SWAN

Southwest Acupuncture Network

Initial Intake Form Date: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

_____ Employer: _____

_____ Occupation: _____

Phone: (H) _____ (W) _____ Social Security # (last four only): _____

Marital Status: _____ email: _____ Spouse's Name: _____

Physician: _____ Were you referred by your Family Physician? : _____

In Emergency, Notify: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

☐Medicare ☐Medicaid ☐PPO ☐HMO ☐POS

Insurance Company Name & Address: _____

Policy holder's Name: _____ Name Birth Date: _____

Relationship to patient: _____ Social Security #: _____

Phone: _____ Identification #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name & Address: _____

Policy holder's Name: _____ Birth Date: _____

Relationship to patient: _____ Social Security #: _____

Phone: _____ Identification #: _____ Group #: _____

REFERRED BY:

☐Friend ☐Physician ☐SwanWellnessCenter.net ☐www.Alamo-Acucare.com ☐Other: _____

Have you or any of your family have been previous patients? ☐Yes ☐No

If yes, Name of Patient: _____ When: _____

If referred by physician, Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Main problem you would like help with: _____

_____

When did the problem begin (be specific): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

_____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____

Other concurrent therapies: _____

Are you currently having any of the following conditions?

_____Cold/Flu _____Infection/Inflammation _____Pregnancy/Lactation

Are you wearing any electronic device? Yes☐ No☐
If yes, what? _____
(For example, cardiac pacemaker, hearing aid, etc.)

Are you taking any blood thinning medications? Yes☐ No☐ If yes, which one?_____
(For example aspirin, plavix, warfaring, etc.)

Are you taking any drug, therapeutic or recreational? Yes☐ No☐

If yes, Please indicate the name and dosage of the medication, as well as the frequency and duration of the use of the medication_____

_____

Have you tried Chinese acupuncture and herbal medicine before? Yes☐ No☐

Have you received alternative health services? If yes, please indicate below.

_____

Past Medical History – please note dates:

Cancer: _____ HIV/AIDS: _____ Thyroid Disease: _____
Diabetes: _____ High Blood Pressure: _____ Rheumatic Fever: _____
Hepatitis: _____ Heart Disease: _____ Venereal Disease: _____

Surgeries (types & dates): _____

Significant Traumas: _____

Significant Dental Work: _____

Other: _____

Allergies (drugs, chemicals, foods, etc.) _____

_____

Occupational Stress (chemical, physical, psychological) _____

_____

Birth History (prolonged labor, forceps, premature, etc.) _____

Family Medical History

☐ Cancer	☐ Heart Disease	☐ Asthma
☐Diabetes	☐Stroke	☐ Allergies
☐High Blood Pressure	☐Seizures	☐ Other _____

Habits

Do you have a regular exercise program? Please describe: _____

_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please indicate usage per day or per week:

Cigarettes	_____ per _____	Tea	_____ per _____
Alcohol	_____ per _____	Soft Drinks	_____ per _____
Sugar	_____ per _____	Other	_____ per _____
Coffee	_____ per _____		

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

☐ Recurrent Infections
☐ Night Sweats
☐ Sweat easily
☐ Bleed or bruise easily
☐ Strong thirst (prefer hot or cold?)
☐ Thirst with no desire to drink
☐ Fatigue
☐ Sudden energy drops
Time of day_____
☐ Poor Sleep
☐ Tremors
☐ Poor Balance
☐ Edema
☐ Underweight
☐ Overweight

Skin

☐ Rashes
☐ Itching
☐ Eczema

Skin (cont.)

☐ Oozing
☐ Pimples
☐ Dry skin / scalp
☐ Recent moles
☐ Changes in hair/skin
Other _____

Head/Eyes/Ears/Nose/Throat

☐ Headaches
Where _____
When _____
☐ Migraines
☐ Dizziness
☐ Discharge from ear
☐ Poor hearing
☐ Ringing in ears
☐ Blurry vision
☐ Night blindness
☐ Color blindness
☐ Spots in front of eyes

Head/Eyes/Ears/Nose/Throat (cont.)

