Back to Wellness Clinic - New Patient Form - Acupuncture

Patient Information:

Chart#_____

Name: _____ Date of Birth: _____ Age : _____

Social Security #: _____-_____-_____ Height: _____ Weight: _____

Gender: □ Male □ Female Marital Status: □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

What number do you prefer we reach you at? □ Home □ Cell Referred By: _____

Email Address: _____ Occupation: _____

Employer/School: _____ City/St. : _____

Spouse's Name: _____ Spouse's #: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Phone # : _____

INSURANCE:

Who is responsible for this account: _____ Relation to patient: _____

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Name 2nd Insurance Company (if applicable): _____

Policy #: _____ Group #: _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of company.) And assign directly to Dr. Viviana Viera all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, or Personal Representative

Please print name of Patient, Parent or Personal Representative

_____ _____

Date

Relationship to Patient

Patient Intake Form

Please check all that apply:

Patient Name: _____ **Date:** _____ **Chart #:** _____

Allergies: □ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs □ Latex □ Molds □ Penicillin □ Ragweed/Pollen □ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye **Other:** _____

_____

List any Surgeries and year: □ Back _____ □ Brain _____ □ Elbow _____ □ Foot _____ □ Heart _____ □ Hip _____ □ Knee _____ □ Neck _____ □ Neurological _____ □ Shoulder _____ □ Wrist/Hand _____

Other: _____

List ALL Past Medical History conditions: □ AIDS/HIV □ Alcoholism □ Appendicitis □ Arteriosclerosis □ Arthritis □ Asthma □ Birth Trauma □ Blood pressure (High / Low) □ Broken Bones □ Cancer □ Chicken Pox □ Depression □ Diabetes □ Dizziness □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Fibromyalgia □ Frequent Colds/Flu □ Genetic Spinal Condition □ Goiter □ Gout □ Headaches □ Hearing Problems □ Hepatitis (type:) □ Herpes (type:) □ Joint Stiffness □ Menstrual Problems □ Heart Disease □ Measles □ Multiple Sclerosis □ Mumps □ Neurological Problems □ Pacemaker □ Parkinson's □ Pneumonia □ Polio □ Prostate Problems □ Rheumatic Fever □ Scarlet Fever □ Sciatic nerve pain □ Seizures □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain □ Stones (KD / GB) □ Stroke/Heart Attack □ Thyroid Disorders □ Tuberculosis □ Typhoid Fever □ Ulcers □ Venereal Disease □ Whooping Cough Have you had any auto or other accidents in the past? □ No □ Yes When? _____ Describe: _____

_____

Other: _____

How would you rate your overall heath? : □ Very good □ Good □ Fair □ Poor

Your Lifestyle: □ Alcohol □ Tobacco □ Stress □ Exercise / Activity, type: _____ Frequency: _____ □ Occupational Hazards **Other:** _____

Cravings: □ Sweets □ Salty foods □ Ice **Other:** _____

Average daily menu:

Morning: _____

_____

Mid-day: _____

_____

Evening: _____

_____

Snacks: _____

Water: _____

Other: _____

General Symptoms: □ Appetite: poor / heavy □ Strongly like drinks: cold / hot □ Recent weight: loss / gain □ Sleep: poor / heavy □ Dream-disturbed sleep □ Fatigue □ Lack of strength □ Lack of focus / concentration □ Bodily heaviness □ Cold hands or feet □ Poor circulation □ Shortness of breath □ Fever □ Chills □ Night Sweats □ Sweat easily □ Muscle cramps □ Vertigo or dizziness □ Bleed or bruise easily □ Peculiar taste: _____ **Other:** _____

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

Respiratory: ☐ Difficulty breathing when laying down ☐ Shortness of breath ☐ Tight chest ☐ Asthma / wheezing ☐ Difficult inhalation / exhalation ☐ Cough Wet / Dry ☐ Phlegm thick / thin & what color: _____ ☐ Coughing up blood ☐ Pneumonia Other:_____

Cardiovascular: ☐ High blood pressure ☐ Low blood pressure ☐ Blood clots ☐ Chest Pain ☐ Tachycardia ☐ Heart palpitations ☐ Phlebitis ☐ Irregular Heart beat ☐ Congenital condition Other:_____

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Acid regurgitation ☐ Gas ☐ Hiccup ☐ Bloating ☐ Bad breath ☐ Diarrhea ☐ Constipation ☐ Black stools ☐ Bloody stools ☐ Mucus in the stools ☐ Hemorrhoid ☐ Itchy anus ☐ Intestinal pain or cramping ☐ Burning anus ☐ Rectal pain ☐ Anal fissures ☐ Gall bladder stone ☐ Laxative use
What kind & how often:_____
Bowel movements: Frequency:_____ Texture / Form: _____
Color _____ Odor: _____
Other:_____

