Daphne Acupuncture Center
Client Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex □ F □ M	Date
Date of birth	Age	Occupation	
Cell phone #		Home phone #	
E-mail address		Allow email contact by LGNA □ Yes □ No	
Emergency contact name & phone		Marital status	# of children
Address: Street		City State	Zip
Family physician		Chiropractor	
Do you have health insurance? □ Yes □ No If yes, name of insurance company			
Does your insurance cover acupuncture? □ Yes □ No □ ? Have you ever been treated by acupuncture before?			
How did you find out about our clinic? □ *Friends/ Relatives(name)*_____ □ *Website* □ *Yellow Page* □ *Other (please specify)*			

Chief Complain(s): _____.

What diagnosis, if any, have you received for this problem? _____

What kind of treatment have you tried? _____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Allergies: (drugs, chemicals, foods, environmental):_____

Breathing problem: (asthma, wheezing) _____

Medicines: taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

_____

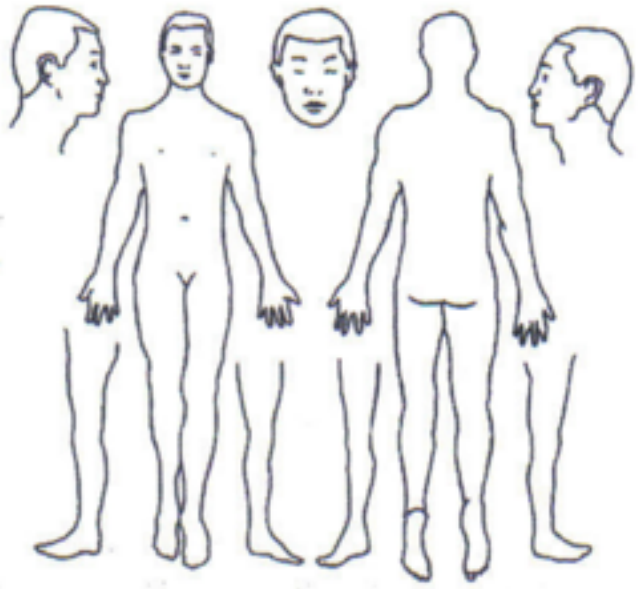
Personal: Height_____ Weight_____

Habits Do you smoke □ Yes □ No How many per day? _____ since when?_____

Diet How much coffee do you drink? ____cups/day: Colas ____ cans/day; Tea ____cups/day
What kind of alcoholic beverages do you usually drink? _____ Average numbers per week? _____
How much water do you drink per day? _____
Are you a vegetarian? □ Yes □ No □ Yes, Not so strict Do you eat a lot spicy food □ Yes □ No

Please describe your daily diet (be as specific as possible):
Breakfast:
Lunch:
Afternoon Snake:
Dinner:

Please Indicate where the Pains are:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

 Poor appetite Poor sleep Fatigue Fevers Chills

 Night sweats Sweat easily Tremors Poor balance Bleed or bruise easily

 Weight loss Weight gain Pain Ear aches Spots in front of eyes

 Ringing in ears Poor hearing Sore throat Sinus problems High blood pressure

 Low blood pressure Chest pain Palpitation Fainting Irregular heartbeat

 Cough Wheezing Bronchitis Pneumonia Nausea

 Vomiting Diarrhea Constipation Gas Depression

 Anxiety Stress Bad temper Bi-polar Kidney stones

 Painful urination Frequent urination Blood in urine Urgency to urinate STD

 Ulcerations Hives Itching Eczema Acne

 Rashes Weight loss Weight gain Varicose veins

Female: Frequent vaginal infections Pelvic infection Endometriosis Vaginal/genital discharge

 Fibroids Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods

 Breast tenderness Breast Lumps Fertility Problems Hot flashes Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? Yes No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long?_____

Male: Prostate problems Discharge Erectile dysfunction Ejaculation problems

 Frequent seminal emission Fertility problems Painful/swollen testicles Other

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I have completed this form correctly to the best of my knowledge.

Signature:_____

Daphne Acupuncture Center

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirement of 22 T.A.C section 183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ Code Ann., section 205.351, governing the practice of acupuncture)

I (patient's name), _____ am notifying Ling's Golden Needle Acupuncture of the following:

Yes ____ No ____ I have been evaluated by a physician or dentist, for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

Yes ____ No ____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

_____

Patient Signature (required) Date

The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

_____

Patient Signature (required) Date

_____

Acupuncturist's Signature Date

Daphne Acupuncture Center

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Daphne Acupuncture Center (DAC) "Notice of Privacy Practices". I understand that I have the right to review DAC's "Notice of Privacy Practices" prior to signing this document.

I understand that DAC staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners or DAC. By signing this form, I am giving Daphne Acupuncture Center authorization to contact me with these reminders and to utilize my information for research and educational purposes.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature LGNA Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Daphne Acupuncture Center the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/ are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

Patient's Signature Date

Daphne Acupuncture Center

New Patient information

Appointment

Treatments are by appointments only, If you found that you need to cancel an appointment, It is important that we receive twenty four (24) hours' notice. This enables us to fill the slot. We reserve the right to charge $25 fee for appointment cancelled with less 24 hours' notice or for "no show" appointment.

Payment for service

Payment is due at the time of service. It may be paid in cash, by check or by credit card. We also accept health insurance. We will need to copy your insurance card and driver's license so that we can check the benefits and file the claim for you. If we are not sure whether your insurance company will pay us or not, we will need to collect money from you first; if your insurance company later pays all or some of the bill, we will fully or partially reimburse you (respectively) with the money you paid at the time service.

Herbal refills

If you request a refill on an herbal formula prescribe during a previous treatment, we encourage you to make a fellow up appointment to determine if the formula is still appropriate for your current need. Herbal refill may be requested in advance by phone.

_____

Patient Signature (required) Date