Adam Acupuncture

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Last Name: First Name: Sex: Preferred Pronouns: Date of Birth:

Address: City: State: Zip:

Home Phone#: Cell Phone#: Email: (for appointment reminders)

In case of an Emergency Contact: Relationship: Phone#:

Occupation: How did you hear about us? / Referred by: Family Physician & Phone:

MAIN PROBLEM(S) YOU WOULD LIKE HELP WITH:

How does it interfere with your activities? When did you first notice your symptoms?

Have you been given a diagnosis by your family physician? If so, what is it?

What kind of treatments or therapies have you tried?

HIPAA Patient Consent

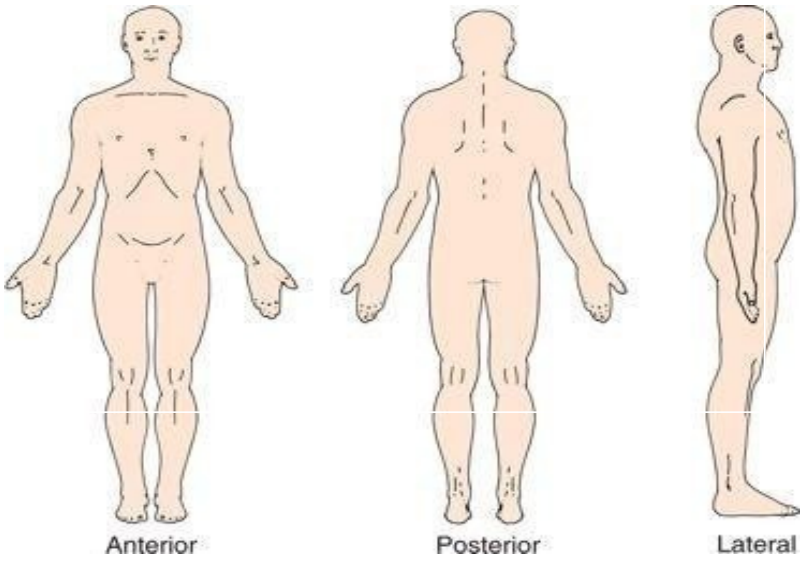
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Polices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The practice may condition treatment upon the execution of this Consent

Patients Signature Print Date

Witness Signature Print Date

PLEASE MARK AREAS OF PAIN OR DISTRESS:



Please mark pain level today:

- ☐ 10 Worst imaginable
- ☐ 9
- ☐ 8
- ☐ 7
- ☐ 6
- ☐ 5 Barely tolerable without medicine
- ☐ 4
- ☐ 3
- ☐ 2
- ☐ 1 No problem
- ☐ 0 None

Accidents, surgeries, or significant trauma:

Occupational stress factors:

PAST MEDICAL HISTORY-please note dates

☐ Cancer	☐ High blood pressure	☐ Thyroid disease	☐ Hepatitis	☐ Seizures
☐ Diabetes	☐ Heart Disease	☐ Venereal disease	☐ HIV/AIDS	☐ Other significant illness

LIFESTYLE:

What medications or supplements are you currently taking? (dosage/frequency)?

Please indicate usage per day/per week:

☐ Cigarettes	☐ Alcohol	☐ Drugs
☐ Caffeine	☐ Sugar	☐ Other

Are you on a special diet? Please specify:

How active are you? Exercise / frequency / intensity?

CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

☐ Poor appetite ☐ Weight loss/gain ☐ Fever ☐ Chills
☐ Night sweats ☐ Cravings ☐ Changes in appetite ☐ Thirst
☐ Sweating easily ☐ Localized weakness ☐ Poor Balance ☐ Edema
☐ Insomnia ☐ Disturbed sleep ☐ Bleeding or bruising easily
☐ Sudden energy drop (time of day_____) ☐ Tremors

Other unusual or abnormal conditions you have noticed in your general sense of health

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SKIN AND HAIR

☐ Rashes ☐ Moles ☐ Itching ☐ Hair Loss
☐ Ulcerations ☐ Changes in hair or skin texture, acne

Any other hair or skin problems: (please specify)

HEAD, EYES, EARS, NOSE, THROAT

☐ Recurrent sore throat ☐ Dry eyes ☐ Earaches
☐ Sores on tongue/lips ☐ Eye pain ☐ Sinus problems
☐ Dizziness ☐ Spots in front eyes ☐ Facial pain
☐ Concussions ☐ Cataracts ☐ Jaw clicks
☐ Poor vision/Night blindness ☐ Change in taste ☐ Grinding teeth
☐ Headaches, Ear ringing, Hearing loss (where?_____ when?_____)

Any other head or neck problems: (please specify)

CARDIOVASCULAR AND RESPIRATORY

☐ Dizziness ☐ High blood pressure ☐ Fainting
☐ Blood clots ☐ Difficulty in breathing ☐ Phlebitis
☐ Swelling of feet ☐ Swelling of hands ☐ Chest pain
☐ Cold hands or feet ☐ Irregular heartbeat ☐ Asthma
☐ Coughing up blood ☐ Pain with breathing ☐ Pneumonia
☐ Bronchitis ☐ Excessive phlegm (color_____ _)

GASTROINTESTINAL

☐ Belching, Constipation ☐ Nausea/Vomiting ☐ Black stools

☐ Diarrhea ☐ Hemorrhoids/Indigestion ☐ Gas

☐ Abdominal pain/cramps ☐ Bad Breath/ Bad taste in mouth

Any other problems with stomach or intestines?_____

GENITOURINARY AND REPRODUCTIVE

☐ Pain on urination ☐ Urgency to urinate ☐ Blood in urine

☐ Sores on genitals ☐ Unable to hold urine ☐ Kidney stones

☐ Frequent urination ☐ Change in sex drive ☐ Decrease in flow

Do you wake up at night to urinate?_____ If so how often?_____
Any particular color to your urine?_____ Other problems?_____

☐ Premenstrual changes ☐ Heavy/Irregular/Light (menses) ☐ Miscarriages

☐ Painful menses ☐ Abortions

☐ Unusual menses ☐ Other problems

Are you pregnant now, or trying to become pregnant?_____Age at first menses_____
Age at menopause_____ Number of pregnancies_____
Time between cycles_____Duration of bleeding_____ First date of last menses_____
Do you practice birth control?_____ If so what type?_____ For how long?_____
Any other gynecologic problems:_____

MUSCULOSKELETAL

☐ Neck pain ☐ Back pain ☐ Hip pain

☐ Hand/wrist pains ☐ Areas of numbness ☐ Shoulder pain

☐ Foot/ankle pains ☐ Muscle weakness ☐ Knee pain

Any other problems:_____

NEUROPSYCHOLOGICAL

☐ Depression ☐ Poor memory ☐ Anxiety

☐ Easily susceptible to stress ☐ Lack of coordination ☐ Bad temper

Have you ever been treated for emotional problems?_____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems?_____

COMMENTS

Please list any other problems you would like to discuss:

_____

_____

_____

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Financial Policy:
Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All Patients must complete our Patient Information Sheet before seeing the physician.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS.

Regarding Insurance:
We do not accept insurance nor do we file claims. We will provide a superbill upon request so that you may file for reimbursement with your insurance. We do not guarantee reimbursement.

Usual and Customary Rates (UCR)
Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that, at times, perhaps all the services may be "non-covered" services and not considered reasonable and necessary under your medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments:
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and maintain your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Returns:
We are unable to refund for any personalized formulas, raw herbs, powdered herbs or outdated herbs. We can refund for patented formulas within 30 days of purchase that are unopened and have no markings on the bottle.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.
A photocopy of this form shall be considered as effective as the original.

Signature of Patient or Responsible Party Date