REJUVENATE
CHIROPRACTIC SPA

Todays Date: ____/________/____

NEW PATIENT INTAKE FORM

Thank you for taking the time to complete the following information which will help me assess your health needs. All information is confidential.

GENERAL INFORMATION

Name: ______________ Birthdate: __________ Age: ______ Gender: ____________

Address: ________________________ City: ________ State: ________ Zip: ________

PHONE NUMBERS (PLEASE MARK * NEXT TO BEST NUMBER)

Home: ____________ Cell: ____________ Work: ____________

Email Address: ________________________________
(email is required for any patient using insurance for services)

Would you like to receive our e-newsletter with supportive health information (only once per season)? YES NO

Marital Status: ______________ # of children: __________ their ages: ________

Your Educational level: ______________ Occupation: __________ hrs per week: ______

Employer & commute time: ______________ Health Insurance Co: ______________

How did you hear about us?: ______________ If via person, name: ______________

May we send a thank you card?: YES NO

EMERGENCY CARD

Name: ____________ Phone: ____________ Relationship: ____________

UNDER 18 --- RESPONSIBLE PARTY INFORMATION

Name: ________________________ Relationship to Patient: ____________

HEALTHCARE PROVIDERS - PLEASE LIST THOSE YOU WORK WITH

Physicians: GP/Primary Care ______________ seeking one? YES NO
OB-GYN: ______________ seeking one? YES NO
Specialist (describe): ______________ seeking one? YES NO
Chiropractor: ______________ seeking one? YES NO
Massage Therapist: ______________ seeking one? YES NO
Physical Therapist: ______________ seeking one? YES NO
Psychotherapist: ______________ seeking one? YES NO
Personal Trainer: ______________ seeking one? YES NO
Midwife: ______________ seeking one? YES NO
Other: ______________ seeking one? YES NO

May I contact these providers to ensure coordination of your care? YES NO

Previous experience with acupuncture? YES NO With whom and results ______________

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HEALTH HISTORY

Please list your major health concerns in order of importance to you:

____

____

____

____

Check those that apply to your past medical history

- ☐ Adverse reaction to medical treatment
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Asthma
- ☐ Attempted suicide
- ☐ Birth Trauma
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Immune disorder
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme's disease
- ☐ Lymph nodes removed
- ☐ Mental illness
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease/STD
- ☐ Other____________________

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

____

____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, injury, family death, bankruptcy, etc).

Date____/______Event________________________ Date____/______Event________________________

Date____/______Event________________________ Date____/______Event________________________

Date____/______Event________________________ Date____/______Event________________________

Family History (List any family physical or mental illnesses and age of death):

Mother ____________________________________

Father ____________________________________

Grandparents ________________________________

Siblings ____________________________________

Children ____________________________________

Medications, Herbs, Supplements (List those you are currently taking):

Name____________________ Reason ____________________ How long and Dose____________________

Name____________________ Reason ____________________ How long and Dose____________________

Name____________________ Reason ____________________ How long and Dose____________________

Name____________________ Reason ____________________ How long and Dose____________________

Name____________________ Reason ____________________ How long and Dose____________________

Name____________________ Reason ____________________ How long and Dose____________________

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NEW PATIENT INTAKE FORM

LIFESTYLE HABITS

Describe your typical daily diet:

Breakfast: ______________________ Lunch: ______________________

Dinner: ______________________ Snacks: ______________________

Special diet: ______________________ 3 worst foods you eat: ______________________

DO YOU:

Average 6-8 hours sleep?	YES	NO	What is the major source of joy in your life? ______________________
Have a supportive relationship?	YES	NO	
Have a history of abuse?	YES	NO	
Enjoy your work?	YES	NO	What is the major source of stress in your life? ______________________
Take vacations?	YES	NO	
Spend time outside?	YES	NO	
Exercise?	YES	NO	Describe Exercise: ______________________
Watch TV?	YES	NO	How many hours weekly ______________________
Read Books?	YES	NO	How many hours weekly ______________________
Computer games/browsing?	YES	NO	How many hours weekly ______________________
Spiritual/religious practice?	YES	NO	Describe: ______________________
Smoke cigarettes?	YES	NO	How many packs? ______________________
Smoke cigarettes in the past?	YES	NO	How many years? ______________________
Eat out often?	YES	NO	How many meals a week? ______________________
Drink coffee?	YES	NO	How many cups a day? ______________________
Drink tea?	YES	NO	How many cups a day? ______________________
Drink soft drinks?	YES	NO	How many a day? ______________________
Use sugar?	YES	NO	How much? ______________________
Drink alcohol?	YES	NO	How many drinks a week? ______________________
Use recreational drugs?	YES	NO	What and how often? ______________________
Have an addiction?	YES	NO	To what and how long? ______________________
Been outside the U.S. in past 12 months?	YES	NO	Where? ______________________

What are your goals for your health?

