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Acupuncture POINTS

Your way to Health



Licensed Acupuncturist
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Strictly confidential

Patient Health Appraisal

Please, legibly fill in this form to the best of your ability...add any additional information you deem necessary

Name _____ Age ____ Date of birth ____/____/____ Relationship status _____
 Address _____ Birthplace _____ Number of Children _____
 City _____ State ____ Zip _____ Referred to us by _____
 Phone: (mobile) _____ (work) _____ (home) _____
 e-mail: _____ Occupation _____ # work hrs/wk _____
 Emergency Contact: _____ Relationship _____ Phone _____
 Physicians name: _____ Phone: _____
 May I contact your physician to discuss your condition? ___ Yes ___ No Your Health Ins Co? _____

Height: __ ft. __ in. Weight: _____ pounds Blood pressure: __high __low __normal WTP__

Why have you come for acupuncture treatment?

New/Acute problems:

Old/Chronic problems:

Treatments to date:

Current medications (taken within last 2 months):

Current "natural" remedies/supplements:

What do you do for exercise?

Present living situation:

Major Stresses in life:

Where do you hold tension?

~ Personal Health History ~

Hospitalizations:

Surgeries:

Injuries//traumas:

Broken bones:

Scars/stitches:

Medicinal allergies:

Environmental allergies:

Food allergies:

Catch cold or virus easily?

Frequent sore throat?

Childhood Illness

___ Chicken Pox
 ___ Measles
 ___ Mumps
 ___ German Measles
 ___ Scarlet Fever

Immunizations

___ DPT
 ___ Tetanus Booster
 ___ Measles/Mumps/Rubella
 ___ Hepatitis B
 ___ Influenza

Exposures

___ Hepatitis
 ___ Tuberculosis
 ___ Herpes
 ___ HIV exposure
 ___ tested positive ___ tested negative

Implants/Prostheses

___ Breast implant (s)
 ___ Pace Maker
 ___ other (describe)



Use of

- alcohol
 tobacco
 caffeine
 sugar
 other drugs (describe)

Energy (Qi) Patterns

(times of the day or season when you feel **very active** or **very tired**)

	High	Average	Low		High	Average	Low
early morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Late Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
late evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family Health and Genetic History

Mother: _____ Maternal Grandparents: _____
 Father: _____ Paternal Grandparents: _____
 Sisters/Brothers: _____ Children: _____

Sleep

Amount (hours per night)
 Quality:
 deep trouble falling asleep
 restless trouble getting back to sleep
 insomnia not refreshed upon waking
 Dreams:
 often
 average
 never

Diet & Food Preferences

Diet patterns and foods eaten:
~ details please ~

~ Please detail answers ~

average appetite bitter like dislike I drink ounces
 always hungry salty of liquid each day
 lack of appetites sour I feel thirsty and drink a lot
 spicy I feel thirsty and don't drink
 sweet I prefer hot cold drinks

breakfast:

 lunch:

 dinner:

Women

~ Please detail answers ~
 date of last menstruation:
 number of days in cycle: _____
 amount of flow: _____
 color: _____
 odor: _____
 cramping: _____
 blood clots: yes ___ no ___
 date of last Pap Smear ___/___

Number of pregnancies:
 deliveries: _____
 caesareans: _____
 miscarriages: _____
 abortions: _____
 Birth control pills used?
 No
 Yes, how long: _____
 Diaphragm / IUD

premenstrual syndrome
 dysmenorrhea
 amenorrhea
 infertility
 endometriosis
 Pelvic Inflammatory Disease
 fibroids
 ovarian cysts

abnormal pap smear
 cervical dysplasia
 vaginal discharge
 breast tenderness
 breast discharge
 Fibrocystic breast disease
 menopause
 peri-menopause

Sexual Energy (Qi) Interest: High Average Low

Sexually active: Yes No

Men

Prostatitis Infertility Impotent:

Sexual Energy (Qi) Interest: High Average Low

Sexually active: Yes No

"General Body Check" Do you have problems with any of these:

