Kendra Lay, AP, DOM, ACN
Be Well Healing Arts, LLC at Jacksonville Chiropractic & Acupuncture

Acupuncture Intake Form

Full Name		Sex ☐ F ☐ M	Date
Date of Birth	Age	Occupation	
Main Phone #		Other Phone #	
E-mail Address			
Allow Email Communication? ☐ Yes ☐ No			
Address: Street	City	State	Zip
Emergency Contact Name & Phone:			
Family Physician		Chiropractor	
How did you hear about us? ☐ *Friends/Relatives (name)*_____ ☐ *Website* ☐ *Event* ☐ *Advertisement* ☐ *Referred by*_____ ☐ *Other (please specify)* _____			

Main Health Concerns:

1.) _____ 2.) _____3.) _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

Are there other health concerns you'd like to work on? _____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Medicines: taken within the last two months and what you take them for (including vitamins, OTC drugs, etc.):

_____

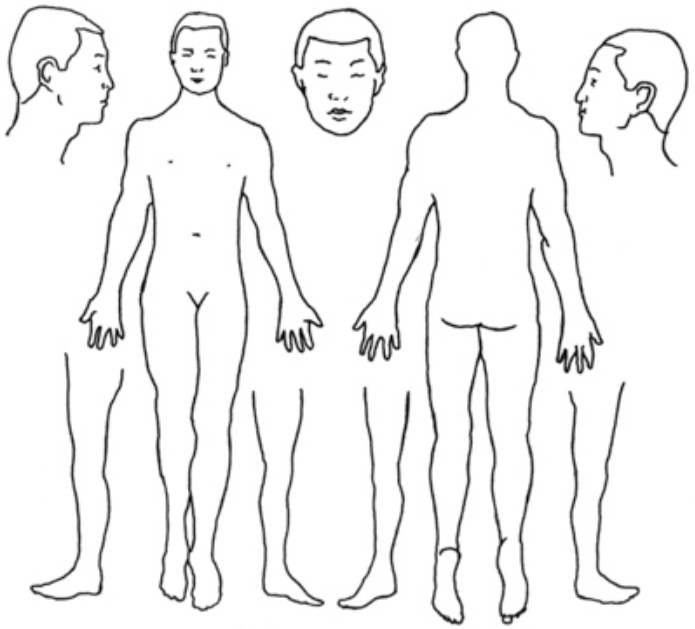
_____

_____

Diet:

Do you adhere to any specific diet? Restrictions? _____

Indicate painful or distressed areas:



How would you describe the pain?
__dull/achy __ sharp/stabbing
__fixed __burning __tingling
__weakness __numbness

What makes it better?
__heat __cold __movement __rest
__pressure __nothing other: _____

What makes it worse?
__heat __cold __damp weather/rain
__rest __movement __pressure
other" _____

Severity (circle)
Mild 1 2 3 4 5 6 7 8 9 10+

General:	☐ Poor appetite	☐ Poor sleep	☐ Fatigue	☐ Fevers	☐ Chills
☐ Night sweats	☐ Sweat easily	☐ Tremors	☐ Change in appetite	☐ Strong thirst	
☐ Poor balance	☐ Bleed or bruise easily	☐ Localized weakness	☐ Weight loss	☐ Weight gain	
Skin & hair:	☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching	☐ Eczema
☐ Pimples	☐ Acne	☐ Dandruff	☐ Dry skin	☐ Recent moles	☐ Loss of hair
☐ Purpura	☐ Change in hair or skin texture		☐ Other?		
Musculoskeletal:	☐ Joint disorders	☐ Muscle weakness	☐ Pain/soreness in the muscles		☐ Tremors
☐ Cold hands/feet	☐ Difficulty walking	☐ Swelling of hands/feet	☐ Spinal curvature	☐ Back pain	☐ Hernia
☐ Numbness	☐ Tingling	☐ Paralysis	☐ Neck tightness	☐ Neck pain	☐ Shoulder pain
☐ Hand/wrist pain	☐ Hip pain	☐ Knee pain	☐ Joint sprain	☐ Other?	
Head, eyes, ears, nose, & throat:		☐ Dizziness	☐ Concussions	☐ Migraines	☐ Glasses/lens
☐ Eye strain	☐ Eye pain	☐ Color blindness	☐ Night blindness	☐ Poor vision	☐ Cataracts
☐ Blurry vision	☐ Earaches	☐ Ringing in ears	☐ Poor hearing	☐ Spots in front of eyes	

□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain □ Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other?

