

Confidential Patient Information Sheet

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____

Would you like to receive a free email newsletter (your email information is held in complete confidence)? ☐ Yes ☐ No

Height _____ Weight _____ Age _____ Sex: ☐ Male ☐ Female Dominant Hand: ☐ Left ☐ Right

Date of birth: _____ Marital Status: _____

Number of children: _____ Ages of children: _____ Number who live with you: _____

Occupation _____ Employer _____

In emergency notify (name): _____ Emergency phone number: _____

Primary Care Doctor _____ Last seen: _____

How did you hear about us: ☐ Social Media ☐ Google Search ☐ Yahoo Search ☐ Email ☐ Other Web

☐ Brochure ☐ Business Card ☐ Other Ad ☐ Referred by: _____

Medical History

Reason for your visit here today: _____

How long have you had this condition? _____

Are you being treated for this condition by anyone else: ☐ Yes ☐ No

If Yes, who? _____ Phone number: _____

Has this condition been diagnosed by a MD? ☐ Yes (Diagnosis: _____) ☐ No

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not much ☐ Not at all

Have you had acupuncture before? ☐ Yes ☐ No Name of Acupuncturist: _____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

If Yes, please identify: _____

Health Inventory

Cardiovascular Conditions : <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	Emotional / Mental: <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	Energy & Immunity: <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies	Respiratory: <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
Musculo-Skeletal: <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain	Head, Eye, Ear, Nose & Throat: <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever	Genito-Urinary Tract: <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence Neurological: <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Migraines	Gastrointestinal: <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Irritable Bowl Syndrome <input type="checkbox"/> Leaky Gut Syndrome
Endocrine : <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold	Other: <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hand / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin / Graying hair	Liver Conditions: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	Men Only: <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions

Women Only:
 Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Method of Birth Control: _____
 Age at first period: _____ Date of last menses: _____ Age at menopause: _____
 Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____
 Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____
 Hysterectomy: ☐ Yes ☐ No Date: _____
 Check all that apply: ☐ Low libido ☐ Excessive libido ☐ Painful Intercourse ☐ Clotting ☐ Painful Periods
☐ Heavy Flow ☐ Scanty Flow ☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Vaginal Discharge ☐ Breast
 Lumps / Tenderness ☐ Nipple Discharge ☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Problems
☐ Endometriosis ☐ Fibroids ☐ Fibrocystic Breasts ☐ Ovarian Cysts ☐ Abnormal Pap Smear

Medications

Please list the medications and supplements you are currently taking:

Drug / Supplement	Reason for taking	For how long	Dose	Frequency
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Known Allergies: _____

I am taking Coumadin / Warfarin ☐ Yes ☐ No

I have a pacemaker ☐ Yes ☐ No

Lifestyle

Are you vegetarian or vegan? ☐ Yes ☐ No

How would you rate the following areas of your health in the past month:

Energy:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Digestion:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Urination:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Sleep:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Appetite:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Diet:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Exercise:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____
Immunity:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments: _____

How do you feel about the following areas of your life in the past month:

Significant Other:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A	Comments: _____
Family:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A	Comments: _____
Sex Life:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A	Comments: _____
Self:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A	Comments: _____
Work:	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> N/A	Comments: _____

Pain

Please answer the following questions if you have pain.

Indicate on the diagrams below the areas of pain:

Quality of pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Cramping ☐ Burning ☐ Constant ☐ Fixed ☐ Moves about

On a scale of 1 – 10 (10 being worst) how strong is your pain? _____

Does the pain radiate? ☐ Yes ☐ No Where? _____

What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing

What aggravates the pain?