PAIN (WHERE) <input type="checkbox"/> sharp/stabbing: <input type="checkbox"/> dull/aches: <input type="checkbox"/> localized: <input type="checkbox"/> crampish: <input type="checkbox"/> moving/tingling:	CIRCULATION: <input type="checkbox"/> numbness <input type="checkbox"/> cold areas <input type="checkbox"/> Reynaud's disease <input type="checkbox"/> hot areas <input type="checkbox"/> bruise easily	<input type="checkbox"/> varicosity <input type="checkbox"/> phlebitis <input type="checkbox"/> postural hypotension (feel faint if you stand quickly or too long)	HEADACHES (DESCRIBE) <input type="checkbox"/> Migraine <input type="checkbox"/> Cluster headaches w/Allergies <input type="checkbox"/> Headaches with nausea <input type="checkbox"/> Frontal <input type="checkbox"/> Temples <input type="checkbox"/> Occipital - base of skull		
MENTAL/NEUROLOGIC <input type="checkbox"/> slow thinking <input type="checkbox"/> fast thinking <input type="checkbox"/> forgetful <input type="checkbox"/> lack concentration <input type="checkbox"/> vertigo <input type="checkbox"/> seizures	EMOTIONAL PROBLEMS <input type="checkbox"/> depression <input type="checkbox"/> anxiety-heart palpitations <input type="checkbox"/> panic attacks <input type="checkbox"/> phobias <input type="checkbox"/> mania stress <input type="checkbox"/> irritable/angry	EYES <input type="checkbox"/> vision problems <input type="checkbox"/> blurry vision <input type="checkbox"/> photosensitivity <input type="checkbox"/> infections <input type="checkbox"/> dryness <input type="checkbox"/> redness <input type="checkbox"/> pain behind eyes	EARS <input type="checkbox"/> hearing loss <input type="checkbox"/> tinnitus <input type="checkbox"/> frequent infections <input type="checkbox"/> clogged <input type="checkbox"/> popping	NOSE <input type="checkbox"/> sinus infections <input type="checkbox"/> sinusitis <input type="checkbox"/> postnasal drip <input type="checkbox"/> deviated septum <input type="checkbox"/> loss of smell <input type="checkbox"/> bleeding <input type="checkbox"/> allergy/sniffles	
SKIN <input type="checkbox"/> acne <input type="checkbox"/> itching <input type="checkbox"/> eczema	<input type="checkbox"/> hives <input type="checkbox"/> rashes	HAIR <input type="checkbox"/> dryness <input type="checkbox"/> alopecia <input type="checkbox"/> premature graying	<input type="checkbox"/> hair loss NAILS (FINGERS/TOES) <input type="checkbox"/> dry <input type="checkbox"/> brittle <input type="checkbox"/> cracks/splits	<input type="checkbox"/> discolored <input type="checkbox"/> infected <input type="checkbox"/> ingrown	TONGUE <input type="checkbox"/> peeling areas <input type="checkbox"/> sores/blisters <input type="checkbox"/> sensitivity
MOUTH <input type="checkbox"/> lips chapped <input type="checkbox"/> cold sores <input type="checkbox"/> bleeding gums <input type="checkbox"/> periodontitis <input type="checkbox"/> lots of cavities <input type="checkbox"/> silver fillings <input type="checkbox"/> teeth loose <input type="checkbox"/> teeth hurt/ache <input type="checkbox"/> without cavities <input type="checkbox"/> Temporo-Mandibular Joint (TMJ) problems	THROAT <input type="checkbox"/> dry <input type="checkbox"/> itchy <input type="checkbox"/> sore <input type="checkbox"/> hot <input type="checkbox"/> excess mucus <input type="checkbox"/> swollen glands <input type="checkbox"/> tight <input type="checkbox"/> thyroid	VOICE <input type="checkbox"/> hoarseness <input type="checkbox"/> stuttering	BLOOD TESTS WITH IRREGULAR RESULTS: <input type="checkbox"/> high cholesterol <input type="checkbox"/> hyperthyroid (high) <input type="checkbox"/> hypothyroid (low) <input type="checkbox"/> diabetes <input type="checkbox"/> high blood sugar <input type="checkbox"/> hypoglycemic <input type="checkbox"/> low blood sugar <input type="checkbox"/> anemia <input type="checkbox"/> Candida/yeast	AUTONOMIC NERVOUS SYSTEM <input type="checkbox"/> low blood pressure <input type="checkbox"/> high blood pressure <input type="checkbox"/> cold hands/feet <input type="checkbox"/> night sweats <input type="checkbox"/> sweat easily <input type="checkbox"/> particular areas: <input type="checkbox"/> never sweat <input type="checkbox"/> often hot <input type="checkbox"/> often cold <input type="checkbox"/> slow pulse (less than 60) <input type="checkbox"/> fast pulse (more than 100)	
HEART & LUNGS <input type="checkbox"/> asthma <input type="checkbox"/> shallow breathing <input type="checkbox"/> short of breath: <input type="checkbox"/> on exertion <input type="checkbox"/> at rest <input type="checkbox"/> when lying down <input type="checkbox"/> pressure on chest <input type="checkbox"/> cough <input type="checkbox"/> chronic bronchitis <input type="checkbox"/> phlegm/mucus <input type="checkbox"/> frequent colds <input type="checkbox"/> mitral valve prolapse <input type="checkbox"/> palpitations	DIGESTION CONT'D. <input type="checkbox"/> belching <input type="checkbox"/> rumbling sounds <input type="checkbox"/> heartburn <input type="checkbox"/> ulcer <input type="checkbox"/> lack of stomach acid <input type="checkbox"/> can't digest fats <input type="checkbox"/> hiccups <input type="checkbox"/> hiatal hernia <input type="checkbox"/> stomach problems <input type="checkbox"/> liver problems <input type="checkbox"/> spleen problems <input type="checkbox"/> gall bladder problems <input type="checkbox"/> pancreas problems <input type="checkbox"/> large intestine problems <input type="checkbox"/> sm. intestines problems <input type="checkbox"/> colitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> appendix <input type="checkbox"/> ileocecal valve <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> undigested food in stool	DIGESTION CONT'D. <input type="checkbox"/> blood in stool <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> hemorrhoids <input type="checkbox"/> itching <input type="checkbox"/> burning <input type="checkbox"/> bleeding <input type="checkbox"/> flatulence <input type="checkbox"/> hernia	URINATION <input type="checkbox"/> kidneys <input type="checkbox"/> adrenal <input type="checkbox"/> bladder <input type="checkbox"/> frequent urge to urinate <input type="checkbox"/> scanty urination <input type="checkbox"/> urinary tract infections <input type="checkbox"/> frequent <input type="checkbox"/> pain or discomfort <input type="checkbox"/> color of urine: <input type="checkbox"/> golden yellow <input type="checkbox"/> pale <input type="checkbox"/> deep yellow/orange <input type="checkbox"/> stones <input type="checkbox"/> strong odor	MUSCULO-SKELETAL <input type="checkbox"/> rheumatism <input type="checkbox"/> arthritis <input type="checkbox"/> connective tissue <input type="checkbox"/> ligament disease <input type="checkbox"/> lupus erythematosis <input type="checkbox"/> upper back/spine <input type="checkbox"/> mid back/spine <input type="checkbox"/> lumbar spine <input type="checkbox"/> whiplash <input type="checkbox"/> neck <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/> wrists <input type="checkbox"/> hands <input type="checkbox"/> fingers <input type="checkbox"/> rib cage <input type="checkbox"/> pelvis sacrum <input type="checkbox"/> coccyx <input type="checkbox"/> hips <input type="checkbox"/> knees <input type="checkbox"/> shins <input type="checkbox"/> ankles	<input type="checkbox"/> feet <input type="checkbox"/> toes

