Acupuncture Patient Admittance Form

United Wellness Center
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www.unitedwellnesscenter.com

Name:____
(Last) *(First)* *(Initial)*

What would you like to be called? __________________ Sex: ❑ Male ❑ Female
Marital Status:__________ Name of Spouse or Parent:______________# of Children:________
Date of Birth:____/_____/_____ Age:__________ Height:_____ft._____in. Weight:__________lbs.
Home Address:_____________________________________ City:______________
State:______________ Zip Code:______ Social Security Number:____-________-________
Phone #:______________Work:__________________Cell:______________
Email address:______________________@______________________
Employer:__________________________ Occupation:__________________________
Work address:____
In case of emergency, who should we notify/phone?______________________________
Your Family Physician/phone:__________________________ (______)______________

Have you ever received Acupuncture treatments? ❑ No ❑ YES
If **YES**, name of previous Acupuncturist:______________________________

How did you hear about our wellness center?

- ❑ Doctor referral: ____________________
- ❑ Friends/Co-Worker: ________________
- ❑ Your Health Insurance
- ❑ Our website
- ❑ Internet Search Engine
- ❑ PT referral: ____________________
- ❑ Others: ____________________
- ❑ Sign / Walk-In
- ❑ Magazine Advertisement

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment (Code of Virginia 54.1-2956.-,18 VAC 85-110-10)________
Initial

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. __________
Initial

Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.________
Initial

If a patient misses an appointment without a 24-hour notice, a $40.00 fee will be charged. All fee charges will be due before the next appointment.________
Initial

I acknowledge that I was given a copy of United Wellness Center Notice of Privacy Practice's, which I have fully understand and have had any questions answered to my satisfaction.________
Initial

Signature:______________________________________ Today's Date:____/_____/______

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Chief Complaint

- Reason for seeking care: *(Please provide an exact description)*

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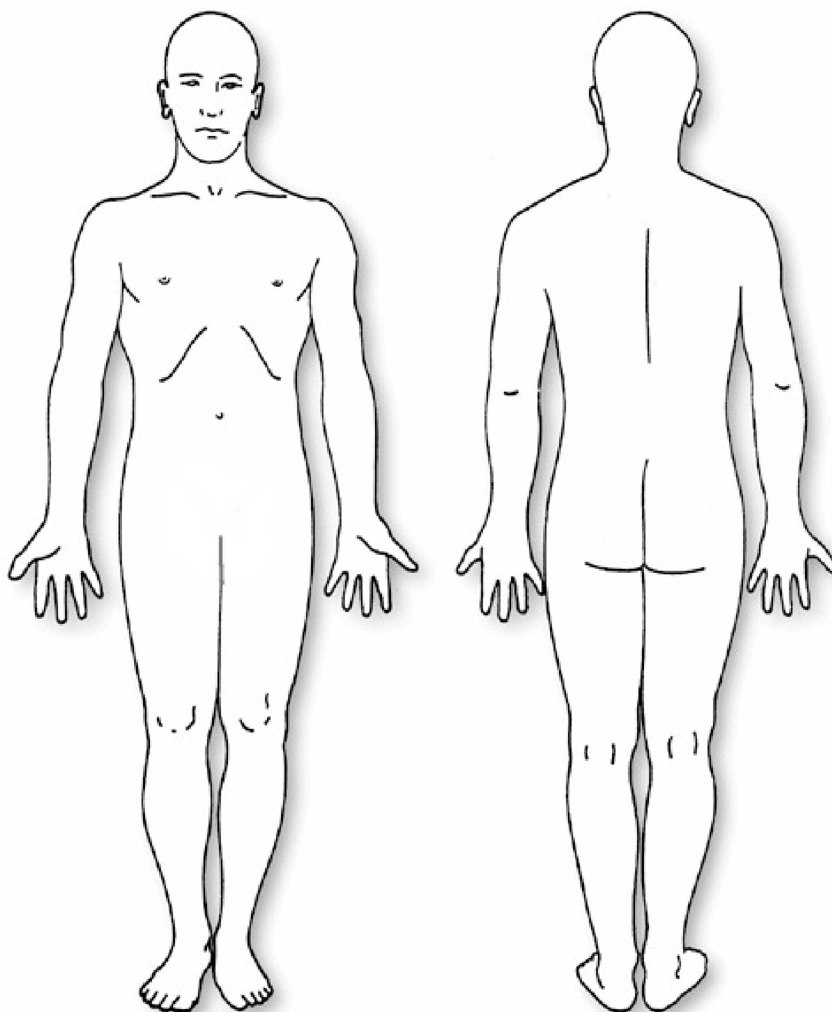
Pain Diagram

(Please number the areas where you are experience pain or discomfort, according to the following pain scale.)