Musculoskeletal: ☐ Neck / Shoulder pain ☐ Elbow Pain ☐ Wrist pain ☐ Hand pain ☐ Rib pain ☐ Hip pain ☐ Upper back pain ☐ Mid back pain ☐ Lower back pain ☐ Groin pain ☐ Knee pain ☐ Foot pain ☐ Joint pain ☐ Muscle pain ☐ Deep (bone) pain ☐ Limited range of motion ☐ Limited use ☐ Unable to lift / carry any weight,
Other:_____
_____

Skin & Hair: ☐ Rashes ☐ Hyves ☐ Ulcerations ☐ Eczema ☐ Psoriasis ☐ Acne ☐ Dandruff ☐ Itching ☐ Hair loss ☐ Change in hair / skin texture ☐ Fungal infections ☐ Other hair or skin problems: _____
_____

Neuropsychological: ☐ Seizures ☐ Numbness ☐ Tics ☐ Poor memory ☐ Anxiety ☐ Depression ☐ PTSD ☐ ADHD ☐ Irritability ☐ Easily stressed ☐ Abuse survivor ☐ Considered / attempted suicide. Other: _____
_____

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

Gynecology: (if the cycle is not present anymore, please mark all that applies to how it was)

Age menses began:_____ **Length of cycle:**_____ □ **Irregular periods** □ **painful periods** □ **PMS**
□ **Vaginal discharge (color):** _____ □ **Vaginal sores** □ **Vaginal odor** □ **Clots** □ **Breast lumps**
□ **Pregnancies** _____ □ **Live births** _____ □ **Premature births** _____
Age at menopause:_____ **Date last period began:**_____ **Menopause issues:**_____

_____

Fertility challenges: _____

_____

Other: _____

_____

List all Medications you are currently taking: **(Example: Ibuprofen – Pain)**

_____

_____

_____

Are you allergic to any medications: □ **No** □ **Yes**

_____

Family History: Mother/Father/Brother/Sister Only: □ **Arthritis** □ **Asthma** □ **Back Pain** □ **Cancer**
□ **Depression** □ **Diabetes** □ **Epilepsy** □ **Genetic Spinal Condition** □ **High Blood Pressure** □ **Heart Problems**
□ **Multiple Sclerosis** □ **Neurological Problems** □ **Parkinson's** □ **Polio** □ **Prostate Problems** □ **Stroke/Heart Attack**

Please list all family members who had/has any of the problems above: **Example: Sister – Diabetes**

_____ _____

_____ _____

_____ _____

_____ _____

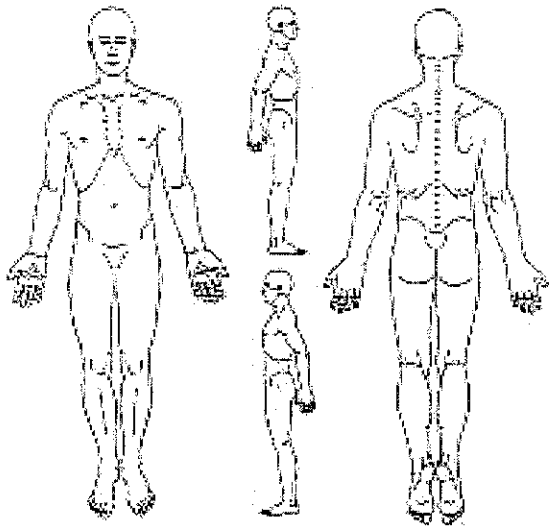
_____ _____

_____ _____

Patient Name: _____ **Date:** _____ **Chart#:** _____

Have you ever had acupuncture?: □ Yes □ No **Where?:** _____
Why?: _____ **When was your last visit?:** _____
Have you ever had Chinese Herbal Medicine?: □ Yes □ No **When:** _____
Is your current complaint due to a fall or accident / auto accident?: _____ **If so, date of accident?:** _____
Describe: _____
_____

Please mark in the image below the painful area(s):



Main reason for consulting the office:

- □ **Become pain free**
- □ **Explanation of my condition**
- □ **Learn how to care for my condition**
- □ **Reduce symptoms**
- □ **Resume normal activity level**

What is your primary complaint?: _____
_____

Date problem began?: _____ **How did this problem begin (falling, lifting, etc.)?:** _____
How is your condition changing?: □ Getting better □ Getting worse □ Not changing
Have you had this condition in the past: □ YES □ NO
How often do you experience your symptoms: □ Constantly □ Frequently □ Occasionally □ Intermittently
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling
□ Radiating Pain □ Tightness □ Stabbing □ Throbbing,
Other: _____