Welcome to Acupuncture POINTS “your way to health”

HEALTH INSURANCE ~

We are often asked, “**Do you accept insurance?**” The simple answer is “no”. **However**, it may still be possible for you to **get reimbursed** by your insurance carrier for treatment. Fortunately, more and more insurance companies are now covering acupuncture treatment, but we still have a long way to go.

We have found that insurance companies are much more responsive to patients rather than providers. We will do whatever we can to help you receive reimbursement.

Here’s a brief explanation of the process. Call your insurance company today (there should be an 800 number on the back of your card). Determine if they cover acupuncture administered by a Licensed Acupuncturist (not an MD, DC or DO). They should be able to tell you how many visits are authorized, if you need pre-authorization or a physician’s referral, etc. See INSURANCE on our website.

We will provide you a receipt with the dates and specific CPT codes (Current Procedural Terminology) for acupuncture treatment. You will submit this receipt to your insurance company for reimbursement. If they require any additional information or documentation, we will be happy to provide it.

FLEX SPENDING ~

Many Flex Spending Accounts support the use of “alternative” medicine provided by licensed acupuncturists. We will provide all necessary receipts for you to submit.

CANCELLATION POLICY ~

While we do understand that sometimes it can’t be avoided, we reserve the right to a \$50 charge for acupuncture appointments cancelled or broken without 24 hours notice and the full fee for cancelled massage appointments without 24 hours notice.

I have read and fully comply with this Cancellation Policy ~ my initials: _____

REFERRALS ~

The highest compliment our patients can pay us is the referral of their friends or family. Thank you for your trust. To show our appreciation, we offer a reduced fee for your next acupuncture session for each activated referral.

PLEASE EXCUSE ANY DELAYS ~

The nature of our business is to give our patients the utmost in care and service. We will give you the same care and attention as soon as possible.

SUPPLEMENTS ~

While we often recommend supplements and herbs to our patients, you are under no obligation to purchase from us. We offer convenience, competitive prices and advice; however you may find better prices elsewhere. We encourage you to make the best decisions for yourself.