Number Listing	Amount of pain
1, 2, 3	Pain or discomfort is an annoyance.
4, 5, 6	Pain or discomfort interferes with activities
7, 8, 9	Pain or discomfort prevents me from performing certain activities
10	Pain or discomfort sends me to the emergency room.



General Systems Review (Please select any items that relate to your condition or body)

Respiratory
Past Present
- ❑ ❑ Allergies
- ❑ ❑ Asthma
- ❑ ❑ Bronchitis
- ❑ ❑ Cough
- ❑ ❑ Emphysema
- ❑ ❑ Frequent Colds
- ❑ ❑ Hay fever
- ❑ ❑ Pneumonia
- ❑ ❑ Smoker
- ❑ ❑ Tuberculosis

Skin
Past Present
- ❑ ❑ Acne Problems
- ❑ ❑ Dermatitis
- ❑ ❑ Eczema
- ❑ ❑ Fungal Infection
- ❑ ❑ Herpes
- ❑ ❑ Polyps
- ❑ ❑ Psoriasis
- ❑ ❑ Singles
- ❑ ❑ Botox Injection

Vision
Past Present
- ❑ ❑ Glaucoma
- ❑ ❑ Light Sensitivity
- ❑ ❑ Blurred Vision
- ❑ ❑ Cataracts
- ❑ ❑ Double Vision
- ❑ ❑ Dyslexia

Cardiovascular
Past Present
- ❑ ❑ Angina
- ❑ ❑ Arrhythmia's
- ❑ ❑ Arteriosclerosis
- ❑ ❑ Blood Clots
- ❑ ❑ Chest pain
- ❑ ❑ Hypertension
- ❑ ❑ Rheumatic
- ❑ ❑ Heart Attack
- ❑ ❑ CHF
- ❑ ❑ High Cholesterol

Please inform us privately if you have active viral conditions (e.g. herpes) or if you have been tested positive for HIV.

Head
Past Present
- ❑ ❑ ADD/ADHD
- ❑ ❑ Concussion
- ❑ ❑ Headaches
- ❑ ❑ Insomnia
- ❑ ❑ Learning Problem
- ❑ ❑ Memory Problem
- ❑ ❑ Mental Illness

Gastro-intestinal
Past Present
- ❑ ❑ Appendicitis
- ❑ ❑ Appetite loss
- ❑ ❑ Black Stool
- ❑ ❑ Blood in Stool
- ❑ ❑ Constipation
- ❑ ❑ Chron's
- ❑ ❑ Colitis
- ❑ ❑ Diarrhea
- ❑ ❑ Heart Burn
- ❑ ❑ Gall Bladder
- ❑ ❑ IBS
- ❑ ❑ Stomach Cramps
- ❑ ❑ Ulcers

Urinary
Past Present
- ❑ ❑ Bladder infections
- ❑ ❑ Blood in Urine
- ❑ ❑ Incontinence
- ❑ ❑ Infections
- ❑ ❑ Kidney Stones
- ❑ ❑ Yeast Infection

Vascular
Past Present
- ❑ ❑ Anemia
- ❑ ❑ Easy Bleeding
- ❑ ❑ Hemorrhoids
- ❑ ❑ Raynaud's
- ❑ ❑ Thromophlebitis
- ❑ ❑ Transfusions
- ❑ ❑ Varicose Veins