☐ Eye Pain
☐ Excessive Tearing
☐ Squint
☐ Glasses
☐ Sore eyes
☐ Facial Pain
☐ Nose bleeds
☐ Nasal discharge
☐ Blocked nose
☐ Snoring
☐ Grinding teeth
☐ Teeth problems
☐ Recurrent sore throat
☐ Hoarseness
☐ Tonsillitis
☐ Swollen glands
☐ Sores on lips/mouth
Other _____

Cardiovascular

☐ Pacemaker
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest discomfort/pain
☐ Heart Palpitations
☐ Cold hands or feet
☐ Swelling of hands or feet
☐ Blood Clots
☐ Spider veins
☐ Fainting
Other _____

Respiratory

☐ Difficulty breathing
☐ Pain with breathing
☐ Shallow breathing
☐ Shortness of breath
☐ Production of phlegm
color _____
☐ Recurrent cough
☐ Bronchitis
☐ Pneumonia
☐ Asthma/Wheezing
☐ Status asthmaticus
☐ Other _____

Genito-urinary

☐ Pain on urination
☐ Urgency with urination
☐ Frequent urination
☐ Blood in urine
☐ Decrease in urinary flow
☐ Unable to hold urine
☐ Incontinence at night
☐ Dribbling urination
☐ Kidney stones
☐ Prostate problems
☐ Impotency
☐ Changes in sexual drive
☐ Rashes
☐ Do you wake at night to urinate?
How many times? _____
Other _____

Gynecological

of pregnancies_____
births_____
premature births_____
abortions_____
Age of 1st menses_____
days between menses_____
Duration of menses_____
1st day of last menses_____

Musculoskeletal

☐ Neck ache/pain
☐ Back ache/pain
☐ Knee ache/pain
☐ Shoulder pain
☐ Elbow/Forearm pain
☐ Hand/Wrist pain
☐ Foot/Ankle pain
☐ Joint/Bone problems
☐ Torn tissues
☐ Prostheses
☐ Muscle pain/weakness
☐ Hernia
Other _____

Neurological

☐ Seizures
☐ Nerve damage
☐ Paralysis
☐ Stroke
☐ Sleep disorder
☐ Concussion
☐ Vertigo
☐ Lack of coordination
☐ Loss of balance
☐ Poor memory
☐ Difficulty in concentrating

Other _____

Digestion
☐ Bad breath
☐ Change in appetite
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Indigestion
☐ Belching
☐ Abdominal pain or cramps
☐ Weight gain
☐ Weight loss
☐ Loose stools / Diarrhea
☐ Strong smelling stools
☐ Bloody stools
☐ Pale stools
☐ Green stools
☐ Black stools
☐ Constipation
(not daily, or difficult)
☐ Pain with passing stools
☐ Gas
☐ Rectal pain
☐ Hemorrhoids
☐ Anorexia nervosa
☐ Bulimia
Other _____

Gynecological (cont.)
Age of menopause_____
Date of last PAP_____
☐ PMS
☐ Irregular periods
☐ Painful periods
☐ Light periods
☐ Heavy periods
☐ Clots
☐ Fibroids
☐ Endometriosis
☐ Infertility
☐ Vaginal discharge
☐ Vaginal sores
☐ Post-coital bleeding
☐ Breast lumps
☐ Nipple discharge
Other _____

Do you practice birth control?
☐ yes ☐ no
what type and for how long?
_____

Are you pregnant now?
☐ yes ☐ no

Behavioral
☐ Vacant
☐ Moody
☐ Easily susceptible to stress
☐ Aggressive/Bad temper
☐ Lose control of emotions
☐ Anxiety
☐ Panic Attacks
☐ Depression
☐ Fear
☐ Substance abuse
Other_____

Have you ever been treated for emotional problems?
☐ yes ☐ no

Have you ever considered or attempted suicide?
☐ yes ☐ no

Please note the severity of your problem right now:

0_____10
No Problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

0_____10
No Problem Worst Imaginable

Comments:_____

Informed Consent for Acupuncture & Chinese Medicine Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture and related procedures on me, or in the patient for whom I am legally responsible, by my acupuncture practitioner. I recognize the potential risk and benefit of this procedure as described below:

Potential Risk: discomfort, pain, infection, weakness, fainting, nausea, bruising or temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to the treatment.

Potential Benefits:
Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being. It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint Stimulation: The insertion of sterile acupuncture needles causes a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental, and spiritual well-being, not merely the absence of infirmity.

Qi imbalance: When the quality, quantity, and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

I do not offer to diagnose or treat any disease or condition other than the quality, quantity, and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and potentially lead to a full expression of your body's innate wisdom.

