New Patient Intake Form

Today's Date____/____/____

Name SS# Birthdate / /
Marital Status Age
Address ❑M ❑F Ht Wt
City, State, Zip
Home Phone Work Phone Occupation
Emergency Contact Name & Phone
Referred by
Reason for visit today Have you had acupuncture before? ❑ Yes ❑ No Chinese herbal medicine? ❑ Yes ❑ No
How long have you had this condition?
Is it getting worse? Does it bother your: ❑ Sleep ❑ Work ❑ Other (what?)
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? ❑ Yes ❑ No If yes, for what?
Who is your physician? Physician's Phone
Other concurrent therapies

Health Insurance Info:
Insurance Co. Name Policy #
Address Phone
City, State, Zip

Medicare Info:
Insurance Co. Name Policy #
Address Phone
City, State, Zip

Family Medical History

❑ Allergies
_____
_____

❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism

❑ Cancer
_____
_____

❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure

❑ Seizures
❑ Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

❑ AIDs/HIV
❑ Alcholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox
❑ Diabetes
❑ Emphy sema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitus
❑ Herpes
❑ High Blood Pressure
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Stroke
❑ Surgery (list)
_____
_____
_____
❑ Thyroid Disorders
❑ Major Trauma (Car, fall, etc--list)
_____
_____
_____
❑ Tuberculosis
❑ Typhoid Fever
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough
❑ Other (Specify)
_____
_____
_____
_____

Your Diet

Appetite ❑ Low ❑ High
❑ Coffee ❑ Soft Drinks
❑ Artificial Sweetener
❑ Sugar ❑ Salty Food
Thirst for water: # glasses per day:_____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in last 2 months:
Vitamins/supplements taken in last 2 months:

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational Hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (describe)

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm

Color of phlegm_____

- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions

Other head or neck problems

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Cough

Wet or Dry?_____
Thick or thin?_____

Color of phlegm_____

- ❑ Coughing blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoid
- ❑ Anal fissures

Bowel movements:
Frequency_____ Texture/form_____
Color_____ Odor_____

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other (describe)

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections

Other hair or skin problems

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing a therapist

Other (specify)

Genito-urinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began

Length of cycle (day 1 to day 1)

- ❑ Duration of flow
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge (color)_____
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots

- ❑ Breast lumps
- # Pregnancies_____
- # Live births_____
- Premature births_____
- Age at Menopause_____

Date of last PAP

Date last period began

Other

OFFICE POLICIES

*Welcome to the Acupuncture office of **Gregory E. LeBlanc, L.Ac.** We want you to be comfortable and to receive the best care possible. We are here to answer any questions you might have regarding your visit, your billing, or our policies.*

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE Many insurance policies cover Acupuncture however policies can vary greatly in terms of deductible and percentage of coverage for Acupuncture. As a courtesy to you we will verify your coverage as well as submit your claims, however we suggest you also verify your insurance benefits with your carrier as quoted benefits are not a guarantee of coverage.

Initial_____

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50.00 fee for any missed appointment or cancellation giving less than 24 hours' notice for any nonemergency situations.

Initial_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand I will be responsible for all "non covered" services and /or coinsurance/co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Signed_____ Date_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

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

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

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

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by the patient:

PATIENT'S NAME _____
(PLEASE PRINT)

PATIENT'S SIGNATURE _____

DATE SIGNED _____

ARE YOU PREGNANT? ☐ YES ☐ NO

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated:

NAME OF PATIENT _____
PLEASE PRINT

PATIENT'S REPRESENTATIVE _____
PLEASE PRINT

RELATIONSHIP OR AUTHORITY OF PATIENT _____

WITNESS _____

NAME OF CLINIC/OFFICE _____

NAME(S) OF TREATING ACUPUNCTURIST(S): _____

APPROVED BY CALIFORNIA ACCUPUNCTURE ASSOCIATION (Rev. 12/92)
This is only one example of informed consent. There are other forms that could satisfy legal requirements for documenting consent. You may wish to consult your own legal counsel and/or your malpractice carrier.

#401-N-AC
MISSION PRINTING (559) 227-7640 • (800) 693-2108

Effective Date: May 11, 2011

Notice of Patient Privacy
Health Insurance Portability and Accountability Act (HIPAA)

LEBLANC Acupuncture Clinic is dedicated in preserving your personal health information.We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.
You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you havenot yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact LEBLANC Acupuncture Clinic @ (510) 527-5330. You may also send a written complaint to the US Department of Health and Human Services.

Patient Signature _____ Date _____

Printed Name _____

Turning Point Acupuncture
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