

# Acupuncture New Patient Paperwork



Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Partner Status: \_\_\_\_\_  
 In Case of Emergency Notify: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Concurrent Health Therapies or Regimens: \_\_\_\_\_

How did you hear about our clinic? Or who referred you?

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Employer          | <input type="checkbox"/> Print Ad          | <input type="checkbox"/> Returning Patient |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Event             | <input type="checkbox"/> Sign on Building  | <input type="checkbox"/> TV Commercial     |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Insurance Website | <input type="checkbox"/> Internet Web Site | <input type="checkbox"/> Radio             |
| <input type="checkbox"/> Health Class  | <input type="checkbox"/> Brochure          | <input type="checkbox"/> Direct Mail Ad    | <input type="checkbox"/> Other             |

If you selected family member/friend/physician please list their name here: \_\_\_\_\_

If you selected internet website/event or other please describe: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Stroke, Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Other: _____        |

**PAST MEDICAL HISTORY (WITH DATES):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Seizures         | <input type="checkbox"/> Vaccinations                |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Surgeries        | <input type="checkbox"/> Childhood Illnesses         |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Other Significant Illnesses |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Accidents or trauma         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease  | <input type="checkbox"/> Birth Trauma                |

**PHYSICAL TRAMAS**

Have you been in an accident? If so, please specify the date and nature of the accident(s): \_\_\_\_\_

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

Please list any surgeries, with dates, that you have had: \_\_\_\_\_

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

## LIFESTYLE & OCCUPATION:

Exercise: \_\_\_\_\_

Dietary Considerations: \_\_\_\_\_

Habitual Consumptions:  Cigarettes  Coffee, Tea or Cola  Alcoholic Beverages  Other

Occupational Stress Factors: \_\_\_\_\_

Medications taken within the last two months (vitamins, drugs, herbs, etc): \_\_\_\_\_

## CURRENT GENERAL HEALTH INDICATORS:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Poor Appetite                               | <input type="checkbox"/> Heavy Appetite              | <input type="checkbox"/> Changes in appetite           |
| <input type="checkbox"/> Disturbed Sleep                             | <input type="checkbox"/> Heavy Sleep                 | <input type="checkbox"/> Insomnia                      |
| <input type="checkbox"/> Fatigue                                     | <input type="checkbox"/> Localized Weakness          | <input type="checkbox"/> Sweating easily               |
| <input type="checkbox"/> Poor Coordination                           | <input type="checkbox"/> Strong Thirst               | <input type="checkbox"/> Cravings                      |
| <input type="checkbox"/> Weight Gain                                 | <input type="checkbox"/> Weight Loss                 | <input type="checkbox"/> Change in Appetite            |
| <input type="checkbox"/> Cold Hands                                  | <input type="checkbox"/> Cold Feet                   | <input type="checkbox"/> Cold Back                     |
| <input type="checkbox"/> Night Sweats                                | <input type="checkbox"/> Fevers                      | <input type="checkbox"/> Chills                        |
| <input type="checkbox"/> Cold Abdomen                                | <input type="checkbox"/> Poor Balance                | <input type="checkbox"/> Sensitive to tastes or smells |
| <input type="checkbox"/> Tremors                                     | <input type="checkbox"/> Bleeding or Bruising Easily | <input type="checkbox"/> Sudden energy drop (when?)    |
| <input type="checkbox"/> Other Unusual or Abnormal Conditions: _____ |  |  |

## SKIN AND HAIR

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Rashes                                 | <input type="checkbox"/> Ulcerations                    | <input type="checkbox"/> Hives        |
| <input type="checkbox"/> Itching                                | <input type="checkbox"/> Eczema                         | <input type="checkbox"/> Pimples      |
| <input type="checkbox"/> Dandruff                               | <input type="checkbox"/> Hair Loss                      | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Purpura                                | <input type="checkbox"/> Change in Hair or Skin Texture |                                       |
| <input type="checkbox"/> Any Other Hair or Skin Problems: _____ |   |                                       |

