ACUPUNCTURE & HEALING ARTS MEDICAL GROUP
www.acupuncturememphis.com

5575 Poplar Ave, Suite 702
Memphis, TN 38119
901-763-0909 fax: 901-763-4060

Patient Intake Form

Date:

Last Name	First Name	Middle Initial	Male / Female	Date of Birth	Marital Status	Are you pregnant?

Street Address	Home Phone	Work Phone

City	State	Zip	Cell Phone	E-mail

Occupation	Employer	Have you had acupuncture? Y N Referred by:

Primary Physician	Last date MD consulted	Emergency contact name	Emergency contact phone number

What is your present complaint/concern?

_____

_____

_____

Significant Past Illnesses

☐ Cancer	☐ Diabetes	☐ HIV+	☐ Heart Disease	☐ Fibromyalgia
☐ Thyroid Disease	☐ Seizures	☐ CFS/EBS	☐ Epilepsy	☐ Hepatitis
☐ Rheumatic Fever	☐ Chicken Pox	☐ Stroke	☐ Measles	☐ Hypoglycemia
☐ High Blood Pressure	☐ Meniere's	☐ Mumps	☐ Mono	☐ Polio

Other Illnesses: _____

Surgeries (include procedure and date)

_____

_____

Significant Traumas (include auto accidents, falls, broken bones, etc.)

_____

_____

Family Medical History

Please indicate Mother, Father, Sister, or Brother

☐ Diabetes M F S B	☐ Alcoholism M F S B	☐ Seizures M F S B	
☐ Asthma M F S B	☐ Mental Illness M F S B	☐ Emphysema M F S B	
☐ Arthritis M F S B	☐ Stroke M F S B	☐ High Blood Pressure M F S B	
☐ Allergies M F S B	☐ Obesity M F S B	☐ Other _____ M F S B	
☐ Heart Disease M F S B	☐ Thyroid Problems M F S B		

Habits

☐ Cigarettes	☐ Tea	☐ Drugs	☐ Sugar	☐ Other _____
☐ Coffee	☐ Cola	☐ Alcohol	☐ Salt	

Do you have any infectious diseases? Y N If yes, please identify _____

Height: _____ **Weight: Currently** _____ **Past Maximum** _____ **When?** _____

Blood Pressure: What is your most recent blood pressure reading? _____ / _____

When was this reading taken? _____

Physical Symptoms

Please check all symptoms you have experienced during the past 6 months. Circle those that have been the most troublesome.

General

- ☐ Poor Endurance
- ☐ Sleep (Avg ___ hrs)
- ☐ Insomnia
- ☐ Wakens easily
- ☐ Unable to fall asleep
- ☐ Heavy Sleep
- ☐ Unable to stay asleep
- ☐ Dream disturbed sleep
- ☐ Nightmares
- ☐ Localized weakness
- ☐ Awaken fatigued
- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Gnawing hunger
- ☐ Food cravings
- ☐ Peculiar tastes/smells
- ☐ Change in appetite
- ☐ Obesity
- ☐ Recent weight loss/gain
- ☐ Tire easily
- ☐ Fevers
- ☐ Chills
- ☐ Cold back
- ☐ Cold abdomen
- ☐ Sweat easily
- ☐ Excessive sweating
- ☐ Lack of perspiration
- ☐ Night sweats
- ☐ Sudden energy drop @___time
- ☐ Fatigue
- ☐ Vertigo
- ☐ Chills easily
- ☐ Low fever, late afternoon or evening
- ☐ Blood transfusion
- ☐ Cold hands/feet
- ☐ Poor coordination
- ☐ Jaundice
- ☐ Anemia
- ☐ Tremors
- ☐ Aversion to talking
- ☐ Strong thirst cold/hot drinks
- ☐ Bleed or bruise easily (where? _____)
- ☐ Cuts bleed excessively
- ☐ Takes afternoon rests/naps
- ☐ Most energized in the am
- ☐ Most energized in the pm
- ☐ Prolonged recovery following illness

Overall energy level: ☐very high ☐ high ☐ medium ☐ low ☐ very low

Skin & Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Ulcerations
- ☐ Psoriasis
- ☐ Fingernail problems
- ☐ Hair/skin changes
- ☐ Pimples/boils
- ☐ Purpura
- ☐ Warts/growths
- ☐ Hives
- ☐ Boils
- ☐ Dandruff
- ☐ Itching
- ☐ Fungal infections
- ☐ Loss of hair
- ☐ Cracks
- ☐ Shingles
- ☐ Dry hair/skin
- ☐ Brittle hair
- ☐ Limp hair
- ☐ Painful scars
- ☐ Lumps or bumps
- ☐ Pasty/pale complexion
- ☐ Other hair/skin problems