I_____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept acupuncture care on this basis.
I hereby release SWAN from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation.

_____ _____
Signature of Patient or Person authorized to consent Date

_____ _____
Print Name of Patient or Patient's Representative Date

FORM TO BE COMPLETED BY PATIENT, NOTIFYING THE ACUPUNCTURIST OF WHETHER HE/SHE HAS BEEN EVALUATED BY A PHYSICIAN, AND OTHER INFORMATION.

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____, am notifying the acupuncturist (practitioner's name), _____ of the following:

___ Yes ___ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that, I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (Initials of patient) Date: _____

___ Yes ___ No I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

OPTIONAL FORM TO BE COMPLETED BY PATIENT, ATTESTING THAT THE ACUPUNCTURIST HAS REFERRED HIM/HER

(Pursuant to the requirement of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann. §205.351, governing the practice of acupuncture.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature _____ Date _____

Acupuncturist's signature _____ Date _____

FINANCIAL POLICY
-PLEASE READ CAREFULLY-

Co-Payments and payments for services not covered by your insurance will be due at the time of your visit. For your convenience, we accept cash, check debit or credit cards (MasterCard, Visa, and Discover)

Southwest Acupuncture Network is proud of the high quality of its clinical services and is pleased to be a member of a number of insurance and provider networks. We accept insurance from providers such as Blue Cross and Blue Shield, and United Healthcare, TriWest Healthcare Alliance, and we are providers for several PPO and HMO insurance plans. ***You are responsible for obtaining the necessary referrals prior to your visit, or you will be asked to reschedule your appointment.*** All health plans are not the same and do not cover the same services. In the event your health plan determines that a service is "not covered", you will be responsible for the completer charge. Payment is due at the end of your office visit.

We expect payment from the adult accompanying a minor for all the services rendered to the minor patients.

Please sign here that you have read this office policy and agree to it. If there is a problem, please speak to the receptionist before seeing the doctor.

X _____ _____
Patient or Parent/Guardian Signature Date

RELEASE OF INFORMATION

I hereby authorize Southwest Acupuncture Network (SWAN) to furnish medical information concerning my present illness or injury, including hepatitis and HIV information, to my family physician(s), and insurance companies. I further authorize my family physician(s), referring physician(s), and other healthcare providers to furnish all medical information concerning my present illness or injury to Southwest Acupuncture Network (SWAN).

X _____ _____
Patient or Parent/Guardian Signature Date

ASSIGNMENT OF BENEFITS

I request payment of medical benefits, otherwise payable to me, directly to Southwest Acupuncture Network (SWAN) for services provided by them. I understand that I am financially responsible to Southwest Acupuncture Network (SWAN) for charges not covered by this Assignment of Benefits.

X _____ _____
Patient or Parent/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____(Printed Name), have read, reviewed, understand and agree to the Notice of Privacy Policies for healthcare services in this office.

This practice has attempted to provide each patient with a Notice of Privacy Policies.

X _____ _____
Patient Signature Date

PATIENT'S CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I,_____(Printed Name) give consent to Southwest Acupuncture Network (SWAN) the use and disclosure of my individual identifiable health information or Protected Health Information for the following specific purposes:

A. Providing treatment to me;
B. Relating to the payment of the services this office has rendered to me;
C. The general administrative operations this practice provides to me.

The Purpose of This Consent: Protected Health Information is any information which includes:

A. Demographic information;
B. Information gathered by this practice as it relates to my past, present and future physical or mental health or condition;
C. Information gathered by this office for past, present or future payments for providing the healthcare services;
D. Healthcare operations purposes will include quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Clinic, but the Clinic is not required to agree to these restrictions. However, if the Clinic agrees to a restriction that I request, the restriction is binding on the Clinic.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures from this Clinic before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Clinic has acted in reliance on this consent.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

Payment and Cancellation Policy

- Payment is by check, cash, or credit card.
  Make checks payable to Alamo Acucare.
  Full payment is expected at the time the services are rendered.

- A $25.00 charge for the first check returned by the bank. If a second check is returned, subsequent payments must be money order or cash. HCVA forms for insurance reimbursements are available at request.

- Failure to give 24 hours notice for cancellation of any appointment will result in a $25.00 cancellation fee.

I, _____, certify that I have read and understood
(Print Name)
the statements above and agree to abide by them.

Signature: _____Date: _____