

ACUPUNCTURE NEW PATIENT FORM

REGISTRATION INFORMATION

PAGE 1 OF 7

Patient Information

First Name:		Last Name:		Date:	
Address:			City:	State:	Zip Code:
Home Phone: <input type="checkbox"/> yes, we can a leave message		Cell Phone: <input type="checkbox"/> yes, we can leave a message		Work Phone: <input type="checkbox"/> yes, we can leave a message	
Email Address:		Employer:		Occupation:	
Date of Birth:	SS#:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	
Emergency Contact:		Relationship to you:	Emergency Contact Phone:		Emergency Alternate Phone:
How were you referred to our clinic? <input type="checkbox"/> Family / Friend <input type="checkbox"/> Previous CIM Patient <input type="checkbox"/> Physician <input type="checkbox"/> Web Site <input type="checkbox"/> Insurance Company <input type="checkbox"/> Other: _____			Whom May we thank for referring you:		Have you been treated by Acupuncture before? <input type="checkbox"/> No <input type="checkbox"/> Yes: when? ____ / ____

Insurance Information

Insurance Company:	Subscriber Name:	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Subscriber Date of Birth:
Subscriber Employer:	Policy / ID #:	Group #:	Phone:

Secondary Insurance Information

Insurance Company:	Subscriber Name:	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Subscriber Date of Birth:
Subscriber Employer:	Policy / ID #:	Group #:	Phone:

Accident Information

Is your current condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: _____	To whom have you made a report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Worker Comp <input type="checkbox"/> Employer <input type="checkbox"/> Other: _____
Date of accident: ____ / ____ / ____	Phone:	Referring Physician:
Case Manager:		

Payment Method

<input type="checkbox"/> Cash / Check	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Other: _____
---------------------------------------	--------------------------------------	-------------------------------------------	-----------------------------------------------	---------------------------------------

Acknowledgement

I acknowledge that the information stated above is true. I authorize payment of all insurance benefits, if any, for the health care services or goods rendered to be made directly to Moore Acupuncture. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Moore Acupuncture may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Printed Name of Patient / Guardian / Personal Representative

Signature of Patient / Guardian / Personal Representative

Relationship to patient

Date

Moore Acupuncture

1411 NW Raleigh St. | Portland, OR 97209 | Phone: 503-267-7470

PRESENT HEALTH INFORMATION

Primary Health Concern:

When did symptoms appear?

Is this condition getting: Worse Same Better

Does this condition interfere with:

Work Daily Routine Recreation Sleep
 Energy Digestion Emotional State

Are you currently receiving treatment for this condition? Yes No

Medications Physical Therapy Chiropractic Surgery
 Other: _____

Doctor / Practitioner: _____

Have you previously received treatment for this condition? Yes No

Medications Physical Therapy Chiropractic Surgery
 Other: _____

Doctor / Practitioner: _____

What type of treatment has provided the most relief?

Medications Physical Therapy Chiropractic Surgery
 Other: _____

Doctor / Practitioner: _____

Please circle the number that best rates the severity of your pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down

How would you best describe your pain:

Sharp Dull Throb Numb Shooting Cramp
 Ache Burn Tingle Stiff Swelling Other

What are your goals and expectations for treatment of this condition?

Secondary Health Concern:

When did symptoms appear?

Is this condition getting: Worse Same Better

Does this condition interfere with:

Work Daily Routine Recreation Sleep
 Energy Digestion Emotional State

Are you currently receiving treatment for this condition? Yes No

Medications Physical Therapy Chiropractic Surgery
 Other: _____

Doctor / Practitioner: _____

Have you previously received treatment for this condition? Yes No

Medications Physical Therapy Chiropractic Surgery
 Other: _____

Doctor / Practitioner: _____

What type of treatment has provided the most relief?

Medications Physical Therapy Chiropractic Surgery
 Other: _____

Doctor / Practitioner: _____

Please circle the number that best rates the severity of your pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

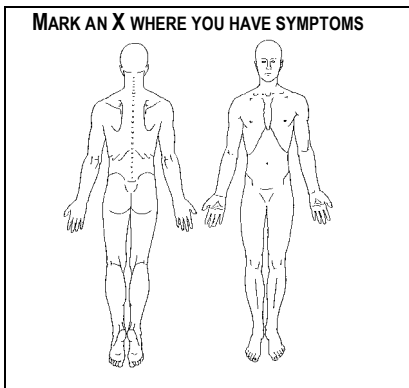
Activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down

How would you best describe your pain:

Sharp Dull Throb Numb Shooting Cramp
 Ache Burn Tingle Stiff Swelling Other

What are your goals and expectations for treatment of this condition?



