John Hanson, Licensed Acupuncturist

Acupuncture Intake Form

Henry Chiropractic & Wellness Center
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616 East Charles St.
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LaPlata, MD 20646
Phone: (301)-481-3821 (cell)

PERSONAL INFORMATION

Name_____ Date_____
Address_____
City_____ State_____ Zip_____
Phone Number(s): _____ _____ _____
Home Work Cell
Date Of Birth_____/_____/_____ Gender [ ]Male [ ]Female Height_____ Weight_____
Blood Type_____ Marital Status (circle one) **S M W D**
Children's Ages (if any)_____ Occupation_____ Hours Worked/Week_____
Employer_____ May We Contact You At Work [ ]Yes [ ]No
How Did You Learn Of Acupuncture?_____
How Did You Hear Of My Office?_____
Primary Care Physician & Phone_____
What Are Your Expectations Of The Acupuncture Treatments?_____
_____

INSURANCE INFORMATION:

Insurance Company Name & Address:_____
_____
Id#:_____Group #:_____
Name of Insured:_____ Insured's Date of Birth:_____
Relationship To You:_____Insured's Employer:_____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ & assign directly to John Hanson, Licensed Acupuncturist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. John Hanson, Licensed Acupuncturist may use my health care information & may disclose such information to the above-named insurance company(ies) & their agents for the purpose of obtaining payment for services & determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

_____
(Signature)

_____
(Name Printed)

_____ _____
(date) (relationship to patient)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan & direct my treatment & follow – up among the multiple healthcare providers who may be involved in that treatment directly & indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments & physician certifications.

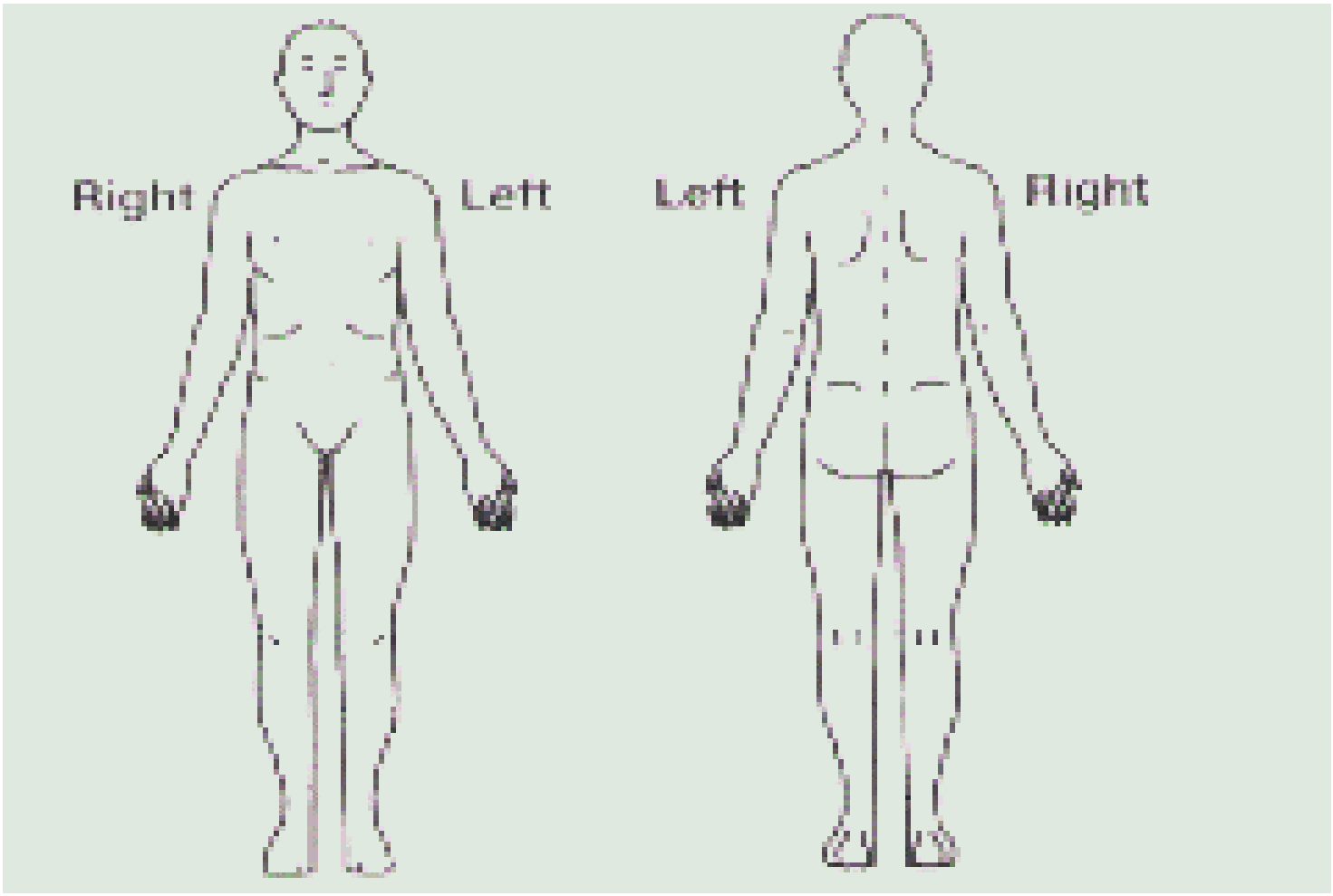
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Primary Health Concern That You Would Like To Address With Acupuncture:_____
_____
_____
_____
_____
_____
_____

