

## Alaska Center for Acupuncture – New Patient Information Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Age \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Living with \_\_\_\_

Education \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for visit today \_\_\_\_\_

Other problems \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you ever experienced this before? \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does it bother your Sleep \_\_\_\_ Work \_\_\_\_ other (what?) \_\_\_\_\_

**FAMILY HISTORY** - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

**PERSONAL LIFESTYLE HABITS** (how much, how many, or how often)

Cigarettes (packs) \_\_\_\_\_ Coffee/Tea (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

Marijuana \_\_\_\_\_

Other recreational drugs \_\_\_\_\_

Vitamins & herbs \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Food cravings \_\_\_\_\_

Diet: What might you eat on a typical day?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Exercise \_\_\_\_\_ How often? \_\_\_\_\_

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) \_\_\_\_\_

\_\_\_\_\_

**MEDICINES:**

Prescription drugs you are currently taking:

For what condition?

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

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

Over-the-counter medication you are currently taking:

For what condition?

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

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

**MAJOR HOSPITALIZATIONS** If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: \_\_\_\_\_

Name & address of physician \_\_\_\_\_

Phone number of physician \_\_\_\_\_

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes No

**GYNECOLOGY**

Age of first menses: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_ Duration of flow \_\_\_\_\_

Blood clots: yes/no when: \_\_\_\_\_ Length of cycle \_\_\_\_\_

Color of menstrual blood: pale/bright red/dark red/brown other \_\_\_\_\_

Texture of menstrual blood: thick/thin/watery/normal

Pain: yes/no when: \_\_\_\_\_

Irregular periods (describe): \_\_\_\_\_

PMS (please describe): \_\_\_\_\_

Current method of contraception: \_\_\_\_\_ Past method of contraception: \_\_\_\_\_

Are you currently pregnant? yes/no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_

Urinary tract infections: \_\_\_\_\_ How frequent? \_\_\_\_\_

Vaginal infections/ discharges (describe color): \_\_\_\_\_

Pain/itching of genitalia: \_\_\_\_\_

Pap smear: normal/abnormal Date of last Pap smear: \_\_\_\_\_

Uterine fibroids: \_\_\_\_\_ Endometriosis: \_\_\_\_\_ Other: \_\_\_\_\_

Menopause (date of onset): \_\_\_\_\_ Symptoms: \_\_\_\_\_

Any bleeding since? \_\_\_\_\_

Are you currently on Hormone Replacement Therapy (HRT)? yes/no Dose: \_\_\_\_\_

How long have you been on HRT? \_\_\_\_\_ Any side effects? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

### General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

### Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

### Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

### Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

### Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems

### Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

### Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

### Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

### Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids

- Gall Bladder disorder

### Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

### Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

### Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

### Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

**Other** \_\_\_\_\_

**Blood Type:** \_\_\_\_\_

**Alaska Center for Acupuncture**  
**642 S. Alaska St. Suite 208**  
**Palmer, AK 99645**  
**907-745-8688**

## **Payment and Insurance Policy**

Alaska Center for Acupuncture requires full payment at the time of service. We accept Visa, MasterCard, cash and checks. If your insurance covers acupuncture, we will provide you with a coded receipt which can be submitted to your insurance company for reimbursement. **Alaska Center for Acupuncture does not bill insurance.**

**If you are uncertain about your insurance coverage for acupuncture, give your insurance company a call and ask the following questions:**

1. Do you cover acupuncture?
2. Do I need a referral from a doctor to qualify for acupuncture coverage?
3. What are the conditions of coverage? (Back pain, knee pain etc.)
4. Are there limits to the coverage? (i.e. cap on number of treatments per year or monetary limit)

**HSA/MSA:** If you have a Medical Savings account (MSA) or Health Savings Account (HSA) these funds may be used to pay for your acupuncture treatment.

**Cancellation Policy:** Please give at least 24 hours notice for cancelling an appointment. This allows time for another patient to be offered your treatment slot. With the exception of emergencies and exceptional circumstances, missed appointments without proper notice will result in a full charge for the scheduled appointment.

**Lateness Policy:** If you are running late for an appointment, please call our office to let us know. We will do our best to accommodate you with the time available. Treatment fee is not affected by shortened treatments that result from lateness.

**If you have any questions regarding payment please contact our office 9AM-5PM Monday-Thurs. at 907-745-8688.**

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**Office Policies Agreement:**

**I. Appointment Cancellations:**

Alaska Center for Acupuncture, unlike most medical clinics, is not a volume operation. When you commit to an appointment time, we are reserving 1 to 2 hours of our time specifically for you to provide attentive, personalized, comprehensive care.

Therefore, we respectfully request that you give us as much notice as possible in the event that you must change an appointment time. We often have patients on a waiting list and the more notice we have, the easier it is to make appointment times available to those who need them.

**With the exception of emergencies, appointments cancelled with less than 24 hours notice will be charged our full fee.**

**Initials**\_\_\_\_\_

**II. Payment Policy/Insurance Coverage:**

Alaska Center for Acupuncture requires full payment at the time of service. We accept cash, checks, and Visa/MC. If your insurer covers acupuncture, we will provide you with a coded receipt to submit for insurance reimbursement.

**Initials**\_\_\_\_\_

**III. Malpractice Insurance:**

Given our gentle style and technique of acupuncture, Alaska Center for Acupuncture has elected not to carry a malpractice insurance policy. If you have any questions or concerns about our decision to not carry malpractice coverage, please ask us.

**Initials**\_\_\_\_\_

**I have read, understood and agree to the office policies outlined above.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Alaska Center for Acupuncture**  
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**Consent to Treatment**

I hereby voluntarily consent to be treated by Samantha Berg, M.Ac., L.Ac., Dipl.Ac., and Kevin Meddleton, M.Ac., L.Ac., Dipl.Ac., with Oriental medical procedures, which may include acupuncture, moxibustion, cupping, gua sha, acupressure, massage, Chinese herbal medicine, or nutrition and lifestyle counseling. Samantha Berg and Kevin Meddleton are both licensed acupuncturists in the State of Alaska.

I understand that acupuncture is performed by the insertion of sterile needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat body dysfunctions or diseases and to normalize the body's physiological functions.

I understand that all of my patient records as well as information I share with my acupuncturist will be kept confidential. No records or information will be released without my written consent.

While acupuncture is generally a safe method of treatment, I am aware that certain side effects may result. These could include, but are not limited to, some local bruising, bleeding, dizziness, fainting, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days and temporary aggravation of symptoms in existence prior to treatment.

I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, or if a new ailment or condition appears that I should consult my personal physician or any other licensed physician.

I understand that I should inform my acupuncturist prior to being treated if I believe I might be pregnant.

I understand that no guarantees concerning acupuncture's use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate.

I understand I will be charged the full fee for appointments cancelled with less than 24 hours notice.

I have carefully read and understand all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

Patient \_\_\_\_\_ Date \_\_\_\_\_