Eye pain
☐ Poor vision
☐ Night blindness
☐ Color blindness
☐ Cataracts
☐ Blurry vision
☐ Earaches
☐ Ringing in ears
☐ Poor hearing
☐ Eye strain
☐ Sinus problems
☐ Recurrent sore throats
☐ Nose bleeds
☐ Grinding teeth
☐ Sores on lips or tongue
☐ Facial pain
☐ Teeth problems
☐ Jaw clicks/TMJ
☐ Other: _____

CARDIOVASCULAR

☐ Hypertension
☐ Low blood pressure
☐ Chest pain
☐ Irregular heartbeat
☐ Swelling of hands/feet
☐ Fainting
☐ Cold hands or feet
☐ Myocardial Infarction
☐ Thrombophlebitis
☐ Blood clots
☐ Difficulty in breathing
☐ Other: _____

RESPIRATORY

☐ Cough
☐ Coughing up blood
☐ Asthma
☐ Other:_____
☐ Bronchitis
☐ Pain with deep inhalation
☐ Pneumonia
☐ Difficulty breathing when lying down
☐ Excessive phlegm (color?)

DIGESTIVE

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Gas
☐ Belching
☐ Black stools
☐ Blood in stools
☐ Indigestion
☐ IBS
☐ Rectal pain
☐ Hemorrhoids
☐ Abdominal pain or cramps
☐ Chronic laxative use
☐ Other:_____

GENITOURINARY

☐ Pain on urination
☐ Frequent/Urgent urination
☐ Blood in urine
☐ Decrease in flow
☐ Incontinence
☐ Kidney stones
☐ Impotence
☐ Sores on genitals
☐ Other:_____

MUSCULOSKELETAL

☐ Neck pain
☐ Muscle pains
☐ Knee pain
☐ Carpal Tunnel
☐ Back pain
☐ Muscle weakness
☐ Foot/ankle sprain/pain
☐ Sciatica
☐ Hand/wrist pains
☐ Shoulder pains
☐ Hip pain
☐ 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:

_____

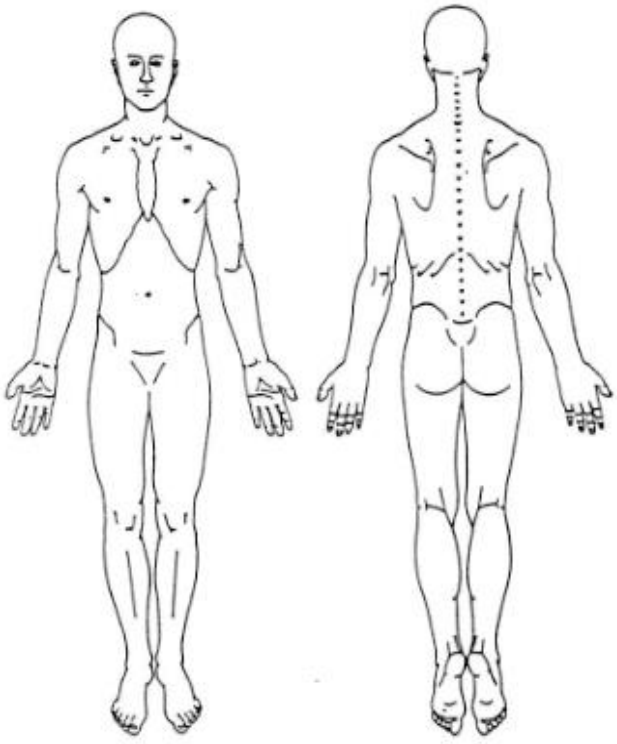
_____

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 treatments, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for PAYMENT. I agree to pay co-payments, deductibles, and/or coinsurances for treatments as required by my policy. I understand that all prepaid treatments must be used within the same calendar year.

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)