Hoops Chiropractic
Family and Sports Medicine

Acupuncture Intake Form

Name Last-_____First_____Middle_____SSN #_____/_____/_____

Date of Birth_____/_____/_____**Gender** F_____M_____**Email** _____

Address_____City_____State_____Zip Code_____

Telephone: Home (_____)_____-_____ Work (_____)_____-_____Ext._____

Marital Status:_____**Education** (Highest grade or degree achieved)_____

Option: Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic?_____

Have you been treated by Acupuncture or Oriental medicine before? _____

Name of your physician:_____Tel:_____

Address of your physician:_____City_____State_____Zip Code_____

In an Emergency Notify Name_____Relationship to client_____

Phone (Day) (_____)_____-_____(Evening) (_____)_____-_____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____
3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? _____
5. Are you currently receiving treatment for your problem?_____If so, please describe:
   _____
6. Does anything improve your problem? _____

PAST MEDICAL HISTORY

Illnesses: _____
_____
Surgeries _____
_____
Significant Trauma (Auto accidents, falls, etc.) _____
Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐
If so, please describe _____

Medicines(prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies:

_____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____
Father's Side _____
Siblings_____
If any of the above is deceased, what was the cause? _____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____
Childhood health _____
Location of upbringing (Geographically prone to certain diseases, habits, etc.) _____
Current Emotional Health _____
Current Quality of Life_____
Current Relationship/Quality_____
Current Predominant Emotiom_____
Occupation_____Stress Level_____
Have you had any unusual stresses recently? _____
Favorite time of year (body type)_____ Worst_____
Hobbies & Recreational Habits _____
Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe: _____
Have you traveled abroad in the past year? Yes ☐ No ☐ Where? _____
If applicable, please describe smoking or alcohol intake : _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Areas of Numbness	☐ Anxiety
☐ Concussion	☐ Lack of Coordination	☐ Poor Memory
☐ Dizziness	☐ Loss of Balance	☐ Easily Angered
☐ Headaches	☐ Fainting	☐ Depression
☐ Migraines	☐ Disorientation	☐ Mania
☐ Easily Susceptible to Stress		

Have you ever been treated for emotional problems?_____
Have you ever considered or attempted suicide?_____
Any other neurological or psychological problems? _____
Any nervous habits?_____

PREGNANCY & GYNECOLOGY

___Age at First Menses	___Number of Pregnancies	☐ Birth Control?
___Period between Menses	___Number of Births	What type? _____
___Duration of Menses	___Miscarriages	How long?_____
☐ Unusual Character	___Abortions	☐ Fertility Problems
☐ Heavy or ☐ Light	☐ Difficult Births	☐ Vaginal Discharge
☐ Irregular Periods	☐ Breast Lumps	☐ Vaginal Sores
☐ Painful Periods	☐ Clots	

First Date of Last Menstrual Cycle_____/_____/_____ Date of Last Pap Smear_____/_____/ _____
Do you experience changes in Body and/or Psyche prior to menstruation? _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Fatigue
- ☐ Tremors
- ☐ Seizures
- ☐ Night Sweats
- ☐ Change in Appetite
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drops?

What time of Day? _____

- ☐ Poor Sleep/ Insomnia
- ☐ Dream Disturbed Sleep
- ☐ Depression
- ☐ Mania
- ☐ Emotional Changes
- ☐ Day Sweating
- ☐ Poor Balance
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Poor Appetite
- ☐ Strong thirst for Hot or Cold drinks?
- ☐ Headaches
- ☐ Localized Weakness
- ☐ Bleeding or Bruising
- ☐ Joint Pain

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold Sweats
- ☐ Swelling of Feet
- ☐ Swelling of Hands
- ☐ Difficulty in Breathing
- ☐ Cold Hands/Feet
- ☐ Phlebitis
- ☐ Blood Clots
- ☐ Palpitations

RESPIRATORY

- ☐ Cough
- ☐ Asthma
- ☐ Easily Winded w/ Exertion when laying down
- ☐ Production of phlegm
- ☐ Pain w/ Deep Breaths
- ☐ Bronchitis

What Color? _____

- ☐ Difficulty in Breathing
- ☐ Shortness of Breath
- ☐ Coughing Blood

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Ulcers
- ☐ Hernia
- ☐ Abdominal Pain/ Cramps
- ☐ Parasites
- ☐ Belching
- ☐ Bad Breath
- ☐ Hemorrhoids
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools

GENITO-URINARY

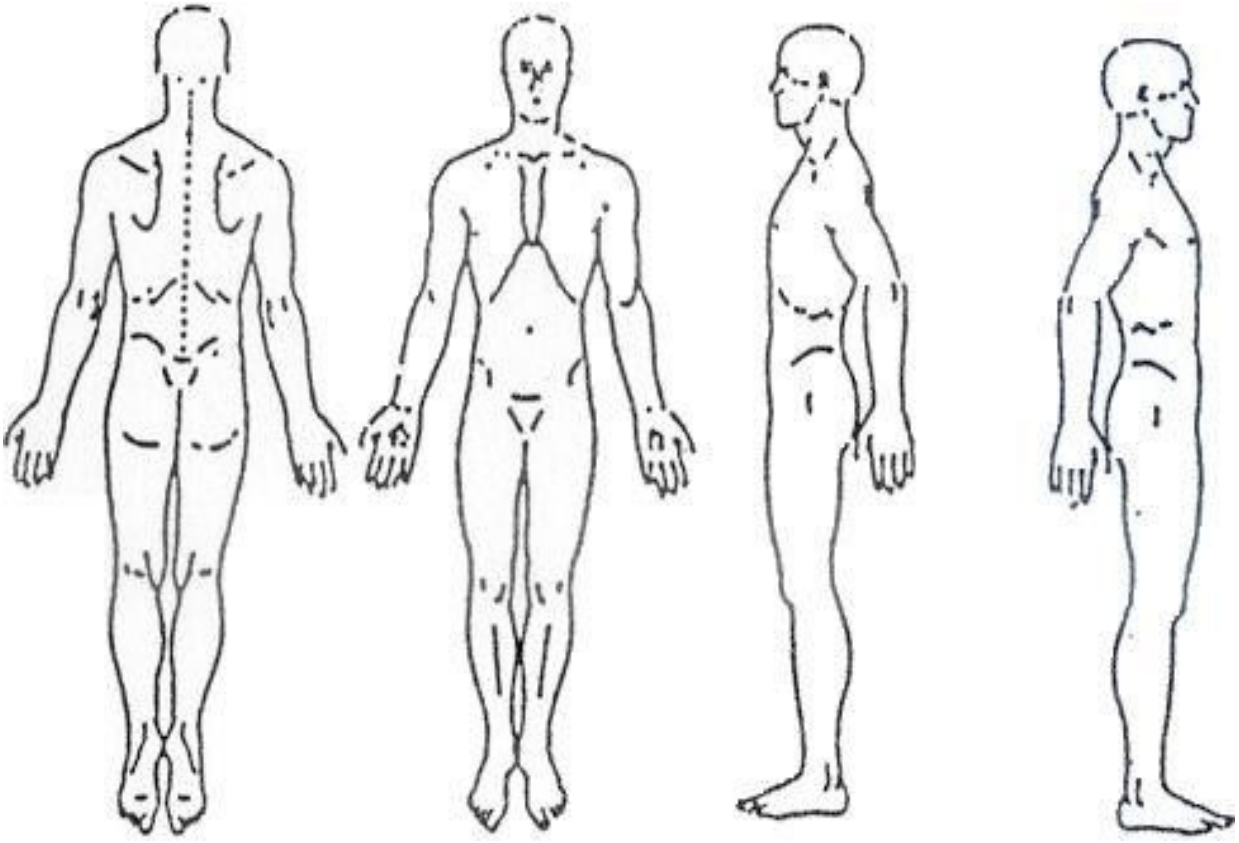
- ☐ Pain on Urination
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Unable to Hold Urine
- ☐ Decrease in Urine
- ☐ Blood in Urine
- ☐ Impotency/ Infertility
- ☐ Genital Sores
- ☐ Kidney sores
- ☐ Waking up to Urinate

How often? _____

MUSCULOSKELETAL

- ☐ Muscular Weakness
- ☐ Muscle Cramps
- ☐ Injuries or Falls
- ☐ General Aches
- ☐ Arthritis
- ☐ Spasms
- ☐ Muscular Atrophy
- ☐ Joint Instability
- ☐ Recent Sprains

Please circle on the diagram any areas of any type of pain or injury.



Please try to describe the type and quality of the pain _____

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain the most intense pain

Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

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Informed Consent Form

I hereby voluntarily request and consent to be treated, or give permission for my child to be treated, with acupuncture and other techniques based on Traditional Asian Medicine. I understand I may be given diet/ lifestyle recommendations and/or nutritional or herbal supplements and that it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

I understand that these treatments may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed my treating doctor of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify them of any changes.

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully, and I have felt free to ask any questions.

_____
Print Name

_____
Signature

_____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE – "AOR"

What is HIPAA Administrative Simplification?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. In a nutshell, we are ordered to make sure all possible measures are in place in order to protect your medical information here in this office. Your medical file / information will not be given out to anyone without your consent. Other forms of protection are also implemented in order to protect your privacy as outlined in the **"NOTICE OF PRIVACY PRACTICES."**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hoops Chiropractic's "NOTICE OF PRIVACY PRACTICES," revision dated April 13, 2003.

As required by the Privacy Regulations, Hoops Chiropractic has explained the **"NOTICE OF PRIVACY PRACTICES," to my satisfaction.**

As required by the Privacy Regulations, I am aware that Hoops Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

I acknowledge that I received a copy of *Hoops Chiropractic* **"NOTICE OF PRIVACY PRACTICES," revision dated April 13, 2003.**

Patient name (print)_____

Signature _____ Date _____

Signed form received by:_____ Date:_____

If Patient Refuses to sign place an "X" on this line:_____

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