Appointment Date:

General Information

Name ______ Date ______

Address ______ City ______ State ______ Zip ______

Married Single Partner Divorced Widowed Date of Birth ______ SS# ______

Work Phone ______ Home Phone ______ Mobile Phone ______

Email ______ Occupation ______

Emergency Contact ______ Referred By ______

Family Physician ______ Contact # ______

Have you had Acupuncture or Oriental medicine before? Yes No

Are your presently under a doctor's care? Yes No Who and for what? ______

Are there any other therapies which you are involved in? Who and for what? ______

Insurance Information

Insurance Company ______ Contact # ______

ID # ______ Co-pay $ ______ Visit # ______ Referral Yes No Covered % ______

Date called ______ Contact Name ______ Deductable amount ______

Focus

What is your primary reason for seeking care at our office? ______

What was the initial cause? ______

When did it begin? ______

What makes it worse? ______

What makes it better? ______

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other ______

What have you done about this? ______

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other ______

What are your health goals? ______

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List any past or future surgeries. ____________________

____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) ____________________

____

List exercise and sport activities you have been or are currently involved in: ____________________

____

Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm
  Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth/gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss/gain
- ❍ Wheezing

Female Concerns

Date of last menstruation ____________ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? ____________

❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

Medical History

Do you have any allergies? Yes No If so, to what? ____________________

Do you take medication? Yes No If so what types and how often ____________________

Do you take supplements? Yes No If so what types and how often ____________________

Please indicate if you or any family members have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

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Do you sleep well? Yes No Do you dream? Yes No

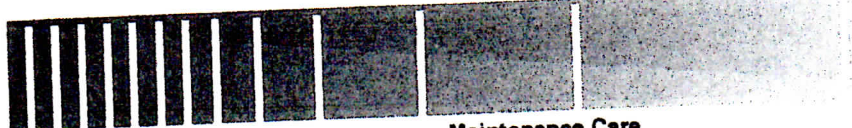
Do you have a high point during the day? Yes No When? ______ Do you have a low point during the day? Yes No When? ______

What are your indulgences? ______________________________

What are your hobbies/pleasures? ______________________________

Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.



Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

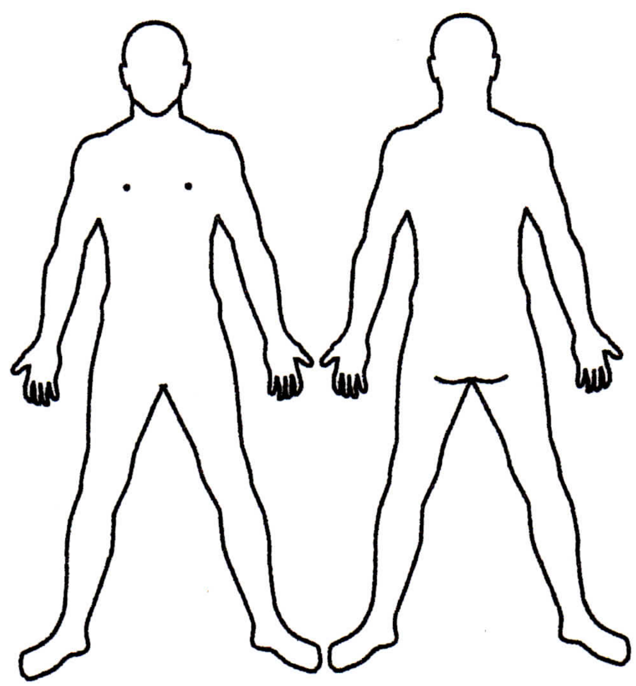
All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit



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How did you hear about Modern Point Acupuncture?______________________________

Would you like to receive our free monthly newsletter?____________________________

May we contact you by:

Mobile Phone:	Y	N
Home Phone:	Y	N
Work Phone:	Y	N
Email:	Y	N
Mail (home address):	Y	N

Cancellation Policy and Treatment Package Agreement

At least a twenty-four hour notice of cancellation of any appointment is requested by Modern Point. I understand that if I arrive more than fifteen minutes late for a scheduled appointment or do not give twenty-four hours notice of a missed appointment that the amount of the entire treatment may be deducted from my prepaid acupuncture package or I may be charged for the entire amount of the missed appointment.

I consent Modern Point to take payment for and to track the number of visits used for my prepaid acupuncture treatment package. I understand that acupuncture treatment packages are non transferrable, non refundable*, and expire one year from the date of purchase. This policy is designed for the benefit of both patients and practitioners so that appointments are available to those in need of treatment.

I have read and I understand the above information:

____
patient name printed

____________________________________ ____________________
patient signature date

____________________________________ ____________________
office signature date

*In the rare circumstance that a refund is given for a partially used treatment package the regular treatment price (notthe discounted package treatment price) is deducted from the total amount paid for the package for each treatment used.

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

Limited access to facilities where information is stored.

Policies and procedures for handling information.

Requirements for third parties to contractually comply with privacy laws.

All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information.:

About your financial transactions with us (billing transactions).

From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 763-494-9500.

I have read and understand this privacy policy:

X:____ Date:__________________