## HEAD AND NECK

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dizziness                              | <input type="checkbox"/> Concussions             | <input type="checkbox"/> Migraines                |
| <input type="checkbox"/> Glasses                                | <input type="checkbox"/> Spots in Front of Eye   | <input type="checkbox"/> Headaches (Where? When?) |
| <input type="checkbox"/> Eye Pain                               | <input type="checkbox"/> Poor Vision             | <input type="checkbox"/> Night Blindness          |
| <input type="checkbox"/> Color Blindness                        | <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Blurry Vision            |
| <input type="checkbox"/> Eyestrain                              | <input type="checkbox"/> Spots in Eyes           | <input type="checkbox"/> Ringing in Ears          |
| <input type="checkbox"/> Poor Hearing                           | <input type="checkbox"/> Earaches                | <input type="checkbox"/> Mucus                    |
| <input type="checkbox"/> Dry Throat                             | <input type="checkbox"/> Dry Mouth               | <input type="checkbox"/> Copious saliva           |
| <input type="checkbox"/> Sinus Problems                         | <input type="checkbox"/> Recurrent Sore Throats  | <input type="checkbox"/> Nose Bleeds              |
| <input type="checkbox"/> Grinding Teeth                         | <input type="checkbox"/> Sores on Lips or Tongue | <input type="checkbox"/> Facial Pain              |
| <input type="checkbox"/> Teeth Problems                         | <input type="checkbox"/> Gum Problems            | <input type="checkbox"/> Jaw Clicks               |
| <input type="checkbox"/> Any other head or neck problems: _____ |  |   |

## CARDIOVASCULAR

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dizziness                                       | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Chest Pain       |
| <input type="checkbox"/> Irregular Heartbeat                             | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Fainting         |
| <input type="checkbox"/> Cold Hands or Feet                              | <input type="checkbox"/> Swelling of Hands       | <input type="checkbox"/> Swelling of Feet |
| <input type="checkbox"/> Blood Clots                                     | <input type="checkbox"/> Difficulty in Breathing | <input type="checkbox"/> Phlebitis        |
| <input type="checkbox"/> Any Other Heart or Blood Vessel Problems: _____ |  |   |

## RESPIRATORY

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cough                          | <input type="checkbox"/> Pain with deep inhalation     | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Bronchitis                     | <input type="checkbox"/> Production of Phlegm (color?) | <input type="checkbox"/> Pneumonia                            |
| <input type="checkbox"/> Coughing up blood              | <input type="checkbox"/> Asthma                        |   |
| <input type="checkbox"/> Any Other Lung Problems: _____ |  |   |

## GASTROINTESTINAL

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea          |
| <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Gas                  | <input type="checkbox"/> Belching          |
| <input type="checkbox"/> Black Stools                 | <input type="checkbox"/> Blood in Stools      | <input type="checkbox"/> Indigestion       |
| <input type="checkbox"/> Bad Breath                   | <input type="checkbox"/> Rectal Pain          | <input type="checkbox"/> Hemorrhoids       |
| <input type="checkbox"/> Abdominal pain or cramps     | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Sensitive Abdomen |
| <input type="checkbox"/> Any Other GI Problems: _____ |   |  |

## GENITOURINARY

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pain on Urination                                     | <input type="checkbox"/> Frequent Urination            | <input type="checkbox"/> Blood in Urine    |
| <input type="checkbox"/> Urgency to Urinate                                    | <input type="checkbox"/> Unable to hold Urine          | <input type="checkbox"/> Kidney Stones     |
| <input type="checkbox"/> Decrease in Work Flow                                 | <input type="checkbox"/> Impotence                     | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Waking at Night to Urinate                            | <input type="checkbox"/> Any Particular Color to Urine |  |
| <input type="checkbox"/> Any Other Problems with Genitourinary Function: _____ |  |  |

## REPRODUCTIVE AND GYNECOLOGIC

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Age at Menarche _____           | <input type="checkbox"/> Age at Menopause _____   | <input type="checkbox"/> Birth Control Method (since _____) |
| <input type="checkbox"/> Number of Live Births _____     | <input type="checkbox"/> Premature Births _____   | <input type="checkbox"/> Number of Pregnancies _____        |
| <input type="checkbox"/> Menstrual Clots                 | <input type="checkbox"/> Painful Menses           | <input type="checkbox"/> Miscarriages/Abortions _____       |
| <input type="checkbox"/> Strong Menstrual Odor           | <input type="checkbox"/> Duration of Menses _____ | <input type="checkbox"/> Vaginal Odor                       |
| <input type="checkbox"/> Vaginal Discharge               | <input type="checkbox"/> Irregular Menses         | <input type="checkbox"/> Breast Lumps or Swelling           |
| <input type="checkbox"/> Premenstrual Changes            | <input type="checkbox"/> Other Problems: _____    |   |
| <input type="checkbox"/> Other Menstrual Problems: _____ |   |   |

