New patient Intake Form (Confidential)
Acupuncture & Natural Healing Center

Name: ______________________ Today's Date: ____________

Address: ______________________ Date of Birth: ____________

City, State: ______________________ Zip: __________ Age: __________

Work Phone: (____) ______________ Cell Phone: (____) ______________

Home Phone: (____) ______________ E-mail: ______________________

Employer: ______________________ Occupation: ______________________

Emergency Contact Name: ______________________ Phone#: ______________________

Marital Status: ______ Height: _____ Weight: _____ Referred by: ______________

Family History (please specify who. Ex: Mother, Father, Child, Brother…)

Allergies: ______________________ Heart Disease: ______________________

Asthma: ______________________ High Blood Pressure: ______________________

Alcoholism: ______________________ Stomach Disorder: ______________________

Arteriosclerosis: ______________________ Seizures: ______________________

Cancer: ______________________ Strokes: ______________________

Diabetes: ______________________ Other: ______________________

Drug Abuse: ______________________

Your Medical History (Check any of the following disorders you have)

___ Aids
___ Alcoholism
___ Allergies
___ Appendicitis
___ Arteriosclerosis
___ Asthma
___ Cancer
___ Diabetes
___ Emphysema
___ Epilepsy
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Herpes
___ High Blood Press.
___ Measles
___ Multiple Sclerosis
___ Pacemaker
___ Pleurisy
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Scarlet Fever
___ Seizures
___ Skin Disorder
___ Stomach Disorder
___ Stroke
___ Thyroid
___ Tuberculosis
___ Typhoid
___ Ulcers
___ Venereal Dis.
___ Others
____
____

Major Hospitalizations (do not include normal pregnancies)

Operation / Illness ______________ Year ______ Name of Hospital ______________ City & State ______________

______________ ______ ______________ ______________

Major Trauma (car, fall etc—list)

Medications (list medications you are currently taking)

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Your Lifestyle

(check which substances you use now or in the past and specify how much per day/week, if you quit specify how long ago)

____ caffeine ______________ ____Alcohol ______________

____ Tobacco ______________ ____Cocaine______________

____ Marijuana ______________ ____Street drugs (specify) ______________

Pregnancies

Year ____ Complications if any ______________ Year ____ Complications ______________

Year ____ Complications ______________ Year ____ Complications ______________

Physician

Date of last physical Examination __________

Name of Doctor ______________ Phone number of Doctor (____)______________

Address of Doctor ______________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my Licensed Acupuncturist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ______________________________ Date ______________

Name ______________________________ Date ____________________

What is your reason for visit? ______________________________

Please Print a "C" for current conditions OR a "P" for previous conditions you experienced in the past.

General Symptoms
___ Recent weight loss/gain
___ Fever
___ Fainting
___ Chills
___ Agitation
___ Dizziness
___ Numbness
___ Nervousness
___ Irritability
___ Other

Skin
__ Itching
__ Dryness
__ Eczema
__ Rashes
__ Hives
__ Changes in moles or lumps
__ Sore that won't heal
__ Scars
__ Other

General Conditions
__ Anorexia
__ Arthritis
__ Mononucleosis
__ Bronchitis
__ Bulimia
__ Cataracts
__ Goiter
__ Hernia
__ High Cholesterol
__ HIV Positive
__ Kidney disease
__ Liver disease
__ Prostate Problem
__ Other

Head and Neck
__ Enlarged Lymph glands
__ Headache
__ Other

Nose, Throat, Mouth
__ Nosebleeds
__ Bleeding Gums
__ Sinus problems
__ Hay fever
__ Sore throat
__ Hoarseness
__ Oral ulcers
__ Other

Ears
__ Decreased hearing
__ Infection
__ Discharge
__ Ringing
__ Other

Eyes
__ Blurred vision
__ Visual Changes
__ Spots/floaters
__ Poor night vision
__ Glaucoma
__ Bleeding
__ Other