Head

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
  When? _____
  Where? _____
- ☐ Headaches
- ☐ Paralysis
- ☐ Eye strain
- ☐ Color blindness
- ☐ Eye pain/itch
- ☐ Cataracts
- ☐ Spots in eyes/floaters
- ☐ Eyes watering
- ☐ Double vision
- ☐ Blurry vision
- ☐ Dry eyes
- ☐ Poor vision
- ☐ Night blindness
- ☐ Glaucoma (pressure in eyes)
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Frequent head colds
- ☐ Earaches
- ☐ Loss of balance
- ☐ Mucus
- ☐ Ear drainage
- ☐ Hoarse voice
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Facial pain
- ☐ Mouth/lip sores
- ☐ Jaw clicks
- ☐ Sinus infections
- ☐ Sneezing spells
- ☐ Teeth problems
- ☐ Loss of teeth
- ☐ Teeth hurt
- ☐ Sore/bleeding gums
- ☐ Bad taste in mouth
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Loose teeth
- ☐ Bad breath
- ☐ Difficulty swallowing
- ☐ Nasal congestion
- ☐ Glasses
- ☐ Recurrent sore throat
- ☐ Grinds teeth
- ☐ Sore tongue
- ☐ Facial pain/tics
- ☐ Excess saliva
- ☐ Stuffy/runny nose
- ☐ Nose bleeds
- ☐ Sinus pressure
- ☐ Sinus congestion
- ☐ Post nasal drip

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain/pressure
- ☐ Rapid heart beat
- ☐ Blood clots
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Fainting
- ☐ High cholesterol
- ☐ Vascular spiders
- ☐ Leg cramps
- ☐ Swelling in hands/feet
- ☐ Varicose veins
- ☐ Blood disorder
- ☐ Raynaud's disease
- ☐ Skipped heartbeats
- ☐ Phlebitis (inflamed veins)
- ☐ Mitral valve prolapse

Respiratory

- ☐ Cough
- ☐ Shortness of breath
- ☐ Coughing blood
- ☐ Asthma
- ☐ TB
- ☐ Tight chest
- ☐ Wheezing or gasping
- ☐ Dry cough
- ☐ Bronchitis
- ☐ Seasonal allergies
- ☐ Frequent colds
- ☐ Emphysema
- ☐ Excessive phlegm
- ☐ Whooping cough
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ How many pillows used? ___

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Belching
- ☐ Food sits in stomach
- ☐ Bitter taste in mouth
- ☐ Ulcer
- ☐ Hiatal hernia
- ☐ IBS
- ☐ Acid reflux
- ☐ Indigestion
- ☐ Bad breath
- ☐ Constipation
- ☐ Diarrhea/loose stool
- ☐ Sweet taste in mouth
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Colitis
- ☐ Stomachache
- ☐ Pain/cramps
- ☐ Rectal pain/itch
- ☐ Bloody stools
- ☐ Black stools
- ☐ Intestinal gurgling
- ☐ Colon problems
- ☐ ST problems
- ☐ Bowel frequency
- ☐ Hemorrhoids
- ☐ Number of daily BMs ___
- ☐ Recent weight loss/gain
- ☐ Laxative use
- ☐ Fecal incontinence
- ☐ Bloating
- ☐ Parasites

Genitourinary

- ☐ Burning/pain with urination
- ☐ Unable to hold urine
- ☐ Wake up to urinate
- ☐ Frequent urination
- ☐ Weakened urine stream
- ☐ Cloudy urine
- ☐ Kidney stones
- ☐ Dribble urine with sneeze
- ☐ Difficulty or slow starting stream
- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ VD
- ☐ Herpes
- ☐ Flank pain
- ☐ Urgency to urinate
- ☐ Painful sex
- ☐ Change in sexual energy
- ☐ Infertility
- ☐ Bedwetting

Women

- ☐ Vaginal burning/itching
- ☐ Vaginal discharge
- ☐ Yeast
- ☐ Vaginal sores
- ☐ Itch
- ☐ Vaginal bleeding between periods
- ☐ Number of pregnancies
- ☐ Endometriosis
- ☐ Change in flow
- ☐ Ovarian cysts
- ☐ Vaginal infections
- ☐ Last menstrual period
- ☐ Number of births
- ☐ Premature births
- ☐ Miscarriages
- ☐ Age of first menses
- ☐ Duration of periods
- ☐ Last Pap
- ☐ Last mammogram
- ☐ Fibroids
- ☐ Water retention
- ☐ Abortions
- ☐ Sexually active
- ☐ Irregular menses
- ☐ Clots
- ☐ Painful menses
- ☐ Birth control
- ☐ Now pregnant
- ☐ Breast lumps
- ☐ Breast tenderness/pain
- ☐ Breast discharge
- ☐ Hysterectomy
- ☐ Menopausal
- ☐ Other surgeries
- ☐ Sexual drive increased
- ☐ Sexual drive depressed
- ☐ PMS
- ☐ Change in body/psych prior to menstruation
- ☐ Hot flashes
- ☐ HRT
- ☐ PID
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Children (names/ages)