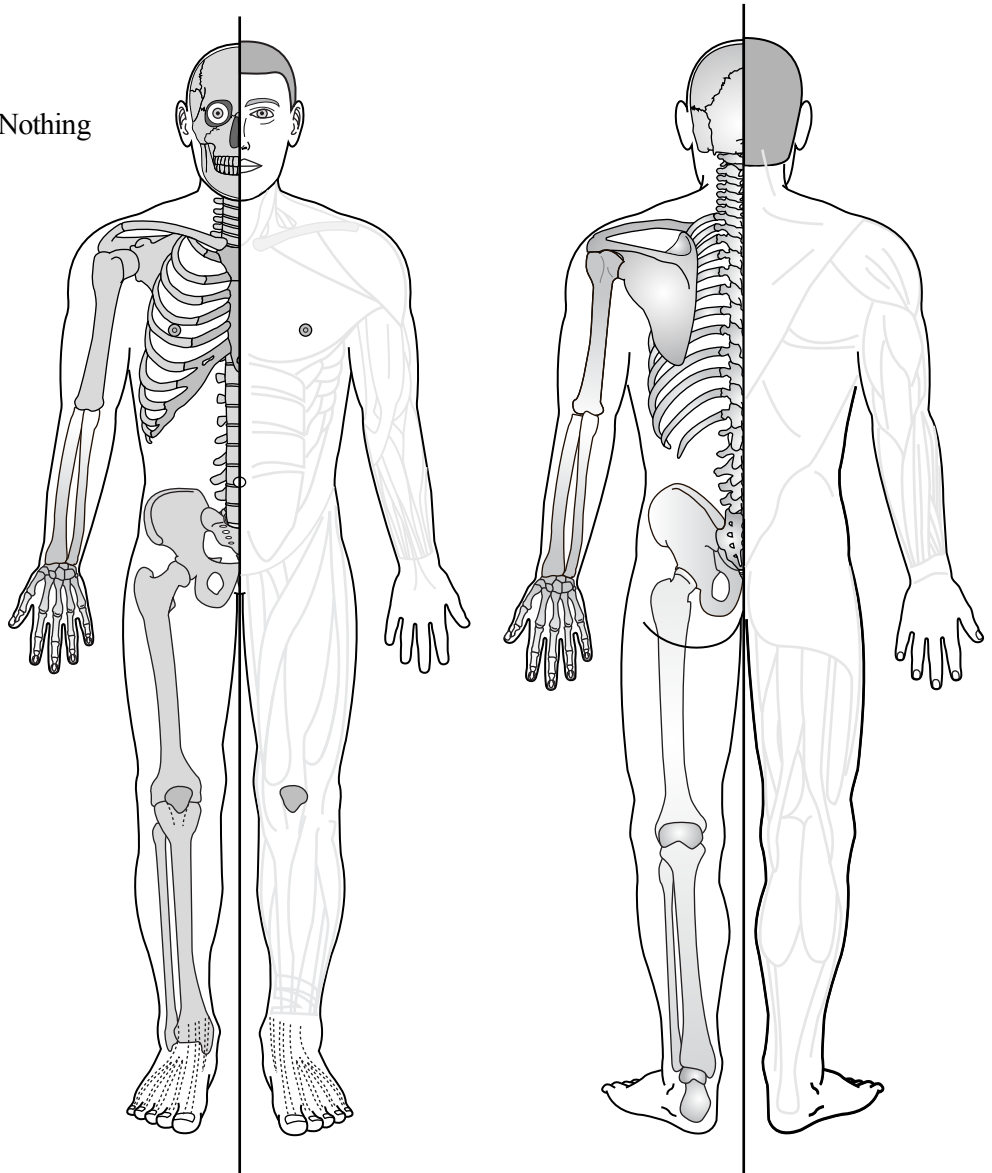
☐ Ice ☐ Heat ☐ Rest ☐ Movement

☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing

When is the pain the worst?

☐ Morning ☐ Afternoon ☐ Evening

Anything you wish to add?