PLEASE ADD ANY ADDITIONAL INFORMATION OR COMMENTS THAT YOU FEEL ARE IMPORTANT FOR ME TO KNOW:

Printed Name of Patient: _____ Date: _____

HEALTH HISTORY

System Review - Please check all that apply

Do you have or have you had any of the following conditions:

- | | | | | |
|--------------------------------------------------------|--------------------------------------------|------------------------------------------|------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure: |
| <input type="checkbox"/> Alcohol / Chemical Dependency | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | Last BP Reading: ____ / ____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Stroke | Date Taken: _____ |

Mental / Emotional

- Anxiety
- Depression
- Mental Tension / Stress
- Mood Swings
- Nervousness
- Poor Concentration
- Poor Memory
- Other: _____

Energy / Immunity

- Chronic Infections
- Fatigue
- Frequent Common Cold
- Slow Wound Healing
- Other: _____

Sleep

- Number of hours per night: _____
- Difficulty falling asleep
 - Disturbing Dreams
 - Insomnia
 - Not rested upon waking
 - Restless Sleep:
wake ____ x / night
 - Other: _____

Musculoskeletal

- Arthritis
- Back Pain - Upper / Mid / Low
- Joint Pain
- Limb Pain - Upper / Lower
- Muscle Weakness
- Muscle Spasms / Cramps
- Neck Pain
- Shoulder Pain
- Stiffness
- Other: _____

Skin

- Acne
- Bruise Easily
- Dryness / Itching
- Eczema / Hives / Rashes
- Lumps
- Other: _____

Head

- Headaches
- Head Injury
- Memory Loss
- Migraine Headaches
- Other: _____

Eyes

- Blurry Vision
- Dryness / Tearing
- Eye Pain / Strain
- Floaters / Spots
- Impaired Vision
- Twitching
- Other: _____

Ears

- Dizziness / Vertigo
- Earache / Pain
- Ear Ringing / Tinnitus
- Impaired Hearing
- Other: _____

Nose / Sinus

- Frequent Colds
- Hay Fever
- Sinus Congestion / Infection
- Nose Bleeds
- Other: _____

Mouth / Throat

- Canker Sores
- Dry Mouth
- Halitosis
- Sore Throats / Hoarseness
- Teeth / Gum Disease
- TMJ / Jaw Pain / Grinding
- Other: _____

Endocrine

- Excessive Thirst / Hunger
- Excessive Sweating
- Feeling Hot or Cold
- Hyper / Hypo Thyroid
- Hypoglycemia
- Other: _____

Respiratory

- Asthma / Wheezing
- Difficulty Breathing
- Persistent Cough
- Shortness of Breath
- Sputum
- Other: _____

Cardiovascular

- Chest Pain / Tightness
- Heart Disease
- High Blood Pressure
- Low Blood Pressure
- Palpitations / Fluttering
- Swelling of Ankles
- Varicose Veins
- Other: _____

Neurological

- Loss of Balance
- Numbness / Tingling
- Paralysis
- Seizure / Epilepsy
- Tremor
- Vertigo / Dizziness
- Other: _____

Gastrointestinal

Bowel Movement how often?
_____ x / every _____ days

- Abdominal Pain
- Acid Reflux
- Blood / Mucus in Stool
- Changes in Appetite
- Constipation
- Diarrhea
- Gall Bladder Disease / Stones
- Gas / Bloating
- Heartburn
- Liver Disease
- Loose Stool
- Nausea / Vomiting
- Ulcers
- Undigested Food in Stool
- Other: _____

Urinary

- Blood in Urine
- Cloudy Urine
- Frequent Nighttime Urination:
x / per / night _____
- Frequent Urination
- Frequent UTI
- Incontinence
- Kidney Disease / Stones
- Painful Urination
- Other: _____

Male Reproduction

- Hemorrhoids
- Hernia
- Impotence
- Penile Discharge / Sores
- Prostate Disease
- Testicular Pain / Swelling
- Other: _____

Female Reproduction

- I am pregnant / Due: _____
- I am trying to get pregnant
- Number of Pregnancies: _____
- Number of Births: _____
- Abnormal Discharge
- Breast Tenderness / Lumps
- Clotting
- Difficulty Conceiving
- Dryness or Itching
- Heavy Flow
- Hemorrhoids
- Hot Flashes
- Irregular Menstruation
- Night Sweats
- Ovarian Cysts
- Pain During Intercourse
- Painful Menses
- PMS
- Spotting
- Other: _____