Respiratory
__ Difficulty breathing
__ Coughing up blood
__ Wheezing/asthma
__ Frequent colds
__ Chronic cough
__ Coughing up phlegm
__ Shortness of breath
__ Other

Cardiovascular
__ Chest pain/tightness
__ Palpitations
__ Rapid heart beat
__ Irregular heartbeat
__ Swelling of ankles
__ Phlebitis
__ Blood clots
__ Other

Emotional
__ Suicide attempt
__ Depression
__ Anxiety
__ Abuse survivor
__ Seeing a therapist
__ History of psychiatric treatment
__ Other

Gastrointestinal
__ Nausea/Vomiting
__ Acid regurgitation
__ Bad breath
__ Stomach Pain
__ Excess hunger
__ Excess Thirst
__Vomiting blood
__ Blood in stool
__ Black stool
__ Hemorrhoid
__ Gall bladder disease
__ Food cravings
__ Other

Muscle and joint
__ Sore Muscles
__ Weak Muscles
__ Difficulty walking
__ Spinal curvature
__ Other

Neurological
__ Tremors
__ Tingling of limbs
__ Paralysis
__ Other

Male
__ Pain/itching of genitalia
__ Genital lesions
__ Discharge
__ Impotence
__ Urination problem
__ Lumps in testicles
__ Prostate problem
__ Other

Female
__ frequent UTI
__ frequent vaginal infections
__ pain/itching of genitalia
__ Genital lesions
__ Discharge
__ Pelvic inflammatory
__ Abnormal PAP smear
__ Bleeding between periods
__ Nipple discharge
__ Breast Lump
__ Painful intercourse
__ Endometriosis
__ Other

Infection screening
__ HIV
__ TB
__ Hepatitis
__ Sexually transmitted disease Gonorrhea/Chlamydia/Syphillis/Warts
__ Other

Acupuncture and Natural Healing Center
47 Raritan Ave, Suite 140
Highland Park, NJ 08854
732-463-0984

PATIENT'S ADVISORY TO CONSULT A PHYSICIAN

To comply with NJ PL 2009 (C.45:2C-5a-2), Acupuncture and Natural Healing Center requests that you read and sign the following statements:

I, the undersigned affirm that

____________________________ (patient)

has been advised by Carole B. Bishop to consult a licensed physician

regarding the condition or conditions which the above patient seeks treatment for through this clinic.

____ ________________

(Signature of the Patient) or representative (Date)

____ ________________

(Signature of the Licensed Acupuncturist. L. Ac) (Date)

Informed Consent for Acupuncture Treatment and Care

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine by Licensed Acupuncturist named below. I have discussed the nature and purpose of my treatment with the Licensed Acupuncturist named below.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation and Tui Na (Chinese Massage), Chinese or Western herbal medicine and nutritional counseling.

I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising, numbness or tingling near the needling sites that may last a few days. There have been rare instances reported of dizziness or fainting and infection. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Burns and/or scarring are a potential risk of moxibustion. 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), which may be recommended, are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify licensed acupuncturist named below of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the licensed acupuncturist named below who is caring for me if I am or become pregnant.

I do not expect licensed acupuncturist named below to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the licensed acupuncturist named below to exercise judgment during the course of treatment which the licensed acupuncturist named below thinks at the time, based upon the facts known to them, is in my best interests.

I understand the licensed acupuncturist named below will keep all of my records confidential and is compliant with the Health Insurance Portability & Accountability Act (HIPAA).

I understand that if I fail to give 24 hour notice when I am unable to keep an appointment, I am responsible for the fee of the missed appointment.