Please rate the pain from 1-10: At its worst: _____ **At the present time:** _____ **At least severe:** _____
How do your symptoms affect your ability to perform daily activities such as working or driving: (0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 **What activities aggravate your condition (working, exercise, etc):** _____

What makes your pain better (ice, heat, massage, etc)?: _____
_____

Patient Name: _____ **Date:** _____ **Chart#:** _____

What is your SECOND complaint?: _____

Date problem began?: _____ **How did this problem begin (falling, lifting, etc.)?:** _____

_____

How is your condition changing?: □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? : □ YES □ NO

How often do you experience your symptoms?: □ Constantly □ Frequently □ Occasionally □ Intermittently

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling

□ Radiating Pain □ Tightness □ Stabbing □ Throbbing □ □ Aching

Other: _____

_____

Please rate the pain from 1-10: **At its worst:** _____ **At the present time:** _____

At least severe: _____

How do your symptoms affect your ability to perform daily activities such as working or driving?:

(0= no effect and 10= no possible activities): □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)?: _____

_____

What makes your pain better (ice, heat, massage, etc)?: _____

_____

****I authorize BACK TO WELLNESS to send appointment reminders: (Initial)_____**********

Cell phone #: _____

Email address: _____

_____

Signature of Patient, Parent, or Personal Representative

Revised 9.24.20 sb

ACUPUNCTURE INFORMED CONSENT TO TREAT

Please initial each paragraph after reading to be able to receive acupuncture treatment. It is all intended to inform you of what is available.

You have chosen to undergo Acupuncture, Moxibustion, Cupping, Gua Sha, Tui Na, Electrical Stimulation, Chinese Herbal Therapy, Dietary Therapy, Acupuncture Injection Therapy, Homeopathic Remedies & Exercise Therapy. Such treatments are quite common in Acupuncture & Oriental Medicine & are considered safe procedures. Nevertheless, any treatment is not without some risks. Please review the following before you consent to its use.

_____1. I have been informed that acupuncture means the insertion of disposable filiform needles into the body including head, ears, face, & limbs. These needles will remain in place for 30 to 40 minutes & I voluntarily consent to participate in acupuncture treatment. I fully understand that acupuncture & Chinese herbal therapy are not treatments for medical emergencies.

_____2. Discomfort, swelling or bruising, at the site where the needles or modalities are placed onto the skin, can occur. In some cases, electrical stimulation may be indicated. This procedure involves the use of an electric or battery powered stimulator, which is either contact pads placed directly on the body, attached with wires to the ends of needles after they have been inserted into the skin. A slight heat or vibratory sensation may be felt during stimulation. Fainting, although not common, can be an unfortunate side effect of acupuncture and electrical stimulation.

_____3. I am aware that a treatment may include the application of moxibustion which consists in the use of direct or indirect heat supplied by burning an herb or combination of herbs.

_____4. Chinese techniques called Gua Sha, Tui Na, & Cupping may be used in certain cases. These procedures may produce a deep redness of the skin which can remain for varying periods of time. For some people, a slight bruising & tenderness may persist for a few hours following the treatment. You will be given instructions on how to manage these reactions at the end of your visit.

_____5. In many cases Chinese Herbal Therapy & Homeopathic remedies, including liniments, creams, or ointments may be used. Exacerbation of symptoms may occur on rare occasions or side effects such as digestive upset, bowel movement irregularities, skin irritations and headaches. In all cases of unexpected side effects, patients are instructed to stop treatments, make contact with the Doctor's office and follow instructions given. In the vast majority of cases, side affect symptoms will resolve within twenty-four (24) to forty-eight (48) hours.

YOUR OBLIGATIONS:

_____1. If an adverse reaction is encountered, it is imperative that you immediately report it to your healthcare attendant, and thereafter, follow all instructions carefully for remedy of the adverse reaction.

_____2. If dietary restrictions are placed upon you for a treatment modality or home care instructions are given, it is imperative that you follow them completely.

_____3. Other:

_____

_____

_____

CONSENT

I have read and understand the above paragraphs and realize that Acupuncture, Moxibustion, Cupping, Gua Sha, Tui Na, Electrical Stimulation, Chinese Herbal Therapy, Dietary Therapy, Homeopathic Remedies, and Exercise Therapy carry with it certain possible risks. I request that these procedures be used for my treatment. All my questions have been answered fully to my satisfaction regarding this consent and I fully understand the risks involved. I also state that I speak, read and write English, or that this has been translated to me in my native tongue.

Patient's Signature: _____ Date:_____

Legal Guardian's Signature:_____ Date: _____

Witness Signature: _____Date: _____

Office Signature: _____ Date: _____