Describe your usual flow

Men

- ☐ Testicular pain
- ☐ Penile pain
- ☐ Genital itch
- ☐ Sexually active
- ☐ Prostate enlargement
- ☐ Hernia
- ☐ Loss of erection, impotence
- ☐ Nocturnal emissions
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Prostatitis
- ☐ Loss of semen during the day
- ☐ Premature ejaculation
- ☐ Syphilis
- ☐ Sexual drive increased
- ☐ Sexual drive depressed
- ☐ Children (names/ages)

Musculoskeletal

- ☐ Muscle pain
- ☐ Muscle spasms, cramps, tension
- ☐ Swollen joints
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Osteoporosis
- ☐ Fractures/broken bones
- ☐ Arthritis
- ☐ Leg cramps
- ☐ Bone pain
- ☐ Neck pain
- ☐ Gout
- ☐ Joints make noise
- ☐ Joint replacement
- ☐ Whiplash
- ☐ Pain down legs
- ☐ Bone problems
- ☐ Trembling, tremors
- ☐ Back pain
  - o Upper
  - o Mid
  - o Lower
- ☐ Numbness, tingling
- ☐ Disc problems
- ☐ Intermittent pain
- ☐ Constant pain
- ☐ Weak muscles
- ☐ Other spinal problems

	No pain		Mildly Annoying		Nagging, uncomfortable		Distressing, miserable		Intense, horrible		Worst possible, unbearable
Current level of pain	0	1	2	3	4	5	6	7	8	9	10

Are you physically active on a regular basis? yes / no Type of exercise: _____ How long: _____ How often: _____