The above information is true to the best of my knowledge.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

South Florida Acupuncture Associates Intake Forms

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TO OUR PATIENTS<

Thank you for choosing South Florida Acupuncture Associates for your health care needs. We are committed to your optimal health and strive to insure that your treatments are successful and your visits here positive. To help achieve this, it is important that you follow all instructions carefully.

When you come for your visits please remember the following:

1. Briefly tell the doctor your present symptoms (or bring a list).
2. Listen carefully to all instructions. Take notes if necessary.
3. Ask all questions while the doctor is seeing you; once he leaves your room, he must give his full attention to other patients who are waiting. Make yourself a list of questions before your visit, if you wish. Also, ask the doctor when you need to see him again to schedule your next appointment at the front desk while paying for treatment.
4. Please extend the same courtesies to other patients that you expect them to show you. Please be on time for your appointments. If something unexpected comes up, please call immediately to see if we can work you in later or re-schedule for another day. And remember to ask all your questions during your time with the doctor.

The following explains our office policies:

PAYMENTS Payments are due at the time of service. We accept cash, checks, MasterCard, Visa, Discover, and American Express.

INSURANCE We do accept assignment, if you don't have coverage, payments are due at time of service. We will file insurance for your reimbursement only if you have verified that acupuncture is covered. Please present your insurance card for us to photocopy.

MISSEDAPPOINTMENTS Unless cancelled 24 hours in advance, our policy is to charge the usual fee for an office visit missed. Your treatments will be more effective if you follow your treatment schedule and the doctor's instructions. Problems do arise and we will work with you as much as possible. However, we must have the courtesy of a call from you well in advance if you need to miss or re-schedule an appointment.

I have read and agree to the policies stated above.

Patient's signature

Date

CONSENT FOR ACUPUNCTURE TREATMENT

I, _____, do consent for treatment in the office(s) of South Florida Acupuncture Associates. I understand that acupuncture, acupressure, injections and cupping treatments may occasionally cause minor, temporary discomforts. I also understand that there are no guarantees regarding the above treatments or any remedies and herbal medicines prescribed.

I further understand that it is my responsibility to immediately report any reactions or discomforts related to the treatment to the health care attendant (if any should occur) and follow the instructions given.

I also state that I speak, read, and write English, or that the contents of this form have been explained to me in my native tongue.

I have read and understand the above paragraphs and request that these procedures be used for my treatment as deemed necessary by my health care provider.

PATIENT'S (OR LEGAL GUARDIAN) SIGNATURE

DATE

**AUTHORIZATION FOR USE OF SIGNATURE ON FILE
FOR CLAIM AUTHORIZATION AND PAYMENT RESPONSIBILITY**

Patient Name: _____

I, _____, do hereby authorize Matthew Enright, AP

Landon Agoado, AP, Andrew Agoado, AP and Maria Madrigal, AP to mark the section "ENROLLEES OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE." This section authorizes:

1. The release of any medical information necessary to process insurance claims on my behalf.
2. The release of medical information from outside sources which may assist in my diagnosis and treatment plan.
3. **Matthew Enright, AP, Landon Agoado, AP, Andrew Agoado, AP and Maria Madrigal, AP** to file insurance claims on my behalf for services rendered.
4. Payment of medical benefits to be paid directly to **Matthew Enright, AP, Landon Agoado, AP, Andrew Agoado, AP and Maria Madrigal, AP** the provider(s).

I hereby agree to be responsible for payment of services rendered by **Matthew Enright, AP, Landon Agoado, AP, Andrew Agoado, AP and Maria Madrigal, AP** in the event I have no medical insurance coverage, or in the event my insurance carrier shall deny payment due to a deductible, non-authorized visit, treatment deemed not medically necessary or other reason. I understand that my coverage may not cover routine maintenance, preventative or wellness visits. Additionally, I shall be responsible for any co-payments mandated by my insurance carrier.

This authorization has been explained to my full satisfaction. I understand its nature and effect, and it will remain in force until terminated by me in writing.

Patient's signature

Date