The Acupuncture Clinic

620 Sims Avenue, Columbia, SC 29205 (803) 256-1000

Date: ____/_____/____

Patient Information

First Name _____ Middle Initial _____Last Name _____

Birth Date _____/_____/_____ Gender _____ SSN _____

Address _____ Suite/Apt _____

City _____State _____ Zip/Postal Code _____

Email _____

Phone, Home _____ Work _____ Cell _____

Employer _____ Occupation _____ Marital Status _____

Primary Responsible Party Information

First Name _____Middle Initial _____Last Name _____

Birth Date _____/_____/_____ Gender _____ SSN _____

Address _____ Suite/Apt _____

City _____State _____ Zip/Postal Code _____

Email _____

Phone: Home _____Work _____ Cell _____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Best Phone: _____ Type_____

Primary Care Physician: _____

Referral

Name: _____

Type: Physician Chiropractor Friend Patient Internet
Massage Therapist Physical Therapist Yellow Pages Other

Appointment Reminders

May we text reminders of your upcoming appointment? Yes No Phone # _____

Please Circle any of the following that apply to you

Pregnancy Blood Thinning Agent Pacemaker Seizures or Epilepsy HIV
Allergies Hepatitis Fibromyalgia Auto-Immune Disorder

Arthritis Type_____ Locations _____

Headaches/Migraines Type _____ Duration _____ Frequency _____

Cancer Type _____ Date _____ Treatment _____

Mood
Anxiety
Fatigue
Irritable
Depression
Foggy Head
Poor Memory
Diminished Libido
Post-Traumatic Stress

Skin
Hives
Rashes
Dryness
Eczema
Psoriasis
Other_____
_____

Ears/Nose
Hearing Loss
Ringing
Earaches
Congested
Runny Nose
Loss of Smell
Sinus

Mouth
TMJ
Dryness
Jaw Click
Bad Breath
Grinding Teeth
Sores or Ulcers
Cracked Tongue

Eyes
Redness
Dryness
Cataracts
Blurred Vision
Other_____
_____

Digestive
IBS
Reflux
Nausea
Belching
Vomiting
Constipation
Stomach Pain

Function
Insomnia
Incontinence
Restless Sleep
Night Sweating
Frequent Urination
Bone Density Issues

Connective Tissue
Bursitis
Tendonitis
Carpal Tunnel
Plantar Fasciitis
Swelling/Pain in:
_____

Internal
Lupus
Jaundice
Lyme Disease
Kidney Stones
Kidney Disease
Diabetes

Cardiovascular
Angina
Palpitations
Tachycardia
Atrial Fibrillation
High Blood Pressure
Stroke, Date_____
Areas Impacted _____

Respiratory
COPD
Asthma
Bronchitis
Pneumonia
Congestion
Emphysema
Shortness of Breath

Female
PMS
Menopause
Hot Flashes
Breast Lumps
Painful Periods
# of Births ___

Others: _____

Reason for this Appointment

Please describe your primary issue: _____

_____

_____

Your diagnosis and medical recommendations: _____

_____

Other issues to discuss: _____

_____

_____

How and when did the problem start: _____

_____

_____

How has it changed: _____

What makes it better: _____

What makes it worse: _____

How is it impacting your life: _____

_____

_____

_____

If there is pain: High number: 0 1 2 3 4 5 6 7 8 9 10 Low number: 0 1 2 3 4 5 6 7 8 9 10

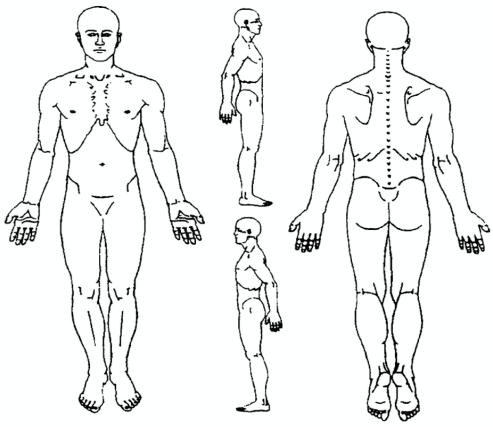
Pain Quality: Aching Burning Dull Gnawing Nagging Needle Numb Weak

Pressure Sharp Shooting Stabbing Tender Throbbing Tingling

Please List Your Current Treatments, Medications, and Supplements

_____

Problem Areas



Please Mark Relevant Areas

Your Comments, Questions, Concerns:

Information and HIPPA Consent Form

Acupuncture Description

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. An acupuncturist is not licensed to practice medicine or able to make a medical diagnosis of a person's condition.

For Patient Safety

Only single-use, sterile, disposable needles are used for treatment at The Acupuncture Clinic.

Acupuncture Side Effects

Acupuncture is generally very safe and serious side effects are rare – less than one per 10,000 treatments. Drowsiness occurs after treatment in a small number of patients. Minor bleeding or bruising occurs after acupuncture in about 3% of treatments. Pain during treatment occurs in about 1% of treatments. Symptoms can get worse after treatment (less than 3% of patients). Fainting can occur in certain patients, particularly during the first treatment. In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

What Your Practitioner Needs to Know

Please apprise your practitioner if you have ever experienced a seizure, dizziness, or fainting episode, if you have a pacemaker or other electrical implants, if you are pregnant, if you have any contagious medical condition, if you have a bleeding disorder, if you are taking anticoagulants or any other blood-thinning medications, if you have damaged heart valves or have any other particular risk of infection, if you have been advised to avoid puncture or pressure in any area of your body.

Cancelation Policy

We ask for 24-hour notice when canceling an appointment. Missed or cancelled/rescheduled appointments with less than 24 hours notice will often be considered as a treatment and charged as such. Cases of emergency or special need are exceptions.

Statement of Payment

Payment is due at the time of service. Insurance patients are responsible for any portion not covered by their insurance.

Statement of Consent

I am seeking to be treated with acupuncture for the condition of: _____

I confirm that I have read and understand the above information and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature _____ Print name in full _____ Date: / /

Please be considerate of our allergy patients and do not wear perfume or other strong scents.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about your rights under the law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below, you understand and agree to the terms of our notice of privacy practices which include:

Protected health information may be disclosed or used for treatment, payment or health care operations.

Authorization is required for certain disclosures of your Protected Health Information.

You have the right to opt out of fundraising communications.

You have the right to restrict disclosures of your Protected Health Information under certain circumstances.

You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below, you understand and agree that:

The practice has a Notice of Privacy Practices that you have had the opportunity to review.

The practice reserves the right to change the Notice of Privacy Practices and if we change our notice, you may obtain a revised copy by contacting our office.

You may revoke this consent in writing at any time and all future disclosures will cease.

Signature _____ Print name in full _____ Date: / /