New Patient Intake Form

Today's Date _____/_____/_____

Name | Marital Status: _____ | Birthdate / / Age _____

Address _____ ☐ Male ☐ Female

_____ Ht _____ Wt _____

Email | Occupation

Home Phone | Work | Cell

Referred by

Reason for visit today | Have you had acupuncture before? Chinese herbal medicine?

How long have you had this condition?

Is it getting worse? Does it bother your ☐sleep ☐work ☐other (specify)?

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? ☐ Yes ☐ No if yes, for what?

Physician's name: | Physician's phone:

Other concurrent therapies:

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
	☐ Asthma		☐ Heart Disease	☐ Stroke
	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	

Your Past Medical History:

☐ AIDs/HIV	☐ Emphysema	☐ Mumps	☐ Cancer type:	☐ Tuberculosis
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker (Date:)	treatment:	☐ Typhoid fever
☐ Allergies	☐ Goiter	☐ Pleurisy		☐ Ulcers
☐ Appendicitis	☐ Gout	☐ Pneumonia		☐ Venereal disease
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Surgery (list)	☐ Whooping cough
☐ Asthma	☐ Hepatitis (Type:)	☐ Rheumatic fever		☐ Other
☐ Birth Trauma	☐ Herpes (Type:)	☐ Scarlet fever		
(your own birth)	☐ High Blood Pressure	☐ Seizures	☐ Major trauma (car,fall, pls list)	
☐ Chicken Pox	☐ Measles	☐ Stroke		
☐ Diabetes (Type:)	☐ Multiple Sclerosis	☐ Thyroid disorders		

Your Diet:

Appetite ☐ Low ☐ High

☐ Coffee/Tea ☐ Soft Drinks/ Fruit Juices

☐ Artificial Sweeteners ☐ Sugar ☐ Salty foods

Protein Intake ☐ Low ☐ High

Thirst for water: # glasses per day:

Pharmaceuticals (name and dosage):

Vitamins/Supplements (name and dosage):

Your Lifestyle:

☐ Alcohol ☐ Marijuana ☐ Stress
☐ Tobacco ☐ Drugs ☐ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms:

☐ Poor appetite ☐ Poor sleep ☐ Bodily heaviness ☐ Chills ☐ Bleed or bruise easily
☐ Heavy appetite ☐ Heavy sleep ☐ Cold hands or feet ☐ Night sweats ☐ Peculiar taste (Describe)
☐ Like cold drinks ☐ Dream-disturbed sleep ☐ Poor circulation ☐ Sweat easily _____
☐ Like hot drinks ☐ Fatigue ☐ Shortness of breath ☐ Muscle cramps _____
☐ Weight loss/gain ☐ Lack of strength ☐ Fever ☐ Vertigo/dizziness _____

Head, Eyes, Ears, Nose, Throat

☐ Glasses (age?) ☐ Night blindness ☐ Gum problems ☐ Recurrent sore throat ☐ Headaches
☐ Eye strain ☐ Myopia/Presbyopia ☐ Sores on lips/tongue ☐ Swollen glands ☐ Migraines
☐ Eye pain ☐ Glaucoma ☐ Dry mouth ☐ Lumps in throat ☐ Concussions
☐ Red eyes ☐ Cataracts ☐ Excessive saliva ☐ Enlarged thyroid Other head or neck problems
☐ Itchy eyes ☐ Teeth problems ☐ Sinus problems ☐ Nosebleeds _____
☐ Spots in eyes ☐ Grinding teeth ☐ Excessive phlegm ☐ Ringing in ears _____
☐ Poor vision ☐ TMJ Color: ☐ Poor hearing _____
☐ Blurred vision ☐ Facial pain ☐ Earaches

Respiratory

☐ Difficulty breathing wh ☐ Tight chest ☐ Cough ☐ Color of phlegm: ☐ Coughing up blood
lying down ☐ Asthma/wheezing Wet or Dry? _____ _____ ☐ Pneumonia
☐ Shortness of Breath □ Difficult inhale? Exhale? Thick or thin? _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Tachycardia ☐ Phlebitis
☐ Blood clots ☐ Fainting ☐ Difficulty breathing ☐ Heart palpitations ☐ Irregular heartbeat/ Afib

Gastrointestinal

☐ Nausea ☐ Diarrhea ☐ Intestinal pain/cramps Bowel movements:
☐ Vomiting ☐ Constipation ☐ Burning anus
☐ Acid regurgitation ☐ Black stools ☐ Rectal pain Frequency_____ Texture/form_____
☐ Gas ☐ Bloody stools ☐ Anal fissures
☐ Hiccup ☐ Mucous in stools ☐ Laxative use Color_____ Odor_____
☐ Bloating ☐ Hemorrhoid What kind?
☐ Bad breath ☐ Itchy anus How often?

