Jade Mountain Acupuncture
Health Intake Form

Please help us provide you with complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential in conformation with our Privacy Policy.

HOW DID YOU HEAR ABOUT US? ____

Jade Mountain Acupuncture Health Intake Form

Intake Form Date: ______________________

Name: ____

Address: ____

City: __________________________ State: ______________________ Zip: ____________

Phone: Home: ___________________ Cell: ____________________ Work: _____________

Date of Birth: ____________________ Age: _______ Email: __________________________

Social Security #: ____

Marital Status (circle one): □M □S □W □D Gender: □M □F □O: ______

Occupation: ____

Emergency Contact's Name: _____________________________ Phone: _____________

Physician's Name: _____________________________________ Phone: _____________

Physician's Diagnosis: ____

Height: ______________________________ Weight: ________________________________

Allergies: ____

____

Medical Insurance Information:

Insurance Company Name: ____

Insurance Plan Name: ____

Insured Policy/Group Number: ____

Primary Insured Name: ____

Primary Insured Date of Birth: ____

What is your relationship to the Primary Insured individual? ____________________________

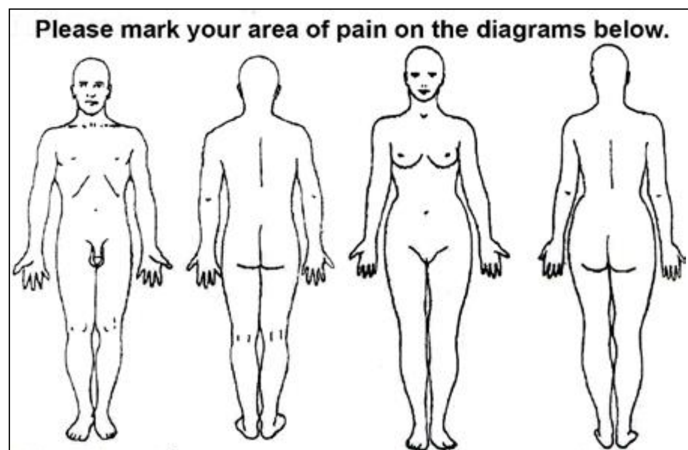
1. Have you ever had acupuncture before? □Yes □No
2. Have you eaten today? □Yes □No
    a. If so, at what time was your last meal? ____

3. What is the problem that brought you here today? ____________________________________

4. Has there been anything that has ever been able to change your problem in any way?
□Yes □No If **Yes**, please describe.____
5. When did this problem first appear? ____

6. Is the problem constant, or does it come and go? _____________________________________

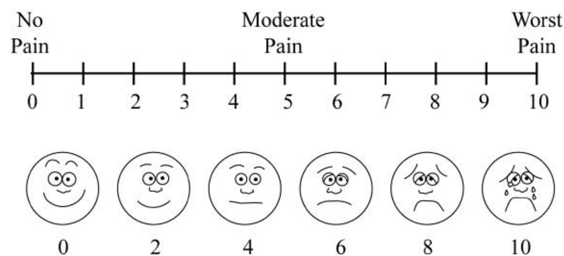
7. If applicable, does the problem ever move? (For example, pain or spasms that occur in different joints or muscles at different times) □Yes □No



8. Do you have a history of chronic pain?
□Yes □No

9. Are you experiencing pain right now?
□Yes □No
    a. If **Yes**, what number best describes your pain (use scale below)?
____

0-10 Pain Intensity Numeric Rating Scale (NRS)



10. What is the frequency of the pain? □Continuous □Intermittent

11. What makes your pain better? (Please check all that apply).
□Heat □Pressure □Movement
□Cold □Massage □Rest
Other: ____

12. Is your illness affected by seasonal changes? Please describe. __________________________
____
13. Are there other problems you would like addressed? __________________________________

____

____

14. Date	Medications, Vitamins & Supplements you take presently	Dosage, Route and Frequency

15. Have you had any surgeries/hospitalization? ☐Yes ☐No
If **yes**, what type of surgery/procedure and when did you have it done?

____

____

16. History of Significant Illness:
Self: (Please include all past accidents, childhood illnesses, and the date that they occurred)

____

____

Siblings: ____
Mother: ____
Father: ____
Maternal Grandmother/Grandfather: _____________________________________
Paternal Grandmother/Grandfather: _____________________________________
17. Have you ever smoked? ☐Yes ☐No If **No**, when did you quit? ________________
18. If **Yes**, do you still smoke? ☐Yes ☐No
18a. How many cigarettes do you smoke daily? ____________________________
19. Do you drink alcohol? ☐Yes ☐No
b. If **Yes**, how many glasses per week? ________________

20. **Describe your sleep habits:**

Number of hours per night that you sleep:		Do you awake very early and are then unable to go back to sleep?	☐Yes ☐No
Do you have trouble falling to sleep?	☐Yes ☐No	Do you wake up frequently? If so when? ________________	☐Yes ☐No

21. Describe your bowel habits: □Regular (Times per day: ________) □Constipation □Diarrhea

22. 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? _______________________________

23. 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? ______________________________

24. Do you regularly experience abdominal pain? □Yes □No

a. If **Yes**, what makes it better? (Please check all that apply)

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

25. Do you have any emotional difficulties? (Please check all that apply)

□Anxiety □Mania
□Panic Attacks □Mood Swings
□Depression □Seasonal Affective Disorder

26. How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? (Please check one choice)

□Excellent □Good □Fair □Poor

27. How many times a day you urinate per day? _______________________

a. Color of Urine: □Clear □Pale □Yellow □Dark Yellow
b. Volume of Urine: □Scant □Normal □Abundant

28. How would you rate your appetite? Please one choice.

Excessive Moderate/Good Poor

29. Do you crave sweets? □Yes □No

a. Do you crave other foods? If yes, what type? ____________________________________

30. Do you get headaches often? □Yes □No
31. Do you ever experience dizziness? □Yes □No
32. Are you often thirsty? □Yes □No
33. What temperature do you prefer your drinks? (Please check one choice)

□Cold □Room Temperature □Warm

34. Do you often feel cold? □Yes □No

a. If **Yes**, where? (Please check all that apply)

□Hands/Feet □Limbs □ Entire Body □Other

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

a. Do you sweat at night? □Yes □No

36. Do you exercise? □Yes □No
   a. If **Yes**, how often? ____
   b. What do you do? ____

37. How would you rate your energy level?
   □Excellent □Good □Fair □Poor □Other

38. **Describe your diet:**
   a. Number of vegetable portions eaten daily: ______
   b. Number of meat product portions eaten daily: ______
   c. Number of dairy product portions eaten daily: ______
   d. Number of caffeine containing products eaten daily: ______
   e. Number of whole grain product portions eaten daily: ______

39. Have you had your lymph nodes removed? □Yes □No
   a. If yes, please describe.____

40. Do you have any infectious diseases? □Yes □No

a. If **Yes**, please list:

41. Do you have a history of drug abuse? □Yes □No

WOMEN ONLY

42. Is there a chance that you could be pregnant? □Yes □No
43. Are your menstrual cycles: □Regular □Irregular □Early □Late
   a. How many days is your cycle from 1st day of bleeding to last day before next period? ___________
   b. How many days does your period last? ___________
   c. Age of Menarche (first menstrual cycle): ____________
44. Is your menstrual flow: □Heavy □Normal □Light
45. Is the blood: □Normal □Purplish □Dark □Light
46. Does your menstrual blood contain clots? □Yes □No
   a. If yes, what color are the clots? □Bright □Red □Dark in Color
   b. Are they larger than a quarter? □Yes □No
47. Do you have vaginal discharge? □Clear □White and Thin □Yellow and Thick
48. Do you have itching or soreness of the vagina? □Yes □No

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

□Better □Worse □Same □Not Applicable

50. Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____
51. Do you have symptoms that only appear prior to your period? □Yes □No
   a. If **Yes**, are they: □Sore Swollen Breasts □Mood Swings □Headaches □Bloating □Anger □Sadness □Other

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some *side effects*, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

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.

While I do not expect the clinical staff 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.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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.

______________________________	______________________________
Printed Name Patient	Signature
______________________________	______________________________
Witness	Date

PATIENT'S ADVISORY TO CONSULT WITH A PHYSICIAN

To comply with NJ PL 2009 (C.45:2C-5a-2 Jade Mountain Acupuncture and Wellness Center requests that you read and sign the following Statement:

We, the undersigned affirm that: ___________________________________ has been advised
(Print Patient's Name)
by Marcus Rosario, L.Ac., ABT to consult a licensed physician regarding the condition for which the above patient seeks treatment at Jade Mountain Acupuncture and Wellness Center.

____ __________________________
Signature of the Patient Date

____ __________________________
Signature of the Licensed Acupuncturist, L.Ac. Date

OFFICE POLICIES

Appointments and Scheduling

• Treatments are by appointment only. Emergency appointments are available if there is time in the schedule. Please call.

• Please be on time for appointments. Unfortunately, because schedules are often tight, your treatment time may be shortened if you arrive late. However, if we are running late, you will always receive a full treatment.

Fees and Billing

• The fee for acupuncture is $170 for an initial evaluation/treatment and $120 per subsequent treatment, or $75 if the treatment calls for 30-minute follow-ups.
Treatments typically last from between 40 minutes to one hour, or 20-30 minutes (on the 30-minute follow-up). First time evaluation/treatment lasts about 90 minutes.

- 24 HOURS ADVANCED NOTICE IS REQUESTED FOR CANCELLATIONS. PATIENTS WILL BE RESPONSIBLE FOR A $25 FEE FOR ANY MISSED APPOINTMENTS OR NON-EMERGENCY LATE CANCELLATIONS.

- Payment is requested at the time of visit. Insurance is not accepted unless previously arranged, although you may submit claims to your own company for direct reimbursement. There will be a $25 charge for returned checks. We accept all major credit cards.

If you have any questions or concerns about these policies, please ask.

I have read and agree to the above policies.

Signature: ______________________________________ Date: ____________________