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(s) 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 and/or Chinese herbal medicine before? Yes _____ No_____

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow: _____

Please circle answers below

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 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 (ACA) requires full payment at the time of service. We accept Visa, MasterCard, Discover, 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. **ACA 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-Thursday 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**

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Consent to Treatment

I hereby voluntarily consent to be treated with Chinese Medicine by Samantha Berg, Kevin Meddleton, Aria Walker and Sy Cloud, Licensed acupuncturists in the State of Alaska. I understand that treatment may involve the modalities of acupuncture, moxabustion, herbal medicine, nutritional advice, and lifestyle counseling consistent with the principles of holistic Chinese medicine.

I understand that the licensed acupuncturists at Alaska Center Acupuncture perform treatments with the insertion of acupuncture needles through the skin, or by the application of heat to the skin, or by both in an attempt to support the body's physiological functions. I understand the needles used are sterile, single use disposable needles.

I understand that all of my patient records as well as information I share with my acupuncturists will be kept confidential. No records or information will be released without my written consent. However, the practitioners may publish the information gathered during treatment as long as it is done so anonymously.

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 also understand that Chinese medicine is not primary care medicine and that if my symptoms worsen, new symptoms arise, or I have any concerning change in my health status I should consult a licensed medical doctor.

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.

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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.

_____ _____

Signature **Date**