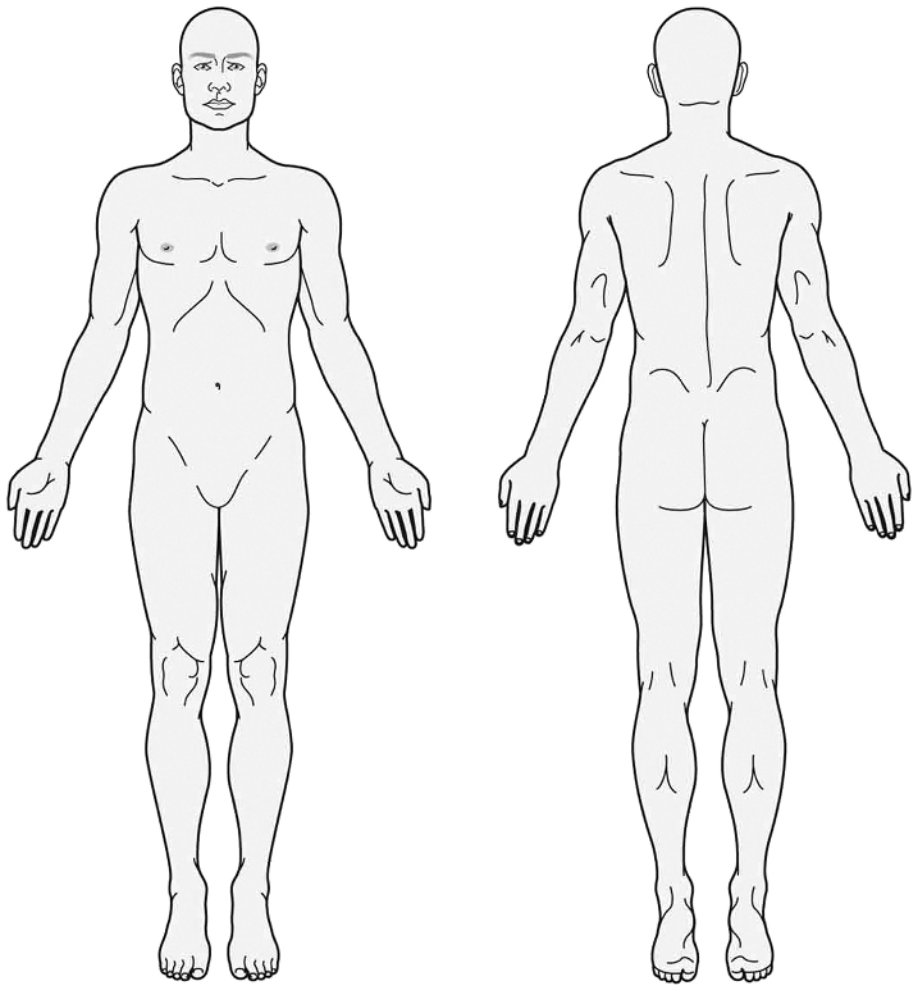
_____

_____

Neuro/Emotional/Psychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Worry a lot
- ☐ Depression
- ☐ Anxious/nervous
- ☐ Feel overwhelmed
- ☐ Poor memory
- ☐ Unusual fears
- ☐ Forgetful
- ☐ Agitation
- ☐ Decisions difficult
- ☐ Lose temper easily
- ☐ Easily stressed
- ☐ Feel unhappy
- ☐ Work/family problems
- ☐ Poor concentration
- ☐ Fatigue
- ☐ Considered suicide
- ☐ Attempted suicide
- ☐ Treated for emotional problems
- ☐ Repeated thoughts
- ☐ Disorientation
- ☐ Mood swings
- ☐ Drug addiction
- ☐ Inability to focus on tasks
- ☐ Hold a grudge
- ☐ Fearful
- ☐ Hyperactivity
- ☐ Dull thinking
- ☐ Stroke
- ☐ Paralysis
- ☐ Pessimistic
- ☐ Optimistic
- ☐ Perfectionist
- ☐ Motivation low
- ☐ Motivation normal
- ☐ Motivation high

Please use the diagram to indicate where you feel pain or symptoms



Acupuncture & Healing Arts Medical Group

Name _____

Allergies _____

List all medicines, herbs, remedies, and supplements used in the last 2 months.

Medicine/herb/supplement Name	Dose	Frequency

List all Doctors and Therapists you have seen in the last 2 years.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Acupuncture and Healing Arts Medical Group
5575 Poplar Avenue Suite 702 Memphis TN 38119

Informed Consent for Treatment

Traditional Chinese Medicine includes various modalities such as acupuncture, herbology, tuina, massage cupping, guasha, moxibustion, acupressure, warming, and other types of hands-on healing, as well as electric stimulation to filaments and infrared cold laser. These ancient oriental techniques utilize a natural system of healing within the body.

I, the undersigned, hereby authorize the licensed staff of the Acupuncture & Healing Arts Medical Group to perform the above listed modalities, including acupuncture procedures induced by the insertion of sterile, single-use needles/filaments into the underlying tissues at certain indicated points on the surface of the body. The nature, consequences, and potential risks and benefits of these procedures have been explained to me.

POTENTIAL RISKS: Discomfort at the insertion site of the needle, bruising, weakness, fainting, nausea, and possible short term aggravation of symptoms existing prior to acupuncture treatment.

POTENTIAL BENEFITS: To allow for drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures. I understand these techniques are not a substitute for conventional medical care. I realize that no guarantees have been given to me regarding cure or improvement of my condition and that no treatment program is effective for everyone.

I understand that I am free to discontinue my treatment at any time. I also understand that my medical and/or clinical records will be kept confidential and only disclosed with my permission or summarized anonymously. (initial _____)

I hereby authorize the licensed staff of the Acupuncture and Healing Arts Medical Group to verify my history or condition with my physician, if required, and to release my medical records to my insurance company if they so require in order to honor my insurance claim.

Payment is due at the time services are rendered. First appointment fees are $140 for adult acupuncture (over the age of 15), $50 for pediatric (under the age of 15), and $50 for herbal consultation. Follow up appointment fees are $75 for adult acupuncture (over the age of 15), $40 for pediatric (under the age of 15), and either $50 or $25 for herbal consultation, depending on the length of the visit. Herbal preparations are additional.

We require 24 hour notice given to change or cancel your appointment. We understand emergency situations but otherwise you will be charged for the missed visit. **Please do not wear colognes, perfumes, or scented lotions to the office.**

Welcome as a new client. We greatly appreciate your cooperation and look forward to treating you.

Print Patient Name _____ Date _____

Patient/Guardian Signature _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help you with your health care or with payment for you health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our offices to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, of health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive it electronically

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA: The U.S Department of Health toll free 877-696-6775
Office of Civil Rights: 200
Washington, D.C. 20201

Acupuncture and Healing Arts Medical Group
5575 Poplar Avenue Suite 702 Memphis TN 38119

Notice of Privacy Practices Acknowledgement

A record of the health care services that we provide to you is used and disclosed by this office when providing you with treatment, collecting payments for treatment provided to you and in other health care operations.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, our obligations in protecting your health information and your rights regarding the information contained in your medical record.

We will not use or disclose the information contained in your record in any way that is inconsistent with the policies detailed in our current Notice of Privacy Practices.

If you have questions or would like additional information about this notice, please notify our office.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual	Date	Time
Printed name if signed on behalf of patient	Relationship to patient (parent, legal guardian, etc.)	

This form will be retained in your medical record.