Acupuncture 8, LLC

More Your Qi!

Patient Intake Form (please complete this form **before** your appointment)

_____	_____	F___ M___
Name: Last	First	Gender
_____	_____	_____
Street Address	City & State	Zip Code
(____)_____-_____	(____)____-_____	(____)____-_____ _____
Telephone: Home	Cell	Work Ext.
____/____/_____	_____	_____
Date of Birth	Age	Email address
_____	_____	
Emergency Contact Name	Relationship to Client	
(____)_____-_____	(____)____-_____	
Phone (day)	Phone (evening)	

Family Physician: _____ **Phone:**_____

Have you had acupuncture or alternative treatments before?_____

Reason for treatment:_____

What other treatments have you had for problem?_____

How did you hear about Acupuncture 8?_____

Please make sure you answer the important questions below:

***Are you currently taking blood thinners/aspirin regiment or have a bleeding disorder?**_____

***Are you taking a diuretic or wearing a pain patch?**_____

***Do you have a pacemaker, cochlear implants, or suffer from seizures?**_____

***Allergies or Intolerances:**_____

Past Medical History: Last three months or anything relevant to "reason for treatment".

Illnesses/Trauma/Accidents:_____

Surgeries:_____

Infectious Diseases:_____

PLEASE LIST YOUR CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS, HERBS

CURRENT MEDICATIONS:

Prescriptions/Over the Counter/Vitamins/Herbs (taken within the last 6 months)

Name:	Dose:	Taken for:

If you have a list of your medications, herbs, vitamins, please attach or include copy.

Office initial_____

Describing your Pain:

When did pain begin?_____

What caused the pain?_____

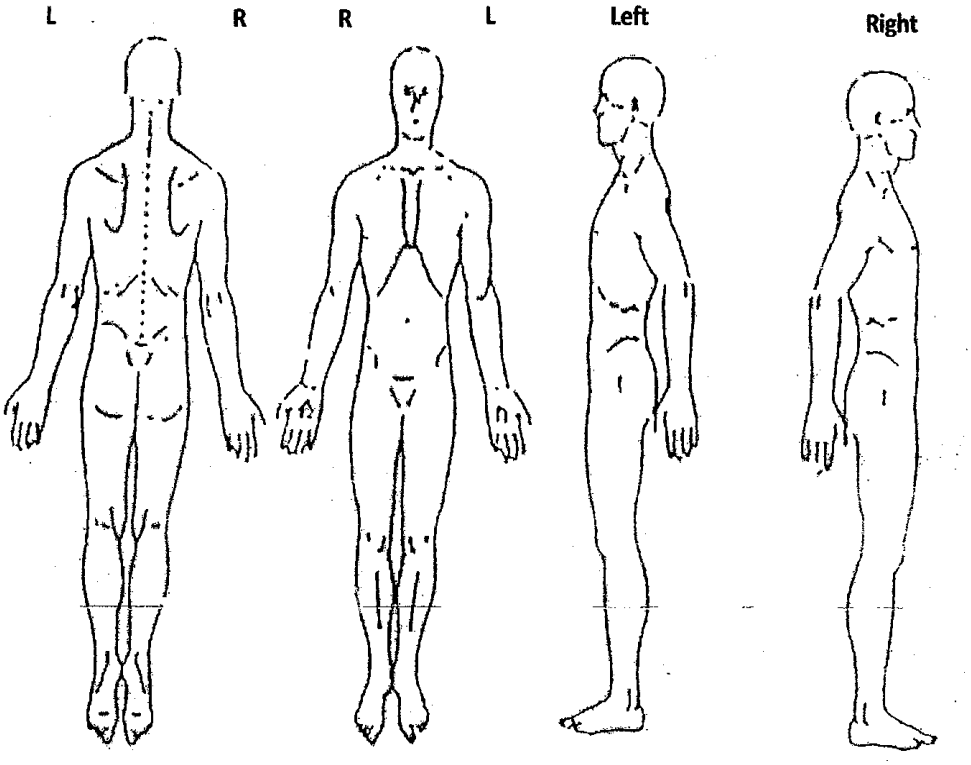
What type of pain? Sharp Dull Achy Burning Weakness Cramp Spasm

Is your pain: Constant or Intermittent

Is there something that makes it BETTER?_____

Is there something that makes it WORSE?_____

Circle or Mark Areas of Pain:



Please circle or mark pain areas

Office initial_____

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. **A copy of the PPN is on this website for printing or review.**

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Acupuncture 8 LLC.
I understand that the Notice describes the uses and disclosures of my protected health information by Acupuncture 8 LLC and informs me of my rights with respect to my protected health information.

_____
Patient's Signature or that of Legal Representative

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____
Employee Name *Today's Date*