Columbus Acupuncture LLC

Keeping Your Health On-Point

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

Last Name:________________________ First Name:____________________ MI:______

Date of Birth:___________________________ SSN:____________________________

Address: ____

City: ____________________________________State:______ Zip:______________

Phone:______________________________ ☐Work ☐Home ☐Mobile

Email: ____

How did you hear about us? ____

Who can we thank for your referral? _____________________________________

Emergency Contact Person:	
Relationship:	Contact Number:

Primary reason for seeking care with us? __________________________________

How long ago did this problem begin? _____________________________________

What makes your symptoms better? _______________________________________

What makes your symptoms worse? _______________________________________

Please indicate if you have or had any of the following conditions:

☐ AIDs / HIV	☐ Gall Bladder Issues	☐ Measles	☐ Pneumonia
☐ Alcoholism	☐ Heart Disease	☐ Meningitis	☐ Seizures
☐ Anemia	☐ Hepatitis	☐ Mental Breakdown	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Mental Illness	☐ Thyroid Issues
☐ Diabetes	☐ Jaundice	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Epilepsy	☐ Kidney Issues	☐ Mumps	☐ Venereal Disease

Surgeries / Significant Traumas: ____

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Current Medicines:____

____

____

List any allergies you have: ____

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Signs & Symptoms:

				Male Concerns
☐ Abdominal Pain	☐ Depression	☐ Kidney Stones	☐ Spots in Vision	☐ Testicle Pain
☐ Abuse Survivor	☐ Dizziness/Vertigo	☐ Loss of Hair	☐ Sweat Easily	☐ Penis Pain
☐ Acid Reflux	☐ Diarrhea	☐ Low Back Pain	☐ Upper Back Pain	☐ Penis Sores
☐ Asthma	☐ Eye Strain/Pain	☐ Migraines	☐ Urgent Urination	☐ Discharge
☐ Blood in Stools	☐ Fatigue	☐ Muscle Cramps/Pain	☐ Vomiting	☐ Premature Ejaculation
☐ Blood in Urine	☐ Frequent Urination	☐ Nasal Congestion	☐ Waking to Urinate	☐ Nocturnal Emissions
☐ Blurry Vision	☐ Grinding Teeth	☐ Neck/Shoulder Pain	☐ Weight Gain/Loss	☐ Erectile Dysfunction
☐ Bruise Easily	☐ Headache	☐ Night Sweats	☐ Wheezing	
☐ Chest Pains	☐ Heat Intolerance	☐ Numbness		
☐ Chills	☐ Hemorrhoids	☐ Painful Urination		
☐ Cold Hand/Feet	☐ Heart Palpitations	☐ Poor Appetite		
☐ Concussion	☐ High Blood Pressure	☐ Poor Circulation		
☐ Confusion	☐ Increased Libido	☐ Poor Memory		
☐ Constipation	☐ Indigestion	☐ Poor Sleep		
☐ Cough	☐ Irritable	☐ Seizures		
☐ Cough w/ Blood	☐ Itchy Eyes	☐ Short Temper		
☐ Dark Stools	☐ Itchy Skin	☐ Shortness of Breath		
☐ Decreased Libido	☐ Joint Pain	☐ Sinus Pressure		