Musculoskeletal

☐ Neck/shoulder pain ☐ Upper back pain ☐ Joint pain ☐ Limited range of motion ☐ Other
☐ Muscle pain ☐ Low back pain ☐ Rib pain ☐ Limited use _____

Skin and Hair

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Change in hair/skin texture Other (Specify)
☐ Hives ☐ Psoriasis ☐ Itching ☐ Fungal infections _____
☐ Ulcerations ☐ Acne ☐ Hair Loss _____

Neuropsychological

☐ Seizures ☐ Poor memory ☐ Irritability ☐ Considered/attempted Other (Specify)
☐ Numbness ☐ Depression ☐ Easily sressed suicide _____
☐ Tics ☐ Anxiety ☐ Abuse survivor ☐ Seeing a therapist _____

Genitourinary

☐ Pain on urination ☐ Blood in urine ☐ Venereal disease ☐ Increased libido ☐ Impotence
☐ Frequent urination ☐ Unable to hold urine ☐ Bedwetting ☐ Decreased libido ☐ Premature ejaculation
☐ Urgent urination ☐ Incomplete urination ☐ Wake to urinate ☐ Kidney stone ☐ Nocturnal emission

Gynecology

☐ Age menses began ☐ Duration of flow ☐ Vaginal discharge ☐ Breast lumps Date of last PAP
_____ _____ days (color)_____ # Pregnancies_____ _____
Length of cycle (day 1-day 1) ☐ Irregular periods ☐ Vaginal sores # Live births_____ Date last period began
_____ ☐ Painful periods ☐ Vaginal odor # Premature births_____ _____
☐ PMS ☐ Clots Age at menopause_____

SARASOTA CENTER FOR ACUPUNCTURE & NUTRITION

INFORMED CONSENT TO TREAT

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 above 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, nutritional counseling, botanical medicine, cosmetic acupuncture, JMT, homeopathy, gua sha, and acupuncture injection therapy. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including 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 and injection therapy. Unusual risks of acupuncture include spontaneous miscarriage, 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, at all times.

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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. 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 results are not guaranteed. 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.

By voluntarily signing below, I show 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 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 SIGNATURE_____DATE_____

Christina Captain, DAOM,L.Ac. - Leo Gallego, DOM, L.Ac.

Sarasota Center for Acupuncture & Nutrition 2650 Bahia Vista St, Suite 101,Sarasota, Florida 34239

drcaptain@SCANsrq.com SCANsrq.com (O) 941.951.1119 (F) 941.951.1129

SARASOTA CENTER FOR
ACUPUNCTURE
& NUTRITION

Consent for Communication and/or Disclosure

1. May our Patient Care Coordinator contact you:

   At home? Yes No
   If yes, may we leave the following information on your home voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

   At work? Yes No
   If yes, may we leave the following information on your work voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

2. Please indicate the number you wish us to use to contact you:

   Home:_____ Work:_____ Cell:_____

3. Please print the names of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and heath care operation):
   - NONE

   Name_____Phone_____

   Name_____Phone_____

   Name_____Phone_____

4. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:
   Name_____Phone_____

5. Please print the address where you wish billing statements and/or correspondence from our office to be sent.
   - Use my home address
   - Use this one:_____

6. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? Yes No

7. May we send you email messages, such as newsletters and Sarasota Center for Acupuncture & Nutrition updates, events and specials?
   Yes, at this email_____ No

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Sarasota Center for Acupuncture & Nutrition and give my permission to share the information as indicated with the person(s) named above.

PATIENT SIGNATURE_____DATE_____

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□ Acknowledgement of Receipt Patient Privacy Policies

I have been provided with the SCAN patient private health care information policies and procedures, including examples of the use of Private Health Information (PHI).

□ Fragrances

We are a **fragrance free** office. Many of our patients are sensitive to fragrances and odors. Please refrain from wearing perfumes/colognes and scented body lotions on the day of treatment.

□ Supplement Sales

Supplements purchased at the Sarasota Center for Acupuncture & Nutrition are refundable ONLY –if returned 30 days from date of purchase, unopened, and undamaged with a valid receipt.

By signing this form, you understand and agree with these policies.

PATIENT
SIGNATURE_____DATE_____

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SARASOTA CENTER FOR ACUPUNCTURE & NUTRITION

Financial Responsibility

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 required you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the doctor.

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

Regarding Insurance: We will verify coverage prior to treatment. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for each treatment until verification is obtained. Our fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on your treatments is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you submit all your insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event we do not accept assignment of benefits we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. In signing this document you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

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 some and at times perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other 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 cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Should a membership package be in force then upon missing an appointment without 24 hours' notice, one visit from said package shall be forfeited. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with SCAN incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay a reasonable collection expense, all court costs and a reasonable attorney's fee incurred thereby.

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.

_____ _____

Patient/Authorized Person/Responsible Party Date

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