

# New Patient Intake Form

Acupuncture Associates

Bellevue • Marysville • Puyallup • Shoreline

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthday: \_\_\_/\_\_\_/\_\_\_

Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

## Contact Information:

Cell: (\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact (Name & Phone) \_\_\_\_\_ Occupation/Employer \_\_\_\_\_

Referred by: \_\_\_\_\_ Have you had Acupuncture before?  No  Yes

Reason for today's visit: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Does it bother your:  Sleep  Work  Other \_\_\_\_\_

What seems to make it **better** or **worse**? \_\_\_\_\_

Is this related to an Auto Accident or work injury? \_\_\_\_\_ If Auto, PIP or PI? \_\_\_\_\_ Date of Accident: \_\_\_/\_\_\_/\_\_\_

If work related, L&I or company liability? \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No If yes, for what reason? \_\_\_\_\_

Who is your Physician? (Name & Phone) \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other concurrent therapies: \_\_\_\_\_

## Please check if YES to any of the following Medical Condition(s):

(check any of the following conditions you currently have, of have experienced in the past. Please also check if you feel any of the following are a significant part of your medical history.)

- |                                     |  |   |  |  |
|-------------------------------------|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Pregnant        |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Seizure        | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Whooping Cough  |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Trauma            | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Surgery (List) | _____                                      | _____                                    |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> High Blood Pressure | _____                                   | _____                                      | _____                                    |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Multiple Sclerosis  | _____                                   | _____                                      | _____                                    |

# New Patient Intake Form

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## YOUR LIFESTYLE

- |                                  |                                    |  |   |
|----------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress                | <input type="checkbox"/> Regular Exercise |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs     | <input type="checkbox"/> Occupational Hazards: | Type: _____ Frequency: _____              |

## GENERAL SYMPTOMS

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> Poor Sleep            | <input type="checkbox"/> Bodily Heaviness    | <input type="checkbox"/> Chills               | <input type="checkbox"/> Bleed or Bruise easily    |
| <input type="checkbox"/> Heavy Appetite      | <input type="checkbox"/> Heavy Sleep           | <input type="checkbox"/> Cold Hands or Feet  | <input type="checkbox"/> Night Sweats         | <input type="checkbox"/> Peculiar Taste (describe) |
| <input type="checkbox"/> Prefer Cold Drinks  | <input type="checkbox"/> Dream Disturbed Sleep | <input type="checkbox"/> Poor Circulation    | <input type="checkbox"/> Sweat Easily         | _____  |
| <input type="checkbox"/> Prefer Hot Drinks   | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Muscle Cramps        | _____  |
| <input type="checkbox"/> Weight Gain or Loss | <input type="checkbox"/> Lack of Strength      | <input type="checkbox"/> Fever               | <input type="checkbox"/> Vertigo or Dizziness | _____  |

## HEAD/EYES/EARS/NOSE/THROAT

- |  |  |  |   |                                      |
|--|--|--|---|--------------------------------------|
| <input type="checkbox"/> Glasses       | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Sores on Lips or Tongue | <input type="checkbox"/> Sore Throat      | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> Eye Strain    | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Dry Mouth               | <input type="checkbox"/> Lumps in Throat  | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Eye Pain      | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Excessive Saliva        | <input type="checkbox"/> Enlarged Thyroid | Other Head/Neck Problems             |
| <input type="checkbox"/> Red Eyes      | <input type="checkbox"/> Teeth Problems  | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Nose Bleeds      | _____                                |
| <input type="checkbox"/> Itchy Eyes    | <input type="checkbox"/> Grinding Teeth  | <input type="checkbox"/> Excessive Phlegm        | <input type="checkbox"/> Ringing in Ears  | _____                                |
| <input type="checkbox"/> Spots in Eyes | <input type="checkbox"/> TMJ             | <input type="checkbox"/> Color of Phlegm         | <input type="checkbox"/> Poor Hearing     | _____                                |
| <input type="checkbox"/> Poor Vision   | <input type="checkbox"/> Facial Pain     |  | <input type="checkbox"/> Earaches         |                                      |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Gum Problems    |  |   |                                      |