Female Concerns

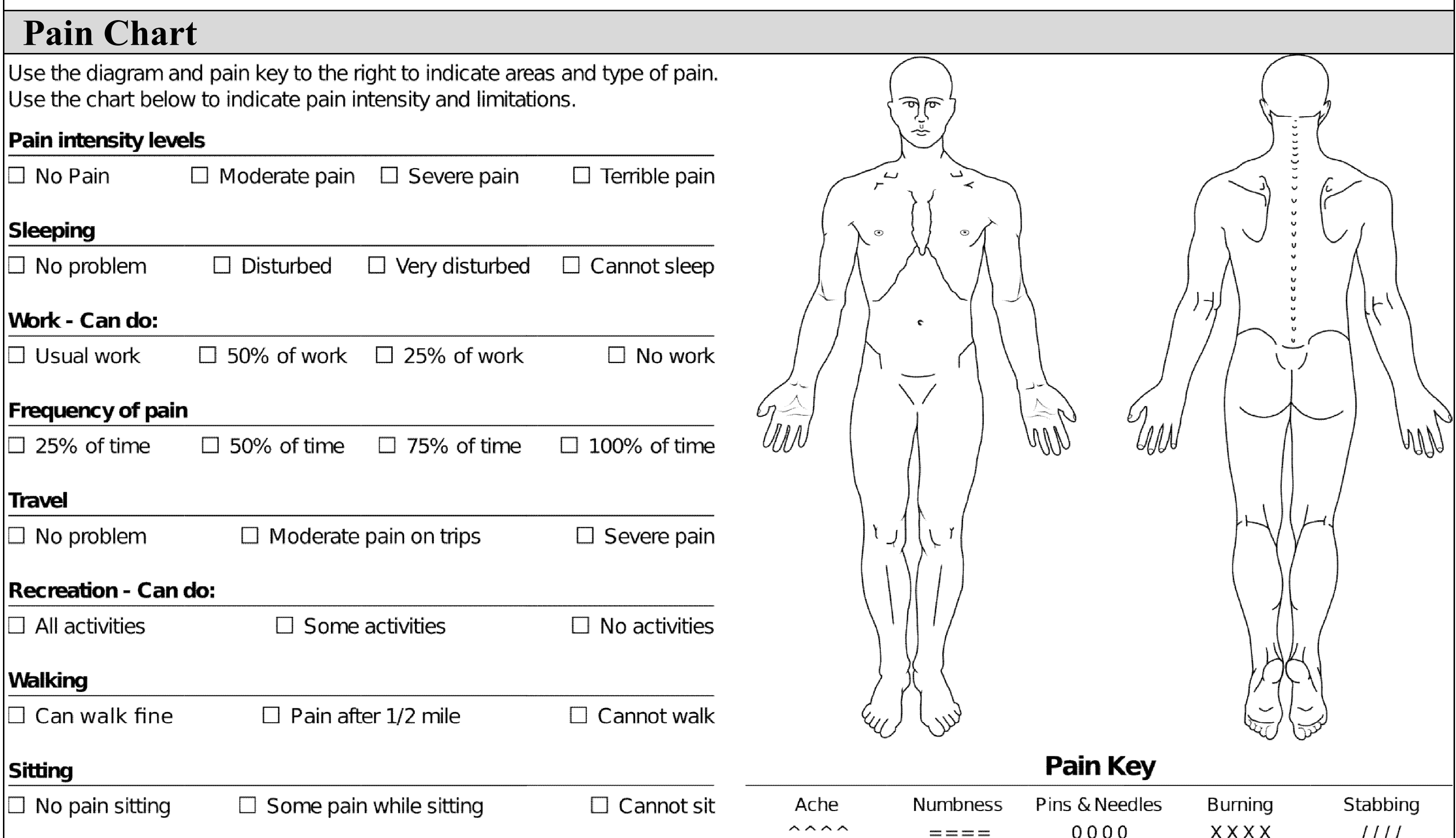
Date of Last Menstruation:

Days Between Menstruation:

Duration of Menstruation:

Number of Pregnancies:

☐ PMS	☐ Vaginal Sores
☐ Painful Periods	☐ Vaginal Pain
☐ Clotting	☐ Discharge



Pain Chart

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit

Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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CONSENT TO TREATMENT:
I hereby request and consent to acupuncture and other procedures within the scope of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Columbus Acupuncture LLC. I understand the methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Chinese herbal medicine, and nutritional counseling.

Acupuncture is a generally safe method of treatment, but that it may have a small change of side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. **I will notify a clinical staff member if I am or become pregnant.**

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do not expect the Columbus Acupuncture LLC to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

AUTHORIZATION AND RELEASE:
I authorize payment of insurance benefits directly to Columbus Acupuncture LLC. I authorize Columbus Acupuncture LLC to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of acupuncture care, regardless of insurance coverage. I understand that if my account becomes delinquent, Columbus Acupuncture LLC will hire a collection agency and I will be responsible for any additional attorney fees and court costs associated with that.

I understands and agrees to allow Columbus Acupuncture LLC to use Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

MISSED APPOINTMENT POLICY:
At Columbus Acupuncture LLC, we understand that "life happens" and that appointments need to be rescheduled. Rescheduling should be made at least 24-hours prior to an appointment. Cancellations made less than 24-hours before an appointment are subject to a $25 fee, to cover our office's lost production time. A one-time courtesy will be given for a less-than-24-hour-cancellation. After the first time you will be billed at $25. We appreciate your understanding and courtesy in regards to missed appointments.

____________________________________ ________________________
Signature of Patient or Authorized Representative: Date:

____
Printed Name of Authorized Representative and Relationship :