BERGEN COUNTY
ACUPUNCTURE & WELLNESS

Date:

Patient Name: _____

Address: _____

City, ST ZIP: _____

Date of Birth: _____ (Age): _____ Occupation: _____

How did you hear about us? _____

Contact Information – How can we contact you (i.e. to confirm appointments)? Check one.

☐ Email ☐ Text ☐ Phone call

Email address: _____

Phone: (Home) _____ (Cell / Work): _____

Emer Contact: _____ (Phone): _____

Relationship: _____

Physician Information

Physician Name: _____ (Phone): _____

Physician Diagnosis: _____

Allergies: _____

Insurance ID: _____

Insurance Phone: _____

Have you ever had acupuncture before?

Have you eaten today? At what time was your last meal?

What is the main reason for your visit today?

_____

Has anything been able to help your issue in any way? If so, please describe.

_____

_____

Is it constant OR does it come and go?

If applicable, does the problem ever move? (For example, pain or spasm that occur in different joints or muscles at different times)

_____

Do you have a history of chronic pain? When did it start?

_____

If you experiencing pain right now what number best describes your pain? 0-10 _____

Describe your pain:

☐ Dull ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Other

What is the frequency of the pain? ☐ Continuous ☐ Intermittent

What makes your pain feel better? Please circle all that apply.

Heat Cold Pressure Massage Movement Rest

Other: _____

Is your illness affected by seasonal changes? Please describe:

_____

_____

Are there other problems you'd like addressed?

_____

_____

Date	Medications, Vitamins & Supplements you take presently	Reason for Taking/Ailment

Have you had any type of surgeries? If yes, what type of surgery and when did you have it done?

_____

_____

Describe your sleep habits (for example, the number of hours per night that you sleep, do you have trouble falling asleep, or do you awake very early and are then unable to go back to sleep)

_____

_____

Describe your bowel habits (regular, constipation, diarrhea):

_____

If you suffer from constipation,

a. Do you feel better or worse immediately after moving your bowels?
b. How many days pass before you move your bowels?

If you suffer from diarrhea,

a. Does it occur early in the morning when you first wake up?
b. Does your rectum burn as the stool exits?
c. How many episodes of diarrhea do you have per day?

Do you regularly experience abdominal pain?

a. If yes, what makes it better? Please circle all that apply.

Heat/Cold Eating/Not Eating Rest/Movement Massage Other

Do you have any emotional difficulties? Circle any that may apply.

a. Anxiety
b. Panic Attacks
c. Depression
d. Mania
e. Mood Swings
f. Seasonal Affective Disorder

How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? Circle one choice:

Excellent Good Fair Poor

How many times a day do you urinate?

Is your urine (circle): Clear Pale Dark Scanty Normal Abundant

How would you rate your appetite? Excessive Moderate/Good Poor

Do you crave sweets?

a. Do you crave other foods? If yes, what types? _____

_____

Do you get headaches often?

a. If yes, is the headache always in the same location?
Where? _____

Do you ever experience dizziness?

Are you often thirsty?

Do you prefer cold, room temperature or warm drinks?

Do you often feel cold?
a. If yes, where? Please circle all that apply.

Hands/Feet Limbs Entire Body Other

Describe the degree to which you sweat: Very Little Average Excessive

Do you exercise? How often? What do you do?

_____

_____

How would you rate your energy level? Excellent Good Fair Poor

Do you have any infectious diseases?

WOMEN ONLY – Please fill out based on your past experience. Regardless of application at this time. So when it was applicable what did you experience.

Is there a chance that you could be pregnant?

Are your menstrual cycles:	Regular	Irregular	Early	Late
Is your menstrual flow:	Heavy	Normal	Light	
Is the blood:	Normal	Purplish	Dark	Light

Does your menstrual blood contain clots?

Is your vaginal discharge:	Clear/White and thin	Yellow and thick

Do you have itching or soreness of the vagina?

If you generally experience mood swings, use the choices below to describe how they are around the time of your menses. Please circle one.

Better Worse Same NA

Number of children:	Number of miscarriages:	Number of abortions:

ACUPUNCTURE CONSENT FORM

"Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning artemisia alone or artemisia formulations).

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

"With this knowledge, I voluntarily consent to the above procedures."

_____	_____
Printed Name	Patient Signature
_____	_____
Witness	Date

Privacy Officer: Rachel Lopez

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If there are any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this Notice

Any health care professional authorized to enter information into your medical record, employees, staff and personnel at this practice who may need to access your information must abide by this notice. All subsidiary business associates (e.g. a billing service), sites and locations of this practice that share medical information with each other for treatment, payment purposes or health care operations

Payment Contract and Assignment of Benefits

I, _____, have been made aware that my health insurance company _____ is currently out of network with Bergen County Acupuncture and Wellness, Inc. I hereby authorize insurance payment directly to Bergen County Acupuncture and Wellness, Inc. otherwise payable to me by my insurance company.

I agree to pay $_____ per visit to be applied toward my out of network deductible and coinsurance. I agree to pay at the time of each visit, or in advance, to avoid any confusion in payment application and accounting.

Signature: _____ Date:_____

Insurance Payments and Cancelation Policy Mandatory Credit Card Authorization

Insurance Payments

Your insurance plan may forward payment directly to you rather than mailing the payment to us. While this is a nuisance to our patients we have not been able to change the insurance company policy. If this should happen, we ask that you forward the check immediately. Please include a copy of the statement to ensure the payment is applied. .

Instead of assessing late fees for charges that are outstanding over 30 days, Bergen County Acupuncture and Wellness, Inc. will charge the credit card of your choice for your outstanding balance. **Bergen County Acupuncture and Wellness, Inc. will always make an attempt via phone or mail to inform you of the outstanding balance and to make payment arrangements**.

Cancelation Policy **

Credit card information is mandatory. This information is NOT shared with anyone.

Bergen County Acupuncture and Wellness, Inc. requires 24 hour notice for cancellations. While we understand that emergencies do occur, we reserve the right to bill $45.00 when we do not receive proper notice.

Signing this form authorizes Bergen County Acupuncture and Wellness, Inc. to charge your credit card in the event that insurance payments are not forwarded to the office and are overdue by 30 days.

Signing this form authorizes Bergen County Acupuncture and Wellness, Inc. to charge your credit card in the event of missed appointments not communicated within 24 hours.

CC Number: _____

3 Digit Security Code _____

Expiration: _____

Signature: _____ Date: _____