BODY & SPINE
SOLUTIONS

Acupuncture intake form

Name: _____ **Date:** _____

Mailing Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Email Address: _____ **Home #** _____

Cell #_____ **Work #** _____ **Can we call you at work?** □ Yes □ No

Do you prefer to have appointments confirmed by: □ Text □ Email □ Phone **(check all that apply)**

Date of Birth: _____ **(mm/dd/yyyy)** **Sex:** □ Male □ Female **Social Security #:** _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Minor

Occupation: _____ **Employer:** _____

Person to be notified in the case of an emergency:

Name: _____ **Relation:** _____ **Phone #:** _____

How did you hear about our practice? _____

---

1. **Have you had acupuncture before? Yes No**
2. **What is your chief complaint?** _____
3. **How do you think your problem began?** _____
4. **Is today's problem caused by an :** □ Auto Accident □ Injury at work □ Other _____
5. **How long have you had this problem?** _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)
6. **How often do you experience your symptoms?**

   □ Intermittently (1-25% of the time)
   □ Occasionally (26-50% of the time)
   □ Frequently (51-75% of the time)
   □ Constantly (76-100% of the time)
7. **How would you describe the type of pain?**

   □ Sharp □ Dull □ Burning □ Shooting with motion □ Shooting □ Numb □ Stiff
   □ Diffuse □ Achy □ Sharp with motion □ Tingly □ Other: _____
8. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?** _____
9. **Who else have you seen for your problem?**

   □ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician □ No one
   □ Orthopedist □ Massage Therapist □ Physical Therapist □ Other: _____

10. **Do you consider this problem to be severe?** □ Yes □ Yes, at times □ No

11. **What makes your problem Better/Worse?** _____

12. **What is your: Height**_____ (ft./inch) **Weight** _____ (lbs.) **Age** _____

13. **How would you rate your overall Health?** □ Excellent □ Very Good □ Good □ Fair □ Poor

14. **What type of exercise do you do?** □ Strenuous □ Moderate □ Light □ None

15. **What is your daily intake of the following?** □ Caffeine ___ cups/day □ Alcohol ___ drinks/wk. □ Cigarettes ____ packs/day

16. **Indicate if you have any immediate family members with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Heart Problems □ Cancer □ Other_____

17. **For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

	Past	Present		Past	Present		Past	Present
Headaches			Cancer			Allergies		
Neck Pain			Tumor			Chronic Sinusitis		
Upper Back Pain			Epilepsy			Dermatitis/Eczema/Rash		
Mid Back Pain			Visual Disturbances			Excessive Thirst		
Low Back Pain			Stroke			Frequent Urination		
Shoulder Pain			Dizziness			Abnormal Weight Gain/Loss		
Elbow/Upper Arm Pain			High Blood Pressure			Loss of Appetite		
Wrist Pain			Heart Attack			General Fatigue		
Hand Pain			Chest Pains			Smoking/Tobacco Use		
Hip Pain			Angina			Drug/Alcohol Dependence		
Numbness			Hepatitis			Depression		
Knee Pain			Liver/Gall Bladder Disorder			HIV/AIDS		
Ankle/Foot Pain			Abdominal Pain			Diabetes		
Jaw Pain			Ulcer			Asthma		
Joint Pain/Stiffness			Kidney Stones			Birth Control Pills		
Muscular Incoordination			Kidney Disorders			Hormonal Replacement		
Arthritis			Bladder Infection			Pregnancy		
Rheumatoid Arthritis			Painful Urination			Prostate Problems		
Systemic Lupus			Loss of Bladder Control			Other:		

18. **List all prescription & over the counter medications you are currently taking:** _____
_____

19. **List any medications you are allergic to:** _____

20. **List any surgical procedures and/or hospitalizations you have had:**_____
_____

21. **List any significant past trauma you have had:** _____
_____

22. **How much has the problem interfered with your work?** □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

23. **How much has the problem interfered with your social activities?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

24. **Have you tried any Physical Therapy before?** □ NO □ YES
If yes, when? For how long? What kind? _____