## MUSCULOSKELETAL

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Neck Pain                               | <input type="checkbox"/> Muscle Pains    | <input type="checkbox"/> Knee Pain        |
| <input type="checkbox"/> Back Pain                               | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot/Ankle Pains |
| <input type="checkbox"/> Hand/Wrist Pains                        | <input type="checkbox"/> Shoulder Pains  | <input type="checkbox"/> Hip Pain         |
| <input type="checkbox"/> Any Other Joint or Bone Problems: _____ |  |   |

## Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations



In the course of your care as a patient at the Advanced Wellness Centre, PC we may use or disclose personal and health related information about you in the following ways:

- Personal health information including clinical records may be disclosed to another health care provider or hospital as a means of communication about and coordination of your care.
- Billing and health care records may be disclosed to another party, if they are or may be responsible for payment of your services.
- As a means by which a third party can verify that services billed were actually provided.
- As a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.
- Your name, address, phone numbers and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care
- If we are ordered by the courts or another appropriate agency

I request the following restrictions to the use of disclosure of my health information:

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I state that my health information can be released to the following family members or persons:

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Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail or email information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to the Office Manager. This notice is effective as of April 15, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

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Name (please print)

Signature

Date

**If you are a minor, or if you are being represented by another party:**

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Personal Representative (please print)

Personal Representative Signature

Date

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Description of the authority to act on behalf of the patient.



Medical Services Contract

I hereby authorize **Advanced Wellness Centre, PC** to render medical services to me (or child) and to release any information regarding my medical history, diagnosis and treatment of myself (or child, if applicable) to my insurance company regarding my claim for chiropractic and physical therapy benefits and to my (or child's) primary care physician. I authorize payment directly to **Advanced Wellness Centre, PC** for the benefit otherwise payable to me under the terms of my insurance. I understand that **Advanced Wellness Centre, PC** will file my insurance; however, if the insurance company payments are not timely, it is my responsibility to pay **Advanced Wellness Centre, PC** and pursue my recovery with the insurance carrier. Advanced Wellness Centre, PC will verify your insurance benefits as a courtesy. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that I am financially responsible for all changes arising from chiropractic and physical therapy treatment, which are separate services and may have separate co-pays and/or coinsurance.

*I understand that if my insurance company requires a referral for treatment that I am responsible for obtaining that referral. I agree that if I did not obtain that referral and I receive treatment without the referral, I am fully financially responsible for any services denied for no referral. I understand that I am also responsible for court testimony, medical reports, and any other charges arising from said treatment if necessary. There will be a one time initial X-ray interpretation fee per X-ray series/region, your X-rays will be sent to a medical radiologist for an overread. I understand that it will not be filed to my insurance and I am responsible for this fee.*

Our goal is to provide quality care in a timely manner to all of our patients. In order to accomplish this we have instated a cancellation/no show policy. We require that you cancel your appointment with 24 hour notice. Appointments are in demand and this enables another patient to receive timely care. If 24 hour notice is not given, this will be considered a no show. No shows are an inconvenience to those trying to receive care. **A \$45.00 fee will be charged to all patients that fail to show for their appointments.** Three consecutive no show/cancellation appointments may result in an automatic discharge for the patient.

I hereby further assign the causes of action I have to said doctor on any and all proceeds of any medical payment, insurance benefits and (if applicable) on any settlement or judgement from the injuries for which I have been treated.

If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees in the amount of thirty-three point three percent (33.3%) of the total indebtedness and court costs incurred by **Advanced Wellness Centre, PC**. If this indebtedness is not paid in full within sixty days, I agree to pay a service charge of one and one-half percent (1 1/2 %) per month, eighteen percent (18%) per annum.

Responsible Party/Patient's Signature: \_\_\_\_\_

Your name: \_\_\_\_\_ Date: \_\_\_\_\_  
(please print)

**Advanced Wellness Centre  
Acupuncture**

I hereby authorize any person(s) that is serving under the supervision of my health care provider to be present during all phases of my patient analysis and treatment for observational and assistance purposes.

I understand that any assistant or intern of an Advanced Wellness Centre health care provider, that bears witness to any part of my personal information, is bound by the same laws and expectations of patient confidentiality and responsibility as the healthcare provider him/herself.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date Signed: \_\_\_\_\_

