WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Acupuncture Intake Forms

Name _____ Gender (M/F) _____ Date_____
Address _____City_____ State_____ Zip_____
Home Phone _____Cell Phone_____ Date of Birth _____ Age_____
Email: _____ Occupation: _____
How did you hear about us? _____
Have you ever received acupuncture? Yes__ No__ If yes, when? _____
Would you like to pay with: Insurance (please give front desk your card) OR out of pocket (Circle one).
Is this an Auto Accident or Work Comp related injury? (circle): Insurance/claim #: _____
Date of Accident or injury: _____

Reasons for seeking care:

Primary concern: _____
Secondary concern: _____
Other concern: _____

Acupuncture can help with many health concerns, not all of which are listed here. Are your experiencing any symptoms in the following areas?

Muscle/Joint/Bone □ Eyes/Ears/Nose/Throat/Respiratory □ Skin related issues □ Genito/Urinary □ Cardiovascular □ Gastrointestinal □ Menstrual related issues □ Sexual/Reproductive □
Other (not listed here) _____

Check symptoms you have or have had in the last year:
Anxiety □ Depression □ Difficulty in focusing □ Dizziness □ Easily startled □ Excessive worry and/or fear □ Excessive anger □ Fatigue/tiredness □ Loss of sleep/poor sleep □ Nervousness/irritability □ Overwhelmed by life □

Your current Pain experience:

Where is the pain today? _____
When did this recent concern begin? _____
How did your pain begin?
___Singular event or trauma ___This has happened several times before? YES/NO.
Number of episodes: _____
___Slowly began after a certain activity ___No reason why this occurred.
Circle one: how often does this bother you?
Daily Weekly Monthly Other_____
How long does it last?
Seconds Minutes Hours Other_____
Please circle the quality of the complaint/pain:
dull aching sharp shooting burning throbbing deep nagging Other_____
Grade intensity/severity (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst possible pain imaginable)
What makes the pain worse?
_____

What makes the pain better?

_____

Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where?

_____

Do you have any of these additional symptoms besides the pain:

❑ Numbness ❑ Muscle Weakness ❑ Pins/Needles/Tingling ❑ Difficulty with urination ❑ Difficulty Breathing ❑ Chest Pain ❑ Dizziness ❑ Tension ❑ Excessive sweating ❑ Fever ❑ Fatigue ❑ Sickness ❑ Weight Loss/gain ❑ Bruising ❑ Bleeding ❑ Painful/Swollen Joints ❑ Headache ❑ Nausea ❑ Vomiting ❑ Changes in Vision ❑ Sensitivity to Light/Sound ❑ Cough ❑ Rash ❑ Difficulty Sleeping

Where? _____

Does this complaint interfere with: work, home life, activities or sleep? Y/N

_____

Are you presently under a doctor's care for this complaint? Y/N Doctors/Clinic name: _____

Are you currently pregnant or is there any possibility that you might be pregnant? Yes No Not sure (circle one)

Are there any other health concerns you would like to discuss? _____

Previous pain interventions: treatments, medications, surgery, or care you've sought for this pain:

_____

Past Health History:

A. Previous illnesses/conditions you've had in your life:

❑ Diabetes ❑ Cancer ❑ Stroke ❑ Arthritis ❑ Seizures ❑ Ulcers ❑ AIDS/HIV ❑ Joint replacement ❑ Glaucoma ❑ Hepatitis ❑ Anemia ❑ Alcoholism ❑ Lung disease ❑ Heart disease ❑ Diverticulitis ❑ Pacemaker ❑ Kidney Disease ❑ Thyroid Disease ❑ Tuberculosis ❑ Hypertension ❑ Blood Thinners ❑ Depression ❑ Anxiety ❑ Other_____

B. Surgeries/Hospitalizations/Injuries/Fractures/Dislocations: (Please provide Month/Year)

_____

C. Allergies _____

D. Current medications/supplements: _____

E. Conditions you are taking medications for: _____

(you may use the back of this page if you need more room, or attach another sheet)

Family Health History:

Please label parents, siblings, children:

Family Medical History (Please check all that apply):

☐ N/A, I do not know my family history

❑ Diabetes ❑ Cancer ❑ Rheumatoid Arthritis ❑ Osteoarthritis ❑ Scoliosis ❑ Muscular Disease ❑ Hypertension ❑ Heart-disease ❑ Stroke ❑ Other_____

Other information we should know about:

_____

_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and

supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME: _____

ACUPUNCTURIST NAME: _____

PATIENT SIGNATURE: **X** _____ Date:_____

(Or Patient Representative)

Indicate relationship if signing for patient:

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Patient Authorization Form

I have had the **Notice of Privacy Practice** made available to me and have had the opportunity to review its contents prior to signing this authorization.

I authorize the use of my medical information according to the **Notice of Privacy Practice**.

I authorize the release of any medical information necessary to process my claim.

I authorize the following individual(s) (family, spouse, friends) access to information about my medical records and appointments at **Whitaker Wellness / Powell Valley Wellness**:

Name(s): _____

I authorize **Whitaker Wellness / Powell Valley Wellness** to send text message reminders about my appointments and to leave a message whenever they need additional information from me.

- ☐ Check box if you want to **OPT OUT** of voicemails.
- ☐ Check box if you want to **OPT OUT** of text message reminders.
- ☐ Check box if you want to **OPT OUT** of Email reminders.

I authorize payment of medical benefits to **Whitaker Wellness / Powell Valley Wellness**

I authorize the release of information to any other entity for which I have signed a release.

I authorize **Whitaker Wellness / Powell Valley Wellness** to release information to any entity that I personally instruct them to release information to.

We, at **Whitaker Wellness / Powell Valley Wellness**, will gladly bill your insurance company. However, the full responsibility for payment of all professional services belongs to you, the patient.

If you do not have insurance or choose not to use your insurance, we do offer a Time Of Service Discount (TOSD) here. The TOSD will give you discount on your treatments here. You can use the TOSD for any service offered here. Pricing is dependent on the services performed. Please ask the front desk for specific pricing. **In order to qualify for the TOSD you have pay for your services the day of visit. If you do not pay the same day you were seen then you do not qualify for the TOSD and must pay full pricing.**

_____ _____

Patient Name Date

_____ _____

Patient Signature (Parent Signature if minor) Parent Name (If Minor)

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Cancellation Policy/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

If any appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

_____ _____

Patient name Date

_____

Signature Patient/Guardian