25. Have you tried any Chiropractic treatments before? □ NO □ YES

If yes, when? For how long? What kind? _____

26. Have you had an MRI for this condition? □ NO □ YES

27. If yes, when? What was it ordered for? _____

28. Have you had X-rays for this condition? □ NO □ YES

If yes, when? What was it ordered for? _____

30. Energy Level: High Medium Low

31. Do you have sleep issues? Yes No If yes, please describe _____

32. Are you concerned with your weight or diet? _____

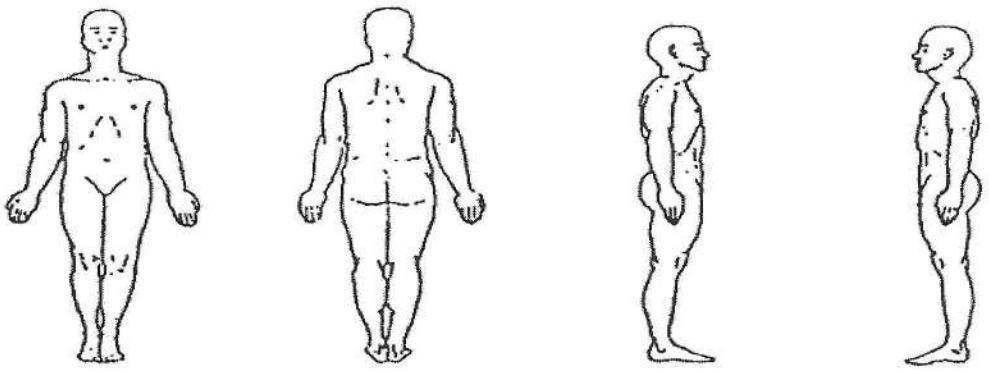
33. Stress Level: High Medium Low

34. For Women Only:

Do you have: (Please Circle)

Fertility Concerns
Very heavy menses
No menses / scant flow
Irregular Menses
Painful periods / Cramps
PMS / PMDD
Mood swings
Menopausal
Candida / Unusual discharge
Pain during or after sex
Pelvic pain
Age of your first period? _____
Are you trying to become pregnant? Yes No
Have you ever been pregnant? Yes No

INDICATE ON THE DRAWING BELOW WHERE YOU HAVE PAIN/SYMPTOMS



_____

Assignment and Release (insured patients)

I, certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICAL/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYBALE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with the appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician. I affirm that I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problem.

I have read and understand the consent to care. I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office.

Patient Signature _____ **Date:** _____

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ **Phone #:** _____

Name of Policy Holder: _____ **Date of Birth of Policy Holder:** _____

Do you have a Secondary Insurance? □No □Yes **Name of Carrier:** _____

Are you enrolled in a □ (HSA) Health Savings Account □ (FSA) Flex Spending Account □ (HRA) Health Reimbursement Account

Credit/Debit Card Information: (please print legibly)

Name of Card Holder: _____ **Card Type:** _____ **Exp. Date:** _____

Credit Card #: _____ **CVV Code (3 or 4 digit #):** _____

❑ I authorize this medical practice to process the above credit card as "card on file". I understand this authorization will remain in effect until the expiration of the credit card account; patient may also revoke this form by submitting a written request to the medical practice.

- It is the sole responsibility of the patient to make sure that their insurance policy is effective, which is primary and which is secondary if applicable and to inform us of any and all insurance plans and/or changes; insurance policies are an arrangement between the insurance carrier and the patient. Failure to do so will result in the patient being billed for any outstanding claims or money recoveries requests.
- After the verification of your coverage & deductibles and/or copays this office may accept assignment on most policies provided the insured/patient signs and appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor. Any medical or other records or information necessary to process any claims will be released from our office. If you have any questions concerning this or any other matter, please speak with the new patient coordinator.
- If you are unable to make your appointment due to an emergency, please call us and let us know so we can reschedule your appointment. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, try to make up the missed appointment within one week as not to disrupt your treatment plan. With the exception of an unexpected emergency, we require that you notify us 6 hours in advance as to any appointment changes to avoid being charged.
- For no call/no show appointments or cancellations less than 6 hours in advance, there is a non-refundable $50.00 service charge that will be billed to you or your credit card/debit card on file.

{below to be completed with our new patient coordinator}

I, _____

❑ I agree to pay $_____for_____ visits towards my deductible, co-insurance, copay and/or out of pocket costs.

❑ I agree to pay $_____ towards my deductible, co-insurance, copay and/or out of pocket costs.

❑ was informed that Body & Spine Solutions does not participate with my insurance company:

○ Aetna	○ Blue Cross Blue Shield	○ Cigna	○ Empire Plan	○ GHI
○ Oxford	○ POMCO	○ United Healthcare	○ 1199	○ Other: _____

❑ I understand that my insurance company may be mailing checks payable to me or the insurance subscriber for services rendered. If this should occur I agree that I will sign and bring all check(s) {along with explanations of benefits and/or all documents attached to said check(s)} to the office of Body & Spine Solutions within 7 days. I am also aware that failure to do so will result in my account being forwarded to the collection department of our attorneys, Kirschenbaum & Kirschenbaum, making me liable for all account balances, attorneys and courts fees.

By signing below you affirm that you have read, understand and agree to adhere to our policies. A copy will be provided for you on your next visit.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____