NEW PATIENT INFORMATION Confidential

Date of Initial Appointment: _____

Personal Information:

Name:		
Address:		
Date of Birth:	Age:	Occupation:
Primary phone number:	Alternate phone number:	
Email:		
Emergency Contact:	Relationship:	Phone:
How did you hear about us? / Referred by:		
Marital status:	Preferred pronoun:	
Primary Care Physician:	Phone number:	

Note on Insurance: *Full payment is due at time of service. Upon request, a Superbill will be provided. A Superbill is an invoice using standardized codes for treatments received, which you can submit directly to your insurance company (or HSA/FSA) for reimbursement. Please call your insurance carrier to find out about your insurance plan's coverage for acupuncture and related services.*

Treatment Information:

Chief Complaint (please list the concerns that brought you in today in order of importance):	
When did this begin?	Suddenly/Gradually?
What makes it better?	What makes it worse?
Describe the quality (e.g. hot/cold, sharp/dull, numbness, etc.) and frequency of your complaint:	
Rate your pain level (0 = no pain, 10 = worst possible pain):	
Have you received other treatments for this issue? If yes, please explain:	
Other relevant history related to your condition:	
Have you had acupuncture before? If so, for what and when:	
Are you presently being treated for any (other) medical conditions?	

Medications/Herbs/Supplements:	**Year started taking:**	**Reason for taking:**

Please list any known food or drug allergies:

HEALTH HISTORY Please indicate any conditions you or your family has experienced **P** if you have had it in the past, **C** if you currently have it, and **F** if anyone in your immediate family has/had it

Cancer	Diabetes	Hepatitis	HIV/AIDS	Thyroid disease
High/low blood pressure	Heart disease	Seizures	Autoimmune disease	Chemical dependency
Alcoholism	Allergies	Anemia	Anxiety	Asthma
Blood clotting disorder	Compromised Immunity	Skin condition	Depression	High Cholesterol
Osteoporosis	Menstrual disorder	Mental health diagnosis	Respiratory disease	Pacemaker
Hospitalizations / surgeries / significant injuries (include dates):				
Other significant illness / medical history:				
Are you pregnant or planning to become pregnant? Number of children:				

Lifestyle and General Health:

Exercise (include frequency / duration):	
Typical daily diet:	
Are you on a special or restricted diet?	
Any trouble digesting foods? Yes/No	How often do you have bowel movements?
Do you sleep well at night? Yes/No	Trouble falling asleep or staying asleep?

Habits: Please indicate amount per day. If you have quit, please state the year.

Tobacco	Coffee/Tea
Alcohol	Soda
Water	
Other treatments or health practices (psychotherapy, massage, yoga, etc.):	
Any other concerns you would like us to know about?	

Financial Agreement:
Payment is due at the time of your visit. We accept cash, personal checks and credit cards. In consideration of people who may be on a waiting list for appointment, we ask that you give us at least 24 hours notice in advance of an appointment that will not be kept.

All appointments that are cancelled with less than 24 hours notice, or are missed altogether without notifying our office, will be charged the same treatment fee you paid at your last appointment payable at the next visit. We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, of course.

Late policy: We will do our best to accommodate you if you arrive late for your appointment. However, if you arrive more than ten minutes late and we are unable to accommodate you, we will consider it a missed appointment and enforce this policy. Thank you for understanding and for helping us to keep our fees as low as possible. With this knowledge, I voluntarily consent to the above procedures.

Acknowledgement of Receipt of Notice of Privacy Practices:
I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Print Name:	Signature:	Date: