



Hoops Chiropractic

Family and Sports Medicine

Acupuncture Intake Form

Name Last- _____ First _____ Middle _____ SSN # _____ / _____ / _____

Date of Birth _____ / _____ / _____ Gender F _____ M _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home (_____) _____ - _____ Work (_____) _____ - _____ Ext. _____

Marital Status: _____ Education (Highest grade or degree achieved) _____

Option: Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic? _____

Have you been treated by Acupuncture or Oriental medicine before? _____

Name of your physician: _____ Tel: _____

Address of your physician: _____ City _____ State _____ Zip Code _____

In an Emergency Notify Name _____ Relationship to client _____

Phone (Day) (_____) _____ - _____ (Evening) (_____) _____ - _____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____
3. Have you been given a diagnosis for this problem? If so, what? _____
4. What kinds of treatment have you tried? _____
5. Are you currently receiving treatment for your problem? _____ If so, please describe: _____
6. Does anything improve your problem? _____

PAST MEDICAL HISTORY

Illnesses: _____

Surgeries _____

Significant Trauma (Auto accidents, falls, etc.) _____

Do you have, or have you ever had, any **Infectious Diseases**? Yes No

If so, please describe _____

Medicines(prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

Allergies:

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____

Father's Side _____

Siblings _____

If any of the above is deceased, what was the cause? _____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____

Childhood health _____

Location of upbringing (Geographically prone to certain diseases, habits, etc.) _____

Current Emotional Health _____

Current Quality of Life _____

Current Relationship/Quality _____

Current Predominant Emotion _____

Occupation _____ Stress Level _____

Have you had any unusual stresses recently? _____

Favorite time of year (warm/cold) _____ Worst _____

Hobbies & Recreational Habits _____

Do you have a regular exercise program? Yes No If so, please describe: _____

Have you traveled abroad in the past year? Yes No Where? _____

If applicable, please describe smoking or alcohol intake : _____

NEUROPSYCHOLOGICAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Easily Angered |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Mania |
| <input type="checkbox"/> Easily Susceptible to Stress | | |

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

Any nervous habits? _____

PREGNANCY & GYNECOLOGY

___ Age at First Menses ___ Number of Pregnancies Birth Control?

___ Period between Menses ___ Number of Births What type? _____

___ Duration of Menses ___ Miscarriages How long? _____

Unusual Character ___ Abortions Fertility Problems

Heavy or Light Difficult Births Vaginal Discharge

Irregular Periods Breast Lumps Vaginal Sores

Painful Periods Clots

First Date of Last Menstrual Cycle ____/____/____ Date of Last Pap Smear ____/____/____

Do you experience changes in Body and/or Psyche prior to menstruation? _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

- | | | |
|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Tremors | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Seizures | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sudden energy drops? |
- What time of Day? _____
- | | | |
|--|--|--|
| <input type="checkbox"/> Poor Sleep/ Insomnia | <input type="checkbox"/> Day Sweating | <input type="checkbox"/> Strong thirst for Hot or Cold drinks? |
| <input type="checkbox"/> Dream Disturbed Sleep | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Localized Weakness |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Bleeding or Bruising |
| <input type="checkbox"/> Emotional Changes | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Joint Pain |

CARDIOVASCULAR

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty in Breathing | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Cold Hands/Feet | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Phlebitis | |

RESPIRATORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain w/ Deep Breaths | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Easily Winded w/ Exertion when laying down | | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Production of phlegm | What Color? _____ | |

GASTROINTESTINAL

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Abdominal Pain/ Cramps | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Parasites | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Belching | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Blood in Stools |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hemorrhoids | |

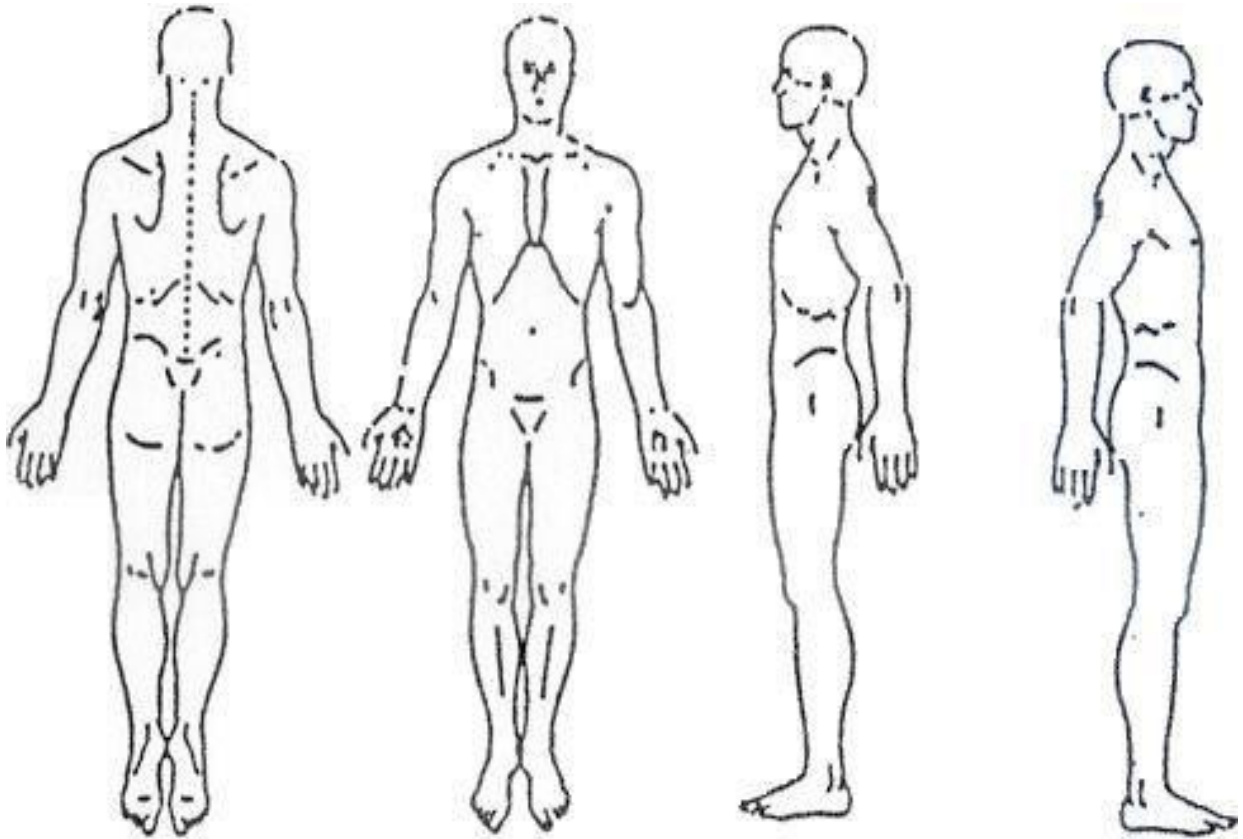
GENTO-URINARY

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Decrease in Urine | <input type="checkbox"/> Kidney sores |
| <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Waking up to Urinate |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Impotency/ Infertility | How often? _____ |
| <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Genital Sores | |

MUSCULOSKELETAL

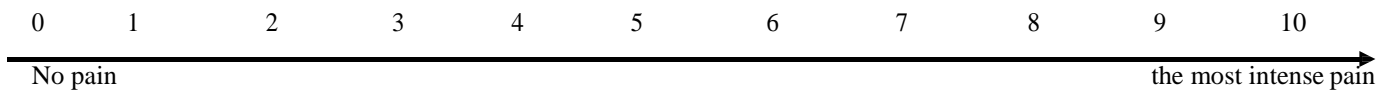
- | | | |
|--|--|---|
| <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Recent Sprains |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Spasms | |
| <input type="checkbox"/> Injuries or Falls | <input type="checkbox"/> Muscular Atrophy | |
| <input type="checkbox"/> General Aches | <input type="checkbox"/> Joint Instability | |

Please circle on the diagram any areas of any type of pain or injury.



Please try to describe the type and quality of the pain _____

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:



Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

Informed Consent Form

I hereby voluntarily request and consent to be treated, or give permission for my child to be treated, with acupuncture and other techniques based on Traditional Asian Medicine. I understand I may be given diet/ lifestyle recommendations and/or nutritional or herbal supplements and that it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

I understand that these treatments may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed my treating doctor of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify them of any changes.

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully, and I have felt free to ask any questions.

Print Name

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE – “AOR”

What is HIPAA Administrative Simplification?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. In a nutshell, we are ordered to make sure all possible measures are in place in order to protect your medical information here in this office. Your medical file / information will not be given out to anyone without your consent. Other forms of protection are also implemented in order to protect your privacy as outlined in the “NOTICE OF PRIVACY PRACTICES.”

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hoops Chiropractic’s “NOTICE OF PRIVACY PRACTICES,” revision dated April 13, 2003.

As required by the Privacy Regulations, Hoops Chiropractic has explained the “NOTICE OF PRIVACY PRACTICES,” to my satisfaction.

As required by the Privacy Regulations, I am aware that Hoops Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

I acknowledge that I received a copy of *Hoops Chiropractic* “NOTICE OF PRIVACY PRACTICES,” revision dated April 13, 2003.

Patient name (print) _____

Signature _____ Date _____

Signed form received by: _____ Date: _____

If Patient Refuses to sign place an “X” on this line: _____

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