Rate Your Pain On A Scale Of 1 (least pain) to 10 (most severe pain): _____ Onset Date:_____
How Often Do You Get This Pain?_____
_____

Is It Constant? [ ] Yes [ ] No
Type Of Pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Shooting
[ ] Burning [ ] Tingling [ ] Cramps [ ] Stiffness [ ] Swelling [ ] Stabbing [ ] Other
What Caused This Pain?_____
_____
What Makes It Better?_____
_____
If Improvements Are Subtle, How Do We Measure This (Range Of Motion, Length of Standing/ Sitting/ Lying Down, Walking, Distance, Etc.)_____
_____

On The Diagram Below Please Mark With "X"'s, Your Areas Of Pain, Discomfort, or Concerns.



Other Health Issues:

1) _____ 2) _____

2) _____ 4) _____

List All Medications & Vitamins You Currently Take:_____

_____

_____

How Does This Health Problem(s) Affect Your Activities Of Daily Living?_____

_____

Have You Had Acupuncture Before? [ ] Yes [ ] No If Yes, With Whom?_____

What Were Your Results?_____

Please List Any Major Accidents & Surgeries_____

_____

_____

_____

Have You Had Any Of The Following Childhood Or Adolescent Diseases or Conditions?

[ ] Anemia	[ ] Food Allergies	[ ] Musculo-skeletal Disorders	[ ] Scarlet Fever
[ ] Asthma	[ ] Frequent Sore Throats	[ ] Polio	[ ] Tonsillectomy
[ ] Colic	[ ] Mononucleosis	[ ] Pneumonia	[ ] Tuberculosis

Do Any Family Members Share Your Main Health Problems? [ ] Yes [ ] No

Check Any Of The Following Signs & Symptoms That Pertain To You:

[ ] **Headaches**
Frequency_____
Location of Headache_____
Quality Of Pain (dull, stabbing, throbbing, etc.)_____
Comes On: [ ] Quickly [ ] Slowly
[ ] Morning [ ] Afternoon [ ] Evening [ ] Other
What Makes It Better or Worse?_____

[ ] **Dizziness** [ ] Mild [ ] Severe
Onset is: [ ] Sudden [ ] Gradual
What, If Anything, Accompanies Your Dizziness_____