Printed Name of Patient:

Date:

HEALTH HISTORY CONTINUED

Surgeries / Hospitalizations

Date:	Procedure:

Date:	Procedure:

Medications / Supplements - Please list all medications and supplements that you are currently taking and your reason for taking them:

Allergies - Please list all food, drug, environmental or chemical allergies or hypersensitivities that you are aware of:

Exercise

<input type="checkbox"/> None
<input type="checkbox"/> Moderate
<input type="checkbox"/> Daily

Stress Level

<input type="checkbox"/> Low
<input type="checkbox"/> Medium
<input type="checkbox"/> High

Habits

<input type="checkbox"/> Alcohol Consumption	Drinks / Week: _____
<input type="checkbox"/> Coffee / Caffeine Consumption	Cups / Day: _____
<input type="checkbox"/> Smoking	Packs / Day: _____

Do you have adequate physical and emotional support at home to meet the challenges of your present condition? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please note:
The information provided on this form is confidential**

It is very important the information given is complete and accurate to properly assist you in your healing process. Please take a moment to review your form and make sure it is complete.

Thank you

Printed Name of Patient:	Date:
--------------------------	-------

INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture and Oriental medicine by licensed acupuncturist, Jana Moore Capristo, L.Ac. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner.

Acupuncture: I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment and very rarely organ puncture, nerve damage or infection. I understand that I may refuse this therapy at any time.

Infrared Mineral Lamp Heat Therapy: I understand that I may receive the infrared mineral lamp heat therapy as part of my treatment, which is used as an adjunct to acupuncture to warm the body and stimulate healing. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: a risk of burning or scarring, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Electro-Acupuncture: I understand that I may receive electro-acupuncture as part of my treatment, which involves the stimulation of acupuncture points with a mild electric current (similar to a TENS treatment). I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Cupping: I understand that I may receive cupping as part of my treatment, which involves a localized suction on the skin where the superficial muscle layer is drawn into and held in the cup. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, on rare occasions blistering may occur, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Acupressure/Tui-Na Massage: I understand that I may receive acupressure/tui-na massage as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Chinese Herbs: I understand that Chinese herbs may be recommended as part of my treatment in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These may include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment.
If I associate any concerns with the use of the herbal substances, I should stop use immediately and call Jana Moore Capristo, L.Ac.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature of Patient / Guardian / Personal Representative:	Date:
Printed Name of Patient / Guardian / Personal Representative:	Relationship to patient:

***Parent / Guardian MUST sign if patient is under 18 years of age**

Printed Name of Patient:	Date:
--------------------------	-------

HIPPA

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation and your employer, or with other medical practitioners that you authorize.

Safeguards in place at Moore Acupuncture include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that Moore Acupuncture may gather and use:

In administering your health care, Moore Acupuncture may gather and maintain information that may include non-public personal information:

- About your financial / billing transactions with us.
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you - e.g. your name, address, Social Security number, etc.).

Moore Acupuncture values our relationship, and respects your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours.

Acknowledgment of Receipt of the Notice of Privacy Practices

I have received the HIPPA Notice, which describes how Moore Acupuncture may use and disclose my protected health care information to carry out treatment, payment of services, health care operations, and other purposes that are allowed by law. This notice also describes my patient rights and requirements to protect my health information.

Signature of Patient / Guardian / Personal Representative:	Date:
Printed Name of Patient / Guardian / Personal Representative:	Relationship to patient:

Printed Name of Patient:	Date:
--------------------------	-------

Financial Policies

As a courtesy to you, Moore Acupuncture will submit charges for medical treatment to your insurance company. However, you are financially responsible for all charges incurred at this office, including your insurance deductible, co-payment, and any portions of charges that your insurance does not pay. Moore Acupuncture requires co-pays and/or payment for treatment to be paid at the time of service. Payment may be made in the form of cash, check, or credit card.

Cancellation Policy

If you need to cancel or reschedule an appointment, Moore Acupuncture requires that you do so at least twenty-four hours before your scheduled appointment time. Failure to do so may result in a charge of \$30.00 billed to your account.

By signing below, I agree to Moore Acupuncture's Patient Financial Responsibility and Cancellation Policy Agreement.

Signature of Patient / Guardian / Personal Representative:	Date:
Printed Name of Patient / Guardian / Personal Representative:	Relationship to patient:

Printed Name of Patient:	Date:
--------------------------	-------