Musculoskeletal
Past Present
- ❑ ❑ Non-Specific Back Ache
- ❑ ❑ Disc Problems
- ❑ ❑ Fractures
- ❑ ❑ Gout
- ❑ ❑ General Joint Pain
- ❑ ❑ Muscle Cramps
- ❑ ❑ Muscle Injury
- ❑ ❑ Paralysis
- ❑ ❑ Neck pain
- ❑ ❑ Osteoarthritis
- ❑ ❑ Osteoporosis
- ❑ ❑ Rheumatism
- ❑ ❑ Rheumatoid
- ❑ ❑ Scoliosis
- ❑ ❑ Smoker
- ❑ ❑ Fibromyalgia
- ❑ ❑ Chronic Fatigue

Endocrine
Past Present
- ❑ ❑ Diabetic
- ❑ ❑ Hyperthyroid
- ❑ ❑ Hypothyroid
- ❑ ❑ Adrenal Problem

Others____________________

Female Reproductive
Past Present
- ❑ Pregnant

Due Date:______________

- ❑ ❑ Fibroids
- ❑ ❑ Pelvic Inflammation
- ❑ ❑ Hysterectomy
- ❑ ❑ Menopause
- ❑ ❑ STD
- ❑ ❑ Fertility Problems

Male Reproductive
Past Present
- ❑ ❑ Impotence
- ❑ ❑ Testicular Pain
- ❑ ❑ Prostate Problem
- ❑ ❑ STD
- ❑ ❑ Urination Trouble

Neurological
Past Present
- ❑ ❑ Epilepsy
- ❑ ❑ Parkinson's
- ❑ ❑ Concussion
- ❑ ❑ Seizures
- ❑ ❑ Alzheimer's
- ❑ ❑ Multiple Sclerosis

Others
Past Present
- ❑ ❑ Alcoholic
- ❑ ❑ Cancer
- ❑ ❑ Chemotherapy
- ❑ ❑ Depression
- ❑ ❑ Hepatitis
- ❑ ❑ Surgery
- ❑ ❑ Radiation Therapy
- ❑ ❑ AIDS
- ❑ ❑ HIV Positive

Family History
- ❑ Arthritis
- ❑ Genetic Problems
- ❑ Auto immune condition
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ High Cholesterol
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Heart Attack
- ❑ Stroke
- ❑ Vascular Problems

Others____________________

Childhood Conditions
- ❑ Measles
- ❑ Mumps
- ❑ Chicken Pox
- ❑ Whooping Cough
- ❑ Scarlet Fever
- ❑ Diphtheria
- ❑ Typhoid , Rheumatic Fever
- ❑ Recurrent Ear Infections
- ❑ Chronically Ill
- ❑ Asthma
- ❑ Allergies

Others____________________

Exercise History

How many days per week are you exercising?
- ❑ None
- ❑ 1-2 days a week
- ❑ 3-4 days a week
- ❑ 5 or more days a week

Do you lift weight on a regular basis?
❑ Yes ❑ No

Do you perform core stabilization exercises on a regular basis?
❑ Yes ❑ No

Do you practice any relaxation techniques on a regular basis?
❑ Yes ❑ No

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Informed Consent

I request and consent to the treatment of my person (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturist. The modalities which may be utilized by the acupuncturist, are as follows: acupuncture, acupressure, diagnostic techniques (health history questioning, pulse evaluation, manual palpation on a variety of areas of my body), modes of manual or physical therapy (massage, acupressure, zero balancing, heat or cold therapy, electrical stimulation) the prescription of herbal and dietary products, dietary recommendations, advice regarding exercise regimens, and lifestyle counseling.

I have had an opportunity to discuss with the acupuncturist the nature and purpose of acupuncture and oriental medical procedures. I understand that although acupuncture and other oriental medical procedures have helped millions of people, no guarantee of cure or improvement in my condition is given or implied.

I have read, or have had read to me, the above consent. I also have had an opportunity to ask questions about the content of this form. By signing below, I agree to the performance of the above-named procedures by a licensed acupuncturist. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition(s) for which I seek treatment, regardless of time span involved.

To be complete by the patient:	To be completed by the patient's representative, if necessary (e.g., if the patient is a minor or is physically or legally incapacitated).
______________________________ Print Name of Patient	______________________________ Name of Representative
______________________________ Signature of Patient	______________________________ Signature of Representative
______________________________ Date Signed	______________________________ Relationship/Authority to Patient
	______________________________ Date Signed

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