____

____

____

Please circle your level of commitment to correcting your health issues? 1 2 3 4 5 6 7 8 9 10
(10 = highest level)

TESTS AND IMMUNIZATIONS

Please list the date of your most recent visit:

Chest X-ray ________	Sigmoidoscopy ________	EKG ________	Stool Blood Test ________
Mammogram ________	TB Skin Test ________	Pap Smear ________	Complete Physical ________
GI Series ________	Flu Shot ________	Pneumonia Shot ________	Other ________

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Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the PAST and do not have it now, check the box like this: ☑
If you are having the symptom CURRENTLY, fill in the box like this: ■

Liver/Gallbladder
- ☐ Depression / Stress
- ☐ Headaches / Migraines
- ☐ Red / Dry / Itchy Eyes
- ☐ Visual Problems / Blurred Vision
- ☐ Dizziness
- ☐ Gall Stones
- ☐ Feeling of Lump in Throat
- ☐ Clenching Teeth at Night
- ☐ Muscle Cramping / Twitching
- ☐ Neck/Shoulder Pain / Tightness
- ☐ Seizures/Tremors
- ☐ Poor Circulation
- ☐ Soft/Brittle Nails
- ☐ Bitter Taste in Mouth
- ☐ PMS/Menstrual Problems
- ☐ Tendonitis
- ☐ Pain Below Ribcage
- ☐ Do you crave: Sour
- ☐ Tend to be Irritable / Angry

Heart/Small Intestine
- ☐ Heart Palpitations
- ☐ Rapid or Irregular Heartbeat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Insomnia / Sleep Problems
- ☐ Vivid Dreams / Nightmares
- ☐ Easily Startled
- ☐ Dark Urine
- ☐ Red Complexion
- ☐ Do you crave: Bitter
- ☐ Anxiety / Nervous or Restless

Spleen/Stomach
- ☐ Body Heaviness
- ☐ Hard to get up in Morning
- ☐ Muscles Often Feel Tired
  ____ Energy Level: 1-10 (low to high)
- ☐ Edema (☐ Hands ☐ Feet)
- ☐ Easily Bruising / Bleeding
- ☐ Bad Breath
- ☐ Sweetish Taste in Mouth
- ☐ Lack of Taste
- ☐ Excess or Low Appetite (circle which)
- ☐ Excess or Lack of Thirst (circle which)
- ☐ Nausea / Vomiting
- ☐ Gas / Belching
- ☐ Hemorrhoids
- ☐ Organ Prolapse (i.e. uterus)
- ☐ Chronic Loose Stools
- ☐ Abdominal Pain

Indigestion / Heartburn
- ☐ Brain Foggy
- ☐ Mouth Ulcers
- ☐ Tendency to Gain Weight
- ☐ Do you crave: Sweet
- ☐ Over-thinking / Worry

Lung/Large Intestine
- ☐ Bloody Cough
- ☐ Dry Cough
- ☐ Chronic Cough
- ☐ Cough with Sputum
- ☐ Nasal Discharge
  ☐ White ☐ Yellow ☐ Green
- ☐ Post Nasal Drip
- ☐ Sinus Infection / Congestion
- ☐ Itchy, Red, or Painful Throat
- ☐ Dry Mouth / Nose / Throat
- ☐ Skin Rashes / Hives
- ☐ Snoring
- ☐ Shortness of Breath
- ☐ Allergies / Asthma
- ☐ Low Immunity
- ☐ Catch Colds Easily
- ☐ Bronchitis
- ☐ Black or Bloody Stools
- ☐ Constipation
- ☐ IBS
- ☐ Diarrhea
- ☐ Colitis / Spastic Colon
- ☐ Do you crave: Pungent / Spicy
- ☐ Grief / Sadness

Kidney/Urinary Bladder
- ☐ Urinary Problems (i.e. night-time) ________________
- ☐ Bladder Infection
- ☐ Incontinence
- ☐ Weakness / Pain in Low Back
- ☐ Osteoporosis
- ☐ Feel Cold or Hot Easily (circle which)
- ☐ Cold Hands / Feet
- ☐ Low or Excess Sex Drive (circle which)
- ☐ Dark Circles under Eyes
- ☐ Thyroid Problems ________________
- ☐ Poor Memory
- ☐ Hair Loss / Grey Hair
- ☐ Hearing Problems / Tinnitus
- ☐ Cavities
- ☐ Hot Flashes / Night Sweats
- ☐ Impotence or Premature Ejaculation (circle which)
- ☐ Do you crave: Salt
- ☐ Fear

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TREATMENT TERMS AND CONDITIONS

The following are specific policies that will govern our work together:

CANCELLATION POLICY

In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hours notice. You will be charged a fee of $25 if you do not show up for your appt or cancel your appt with less than 24 hours. We will try to reschedule your appointment for the same week so you don't miss your treatment.

LATE POLICY

If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the full payment of the session.

PHONE CALLS AND EMAILS

You may phone or email us when necessary and we will respond as soon as possible, or within 24 hours. We are generally unavailable on weekends. Except for emergencies, phone calls and email contacts with our doctors and licensed practitioners are limited to 5-10 minutes of our time. All contacts that require beyond 10 minutes of our time are considered session work and will be billed a flat rate of $40.

CONFIDENTIALITY AND PRIVACY PRACTICES

As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, announcements and to inform you about our practice and its staff. A more complete description of our privacy practices can be requested.

FEES

It is our policy that you pay the entire session fee or co-pay/coinsurance at the time of each session.
If you would like to arrange another payment option, please discuss it with us.

WE ARE PARTNERS IN YOUR HEALTHCARE

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

AGREEMENT

I have read and understood the clinic's policies. I agree to the all of the above treatment terms and conditions.

Signature: ____ Date: __________

INFORMED CONSENT & DISCLOSURE

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling.

I understand that these therapies are safe methods of treatment. As with all medical procedures, they involve potential but unlikely risks. Such uncommon risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very, very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible but highly unlikely (we've never witnessed this), as the clinic uses alcohol, sterile disposable needles, and a safe and clean environment. A burn is a possible
but extremely rare side effect of moxibustion. Temporary bruising (not painful) or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Regular treatment and completing the prescribed treatment plan are what give acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant. I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible but rare side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and hives. I understand that I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

Signature: ____ Date: __________

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