Cardiovascular: □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting
□ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other?

Respiratory: □ Cough □ Coughing blood □ Wheezing □ Difficulty breathing
□ Bronchitis □ Pneumonia □ Chest pain □ Production of phlegm – What color? _____

Gastrointestinal: □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas
□ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain
□ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological: □ Loss of balance □ Lack of coordination □ Concussion
□ Depression □ Anxiety □ Stress □ Bad temper □ Bi-polar

Genito-urinary: □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate
□ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection □ Genital pain □ Genital itching □Genital rashes □ STD □ Other?

Female: □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge
□ Fibroids □ Ovarian cysts □ Irregular periods □ Clots □ Pain/cramps prior/during periods
□ Breast tenderness □ Breast Lumps □ Fertility Problems □ Hot flashes □ Moodiness related to periods
_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions
_____ Premature births _____ C-section _____ Difficult delivery
First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days
Do you practice birth control ? □ Yes □ No. If yes, what type and for how long? _____
Is there any chance you are pregnant? □ Yes □ No

Male: □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems
□ Frequent seminal emission □ Fertility problems □ Painful/swollen testicles □ Other

I have completed this form correctly to the best of my knowledge.

Signature: □ Adult Patient □ Parent or Guardian □ Spouse

_____**Date:** _____

Be Well Healing Arts, LLC at Jacksonville Chiropractic & Acupuncture

HIPAA Acknowledgement and Appointment Reminders

I acknowledge that I have been provided access to the Be Well Healing Arts, LLC "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that Be Well Healing Arts, LLC staff members and associates may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners. By signing this form, I am giving Be Well Healing Arts, LLC authorization to contact me with these reminders and to utilize my information for research and educational purposes.

_____

Patient Name (print) Date

_____

Signature

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Be Well Healing Arts the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____

New Patient Information

Cancellation Policy - Treatments are by appointment, although walk- ins are occasionally accepted. Should the clinic need to close due to inclement weather or other severe circumstances, Be Well Healing Arts, LLC will post the closing or schedule change on its website. If you find that you need to cancel an appointment, it is important that we receive 24- hour notice. This enables us to fill the time slot. **We reserve the right to charge the full fee for an appointment canceled with less than 24- hour notice or for a "no show" appointment.** We will use our discretion when charging "No Show" fees. Also, the clinic reserves the right to charge the full scheduled fee for tardiness to appointments.

Payment for Clinic Services Rendered - Payment is due at the time of service and may be paid in cash, with most major credit cards, a medical savings account card, flexible spending account card or health savings accounts card. We are not in-network providers for any insurance companies. If you have out of network insurance coverage for acupuncture we would be happy to file claims for you. Please note that regardless of insurance coverage, you are ultimately responsible for providing payment for your appointments.

_____

Patient Signature Required Date

Be Well Healing Arts, LLC at Jacksonville Chiropractic & Acupuncture

Acupuncture Informed Consent to Treatment

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturists on staff at Be Well Healing Arts, LLC who now or in the future treat me while employed by, working or associated with or substituting for Be Well Healing Arts, LLC, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as nutritional supplements; dietary recommendations; cosmetic acupuncture; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my professional practitioners, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 at Be Well Healing Arts, LLC.

Patient's name (please print)	Patient's signature
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
Signature of Patient's Representative (if applicable)	Date Signed

Be Well Healing Arts, LLC at Jacksonville Chiropractic & Acupuncture

Acupuncture Summary of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you may access this data. We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if would like to read the complete details.

I. How we may use and share health data about you:
a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices
I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from Be Well Healing Arts, LLC at any time.

_____

Signature of Patient or Representative Date