Name _____ Today's Date _____

Address _____ Date of Birth _____ Age _____

_____ Gender at Birth? M F Height _____ Weight _____

(City/State/Zip Code) Occupation _____

Home Phone (_____) _____ Email _____

Cell Phone (_____) _____ Referred By _____

Emergency Contact Name _____ Relationship _____ Phone Number (_____) _____

Primary Care Physician _____ Phone Number (_____) _____

Other Healthcare Practitioners Treating You _____

_____

_____

Do you have health insurance? ☐ Yes ☐ No

Primary Insurance Company _____ Member ID _____

Group # _____ Insurance Customer Service Phone Number _____

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor's Full Name _____ Guarantor's Date of Birth _____

Guarantor's Phone Number (_____)_____

Guarantor's Full Address _____

_____

Chief Complaint (reason for visit) _____

_____

_____

How important is this problem (medical issue/etc.) to you? (Ex: 10% - 100%) _____

List all previous treatments for this condition (including Medication) _____

_____

_____

_____

Other Medical Issues _____

_____

Current Medication/Supplements _____

_____

Past Medical History (check all that apply and include medication):

☐ AIDS/HIV _____ ☐ Chest Pain _____ ☐ Pneumonia _____

☐ Diabetes Mellitus _____ ☐ Glaucoma _____ ☐ Seizures _____

☐ Herpes (oral, genitals) _____ ☐ Cancer _____ ☐ Thyroid Disorder (type) _____

☐ Rheumatic Fever _____ ☐ Asthma _____ ☐ Ulcers _____

☐ Stroke _____ ☐ Hepatitis (type) _____ ☐ Depression _____

☐ Tuberculosis _____ ☐ High Blood Pressure _____ ☐ Other _____

List any previous surgery/major trauma (include dates) _____

Family History (list major medical conditions):

Father: _____

Mother: _____

Siblings: _____

Do/did you smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Vaping

Number of Years _____ How much? _____ Year quit _____

Do/did you drink alcohol? ☐ Yes ☐ No What type/how often? _____

Do/did you use recreational drugs? ☐ Yes ☐ No What type/how often? _____

Do you regularly drink coffee/soda/diet/energy drinks? ☐ Yes ☐ No How many cups/cans per day? _____

How stressed are you? 1 (not stressed) – 10 (extremely stressed) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Why? _____

Do you exercise? _____ Type _____

Number of hours of Sleep _____ Bedtime _____ Awaken _____

Describe your typical diet:

Breakfast _____

Lunch _____

Dinner _____

Food allergies _____ Food cravings _____

Water consumption per day _____

Women's Wellness & Gynecology

Date of last Menstrual period _____ Date of last pap smear _____ Results _____

Do/Did you ever have any of the following?

☐ Clots with menstrual flow ☐ Ovarian cysts ☐ Uterine fibroids

☐ Menstrual cramping ☐ Hot flashes ☐ Endometriosis

Please mark any PMS symptoms that you experience, if any:

☐ Bloating ☐ Food cravings ☐ Mood changes

☐ Breast tenderness ☐ Headaches ☐ Low back pain

☐ None

Men's Wellness

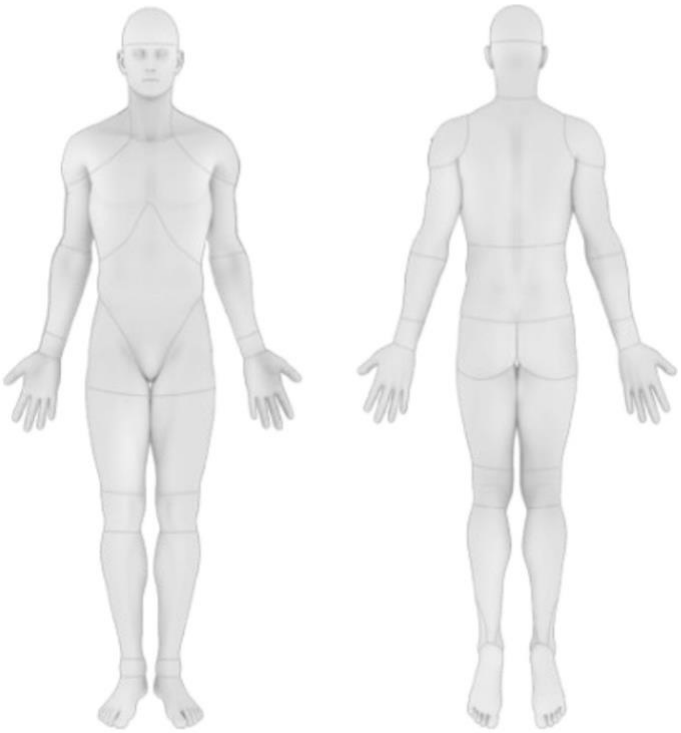
Date of last prostate exam _____ Results _____

Conditions:

☐ Premature ejaculation ☐ Impotence ☐ Erectile dysfunction

General Pain Index Questionnaire

Please select the option that best describes how your typical level of pain affects these six categories and mark the areas that are affected by pain



Family at/home responsibilities – such as yard work, chores, around the house, or driving the kids to school

☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Recreation – including hobbies, sports, or other leisure activities

☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Social activities – including parties, theater, concerts, dining out, and attending other social functions

☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Employment – including volunteer work and homemaking tasks

☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Self-care – such as taking a shower, driving, or getting dressed

☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Life support activities – such as eating and sleeping

☐ No pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Rate each of the following symptoms based on your typical health profile for the past month:
0 – N/A | 1 – Mild | 2 – Moderate | 3 – Severe

	0	1	2	3
GENERAL				
Poor appetite	☐	☐	☐	☐
Increased appetite	☐	☐	☐	☐
Weight loss	☐	☐	☐	☐
Fever	☐	☐	☐	☐
Chills	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Frequent illness	☐	☐	☐	☐
HEAD				
Headaches	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Fainting	☐	☐	☐	☐
EYES				
Watery/itchy eyes	☐	☐	☐	☐
Swollen/red eyelids	☐	☐	☐	☐
Bags/dark circles	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐
Poor vision	☐	☐	☐	☐
Nearsightedness	☐	☐	☐	☐
Floaters	☐	☐	☐	☐
NOSE				
Stuffy nose	☐	☐	☐	☐
Sinus problems	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐
Sneezing attacks	☐	☐	☐	☐
Sinusitis	☐	☐	☐	☐
Mucus/phlegm	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
EARS				
Itchy ears	☐	☐	☐	☐
Earaches/infections	☐	☐	☐	☐
Ear drainage	☐	☐	☐	☐
Ringing in ears	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐
URINARY				
Frequent urination	☐	☐	☐	☐
Painful urination	☐	☐	☐	☐
Bloody urination	☐	☐	☐	☐
Night urination	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐

	0	1	2	3
MOUTH/THROAT				
Chronic coughing	☐	☐	☐	☐
Gagging	☐	☐	☐	☐
Sore throat	☐	☐	☐	☐
Swollen tongue/gums	☐	☐	☐	☐
Canker sores	☐	☐	☐	☐
Tongue/lip ulcers	☐	☐	☐	☐
Hoarseness	☐	☐	☐	☐
Feeling in throat	☐	☐	☐	☐
Teeth grinding	☐	☐	☐	☐
Dental problems	☐	☐	☐	☐
SKIN				
Acne	☐	☐	☐	☐
Hives	☐	☐	☐	☐
Flushing	☐	☐	☐	☐
Excessive sweating	☐	☐	☐	☐
Dry skin	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Itching	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐
Rashes	☐	☐	☐	☐
RESPIRATORY				
Chest congestion	☐	☐	☐	☐
Asthma/bronchitis	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Difficulty breathing	☐	☐	☐	☐
Coughing	☐	☐	☐	☐
Respiratory allergies	☐	☐	☐	☐
Coughing blood	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
HEART				
Chest pain	☐	☐	☐	☐
Irregular heartbeat	☐	☐	☐	☐
Rapid heartbeat	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Low blood pressure	☐	☐	☐	☐
Swollen hands/feet	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐
Bruising	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐

	0	1	2	3
DIGESTIVE				
Nausea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Bloating	☐	☐	☐	☐
Belching/gas	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐
Stomach pain	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐
Burping	☐	☐	☐	☐
Bad breath	☐	☐	☐	☐
Painful defecation	☐	☐	☐	☐
Bloody stools	☐	☐	☐	☐
Black stools	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐
WEIGHT				
Food cravings	☐	☐	☐	☐
Excessive weight	☐	☐	☐	☐
Water retention	☐	☐	☐	☐
Underweight	☐	☐	☐	☐
Compulsive eating	☐	☐	☐	☐
ENERGY/ACTIVITY				
Fatigue	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐
Sluggishness	☐	☐	☐	☐
JOINTS/MUSCLES				
Joint pain	☐	☐	☐	☐
Muscle pain	☐	☐	☐	☐
Stiffness	☐	☐	☐	☐
Weakness	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Muscle fatigue	☐	☐	☐	☐
EMOTIONS				
Mood swings	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Anger/irritability	☐	☐	☐	☐
Depression	☐	☐	☐	☐

	0	1	2	3
NEUROLOGICAL				
Seizures	☐	☐	☐	☐
Numbness	☐	☐	☐	☐
Tingling	☐	☐	☐	☐
Head injury	☐	☐	☐	☐
Paralysis	☐	☐	☐	☐
MIND				
Poor memory	☐	☐	☐	☐
Confusion	☐	☐	☐	☐
Decision difficulty	☐	☐	☐	☐
Stuttering	☐	☐	☐	☐
Slurred speech	☐	☐	☐	☐
Learning disabilities	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐
Poor coordination	☐	☐	☐	☐
Apathy	☐	☐	☐	☐

TOTAL SCORE

AIMC | ACUPUNCTURE & INTEGRATIVE MEDICAL CENTER

Consent & **Payment**

ACUPUNCTURE CENTER INFORMED CONSENT TO TREAT AND PAYMENT AGREEMENT

I hereby request and consent to the performance of acupuncture treatments and the 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 who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist including those working at the clinic or office listed above or any other office or clinic.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 lamp. 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 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 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.

Initial_____

PAYMENTS

We request payment at the time of services rendered. Prepayment will be required for future visits that have previous unpaid balances. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Our office only accepts cash and all major credit cards.

Initial _____

I understand that any billing of my insurance company is a courtesy provided by my doctor and that I am ultimately responsible for 100% of my bill. Should I fail to pay in full, I will be responsible for collection costs. Cancellation Made With Less Than 24 hour notice will be charged $25.00 for the first occurrence, and the full cost of the visit for additional occurrences.

Initial _____

MAJOR MEDICAL INSURANCE

Although we cannot guarantee any reimbursement from your health insurance company, we are glad to answer any questions concerning the billing process. As a courtesy to you, we will bill your insur-ance company. Please provide a copy of your insurance card whenever your plan renews or changes. If your plan requires preauthorization it is your responsibility to inform us in writing when it is required.

It is not our responsibility for missing insurance company preauthorization re-quirements. If your plan changes due to COBRA or other policy chang-es it is your responsibility to inform us in writing of these changes. Your reimbursement may be affected because of these items ultimately it is your responsibility. Please note: Herbal medicine is not covered by insurance and will not be billed to your insurance provider.

Initial _____

In signing below, I understand all these policies and agree to pay for treatments accordingly, and also agree that I am responsible for any unpaid balances. Additionally, I understand that this letter supersedes any previous telephone or other verbal communication about office policies and fees. I understand that AIMC may report me to a credit-reporting agency or take legal action as necessary to be paid for services rendered.

PATIENT SIGNATURE _____ **DATE**_____

IRVING: 1320 W. Walnut Hill Ln. Irving, TX 75038

MESQUITE: 18601 LBJ FWY #501 Mesquite, TX 75150

972.444.0660 www.drchapa.com