## RESPIRATORY

- |   |                                     |                                    |  |  |
|---|-------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Cough              | Productive? _____                   | Wet or Dry? _____                  | <input type="checkbox"/> Color of Phlegm     | _____                                    |

## CARDIOVASCULAR

- |  |   |   |  |                                       |
|--|---|---|--|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Tachycardia         | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Irregular Heartbeat |                                       |

## GASTROINTESTINAL

- |   |   |  |                                      |                                       |
|---|---|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Intestinal Pain/Cramp | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Itchy Anus            | Frequency _____                      | Texture/Form _____                    |
| <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> Laxative Use     | <input type="checkbox"/> Burning Anus          | Color _____                          | Odor _____                            |
| <input type="checkbox"/> Gas                | <input type="checkbox"/> Black Stools     | <input type="checkbox"/> Rectal Pain           |                                      |                                       |
| <input type="checkbox"/> Hiccup             | <input type="checkbox"/> Bloody Stools    | <input type="checkbox"/> Hemorrhoid            |                                      |                                       |
| <input type="checkbox"/> Bloating           | <input type="checkbox"/> Mucous in Stools | <input type="checkbox"/> Anal Fissures         |                                      |                                       |
| <input type="checkbox"/> Bad Breath         |   |  |                                      |                                       |

## MUSCULOSKELETAL

- |   |  |                                     |  |                  |
|---|--|-------------------------------------|--|------------------|
| <input type="checkbox"/> Neck/Shoulder Pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limited Range of Motion | Other (describe) |
| <input type="checkbox"/> Muscle Pain        | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Rib Pain   | <input type="checkbox"/> Limited Use             | _____            |

## SKIN/HAIR

- |                                 |                                    |   |   |                          |
|---------------------------------|------------------------------------|---|---|--------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Dandruff       | <input type="checkbox"/> Change in Hair         | Other Hair/Skin Problems |
| <input type="checkbox"/> Hives  | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching        | <input type="checkbox"/> Fungal Infection       | _____                    |
| <input type="checkbox"/> Tics   | <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Abuse Survivor | <input type="checkbox"/> Change in Skin Texture | _____                    |

## NEUROPSYCHOLOGICAL

- |                                   |                                      |  |   |                 |
|-----------------------------------|--------------------------------------|--|---|-----------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Considered Suicide | Other (specify) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression  | <input type="checkbox"/> Easily Stressed | <input type="checkbox"/> Attempted Suicide  | _____           |
| <input type="checkbox"/> Tics     | <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Abuse Survivor  | <input type="checkbox"/> Seeing Therapist   | _____           |

## GENITO-URINARY

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on Urination  | <input type="checkbox"/> Blood in Urine       | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Premature Ejaculation |
| <input type="checkbox"/> Urgent Urination   | <input type="checkbox"/> Incomplete Urination | <input type="checkbox"/> Wake to Urinate  | <input type="checkbox"/> Kidney Stone     | <input type="checkbox"/> Nocturnal Emission    |

## GYNECOLOGY

- |   |  |  |                                       |                           |
|---|--|--|---------------------------------------|---------------------------|
| <input type="checkbox"/> Age Menses Began | <input type="checkbox"/> Duration of Flow  | <input type="checkbox"/> Vaginal Discharge (color) _____ | <input type="checkbox"/> Breast Lumps | Date of Last PAP          |
| _____                                     | _____                                      |  | # Pregnancies _____                   | ____/____/____            |
| <input type="checkbox"/> Length of Cycle  | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Vaginal Sores                   | # Births _____                        |                           |
| _____                                     | <input type="checkbox"/> Painful Periods   | <input type="checkbox"/> Vaginal Odor                    | Premature Births _____                | Date of Last Period Began |
|   | <input type="checkbox"/> PMS               | <input type="checkbox"/> Clots                           | Age of Menopause _____                | ____/____/____            |

# New Patient Intake Form

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## Office Policies and Authorization for Treatment

I, \_\_\_\_\_, understand that acupuncture is an energetic form of therapy based on the regulation of energy, and is not intended to replace conventional medical treatment. I assume full responsibility for consulting with appropriate physician since I understand that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Acupuncture Associates, to perform the following procedures:

Acupuncture procedures involving insertion of special needles through the skin into the underlying tissue at specific points on the surface of the body, as well as other techniques as specifically described in the Washington State Law for Licensed Acupuncturists, such as moxibustion, cupping, electro-acupuncture and acupressure.

I recognized the potential benefits and risks of the above procedures included reactions as described below:

- ♦ Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention, or elimination of the presenting problem.
- ♦ Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruising, weakness, fainting, nausea and even aggravation of symptoms existing prior to the acupuncture treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Acupuncture Associates, regarding cure or improvement of my condition. I hereby release Acupuncture Associates, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

### FEE:

I understand that any fees for treatments are payable at the time of service unless I am receiving treatment via a medical plan which recognizes Acupuncture Associates, as a Preferred Provider. In such an event, payment shall be provided as per the terms of the plan. If it is found that I am not eligible for coverage of treatment by my medical plan, I assume full responsibility for paying Acupuncture Associates any money owed for treatment.

### MISSED APPOINTMENT:

I will give **24 hours notice** if I need to cancel an appointment. I understand without that advance notice, the time reserved for me is my responsibility and will be charged to me as a missed appointment. Missed appointments are **charged at the same rates** as a regular appointment. Insurance companies do not pay for missed appointments. I understand that any appointments missed are my financial responsibility. Exceptional circumstances will be considered regarding this policy.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Authorized to Consent

\_\_\_\_\_  
Date

# New Patient Intake Form

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## Authorization and Financial Release Agreement for New Patients

I, \_\_\_\_\_, being a patient of Acupuncture Associates located at: \_\_\_\_\_, do hereby acknowledge that certain services may not be covered by my insurance under the terms of my Health Plan. I understand that it is my responsibility to know and understand my insurance policy coverage and its benefits. I give authorization to this office to release information regarding my care and treatment to my Health Plan and its agents for purposes of managing my health benefit payments to me and/or my practitioner. I hereby assign to this office any payments my Health Plan makes for services rendered to me and my eligible family members by this office by reason of its contractual relations with my Health Plan and its agents. I understand that I am responsible to pay for services received at this office and I agree to make financial arrangements with my practitioner to pay for any services not covered by my insurance plan, including, but not limited to, any deductibles, co-payments, co-insurance or charges for non-covered services.

Dated, \_\_\_\_\_, 20\_\_\_\_.  
(month, day)

\_\_\_\_\_  
Patient Signature

Insurance Plan: \_\_\_\_\_

Member Identification Number: \_\_\_\_\_

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Acupuncture Associates

## Professional Fee Schedule

<b>New Patient Consultation/Examination</b>	<b>\$45.00 - \$150.00</b>
Consulting based on Patient's symptom, Tongue and pulse diagnosis	
<b>Established Patient Consultation/ Examination</b>	<b>\$25.00 - \$65.00</b>
<b>Acupuncture Treatment</b>	<b>\$50.00 - \$75.00</b>
<b>Electro Acupuncture Treatment</b>	<b>\$75.00 - \$100.00</b>
<b>Infra-red (TDP) Heat Treatment</b>	<b>\$25.00</b>
<b>Return Check Charge</b>	<b>\$40.00</b>
<b>Missed Appointment Charge</b>	<b>\$40.00</b>

If I am covered by insurance, I am responsible for any balance not paid within 90 days. Any quote of benefits made to me by Acupuncture Associates is only done as a courtesy and is not a guarantee of payment. I am still responsible for any coordination of my insurance.

**Thank you for your cooperation!**