I have read or have read to me the above consent. I have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

______________ (Date Consent Completed)

________________________________ ________________________________

Print patient name or representative Relationship of authority

________________________________ ________________________________

Signature of patient or representative Signature of Licensed Acupuncturist

PAIN ASSESSMENT

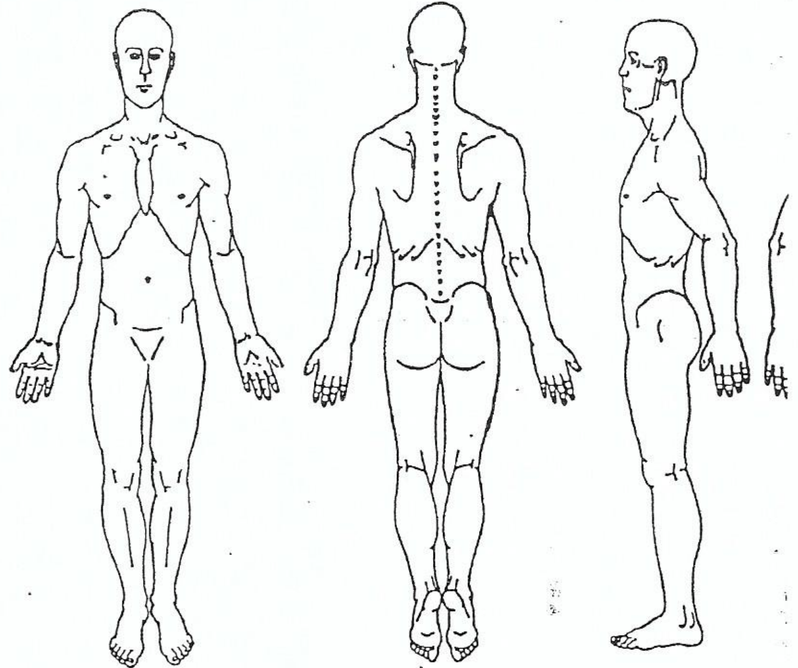
NAME:____________________

DATE:______________

PAIN INTENSITY
(Use Scale Below)
Worst Pain Gets: ____
Best Pain Gets: ____
Pain At Present: ____

0 - No Pain
1-3 - Just Noticeable
4-7 - Moderate
8 - Severe
9 - Very Severe
10 - Excruciating

WHERE IS YOUR PAIN LOCATED?



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PAIN MEDICATION / DOSAGE?

____

____

____

____

****

PERCENT % OF TIME YOU HAVE PAIN

0 ______ 25 ______ 50 ______ 75 ______ 100

****

CIRCLE THE WORDS THAT DESCRIBE YOUR PAIN

Tender	Throbbing	Tightness
Stabbing	Cramping	Aching
Sharp	Dull	Squeezing
Burning	Sore	Other:
Feels like an electric shock	Pressure	__________

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When did your pain begin?______________________
Is your pain constant?______________________
When is your pain the worst?______________________
What makes the pain better?______________________
Does the pain disturb your sleep?______________________
Are you getting better, worst, staying the same?______________________
Previous Treatment:______________________
Diagnostic Tests:

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Office Policy

It is important that you understand that health and accident policies are a contract between you and your insurance company. We are out of network providers, except for Horizon Blue Cross Blue Shield. Some insurance do cover out of network providers. We can bill and fill out all the necessary insurance form for you.

If your deductible has not been met, it should be paid on the first set of visits.

We ask for at least 24 hour notice for All cancellations so those patients waiting for an appointment can have one.

There is a $30.00 charge for any checks returned from the bank.

Sometimes medical insurance companies may send payments to me and I agree to return the check and all statements to the acupuncture office to bring my records up to date.

Release of Information

By signing this form you are authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim.

I have read and agree to the above.

______________________________ ______________

Signature **Date**

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACUPUNCTURE & NATURAL HEALING CENTER
CAROLE B. BISHOP, L.Ac., MS
47 Raritan Ave., Suite 140
Highland Park, NJ 08904

Telephone: (732) 463-0984

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ____ Birthdate __________________

Signature ____

Date ____