[ ] **Eye Problems**
[ ] Blurry Vision [ ] Itching [ ] Pain [ ] Redness [ ] Floaters [ ] Sensitivity To Light

[ ] **Ear Problems**
Ringing: [ ] High Pitch [ ] Low Pitched
Onset is: [ ] Sudden [ ] Gradual
[ ] Hearing Loss Onset is: [ ] Sudden [ ] Gradual
Ear Pain: [ ] Chronic [ ] Acute

[ ] **Nose Problems**
Sinus Congestion [ ] Chronic [ ] Seasonal [ ] Head cold
Mucous Discharge, Describe Color_____
When Did It Begin?_____

[ ] **Throat** (Sore, Scratchy, Mucous, etc)

[ ] **Mouth** (Bleeding, Gums, Unusual Tastes, Jaw Tension, Clenching)

[ ] Abdominal bloating / fullness
[ ] A lot of gurgling sounds in abdomen
[ ] Belching/ gas
[ ] Chronic Coughing
[ ] Color of urine_____
[ ] Constipated/ loose bowels
[ ] Cold hands / feet
[ ] Fever-Tend to feel hot all the time
[ ] Frequency of bowel movements _____/day
[ ] Frequency of urination_____/day
[ ] Getting up at night to urinate_____/night
[ ] Hemorrhoids
[ ] Heartburn or indigestion
[ ] Heart Palpitations
[ ] Hotter or colder than others around you
[ ] Incontinence
[ ] Insomnia
[ ] I am Impatient
[ ] Impotence or frigidity
[ ] Inability to sweat
[ ] Irritable
[ ] Incomplete bowel evacuation
[ ] Joint Bursitis
[ ] Joint Tendonitis
[ ] Lung Problems
[ ] Night or Day Sweats
[ ] Nausea/ vomiting
[ ] Neck tightness or pain
[ ] Pain or hesitation with urination
[ ] Pressure in chest or rib cage
[ ] Prostatitis (males)
[ ] Shoulder tightness or pain
[ ] Stomach pains
[ ] Swelling of hands or feet
[ ] Sleepy after eating
[ ] Thirsty all the time
[ ] Throat (sore, scratchy, mucous etc.)
[ ] Upper back pain

PERSONAL HABITS:

I Consume: [ ] Coffee, Tea or Caffeine @ _____Cups/day
[ ] Alcohol @_____Glasses/day
[ ] Smoke Cigarettes @_____/per day

Describe Your Sleep Regularity_____
_____

LIFESTYLE:

Do You Exercise On A Regular Basis? [ ] Yes [ ] No If Yes, How Often_____
How Do You Feel After Exercise?_____
What Type Of Exercise Activities Do You Do?_____

DIET:

Describe Your Typical Meals:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____

FEMALES:

MENSTRUAL RELATED QUESTIONS:

Age Of First Menstrual Period_____
Length And Regularity Of Monthly Cycle_____
Lasts How Many Days?_____ Spotting Before Or After [ ] Yes [ ] No
Color Of Blood: Beginning Of Period_____
Middle Of Period _____
End Of Period _____
Do You Have Cramping: [ ] Before [ ] During [ ] After

If Yes, What Makes The Cramping Feel Better?_____

FEMALES (CONTINUED):
Do You Have Clotting? [ ] Yes [ ] No If Yes, Describe The Clotting_____
Do You Miss Any Menstrual Periods? [ ] Yes [ ] No Are You Currently Pregnant? [ ] Yes [ ] No

GENERAL QUESTIONS:
Do You Prefer [ ] Cooler or [ ]Warmer Temperatures?
What Is Your Favorite Season? [ ] Spring [ ] Summer [ ] Winter [ ] Fall
What Are Your Favorite Foods? (Spicy, Bland, Solids, Liquids, or Hot Versus Cold etc..)
Rate Your General Energy Level On A Scale Of 1-10, 1=very low, 10=very high:_____

FIRST TREATMENT NOTES:

PULSE **TONGUE** **ABDOMEN**