New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name _____ Date _____

General Information

Address _____ City _____ State _____

Home Phone _____ Occupation _____ Zip _____

Work Phone _____ Mobile Phone _____ SS# _____ Date of Birth _____

Email Address _____

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact _____ Relationship _____ Phone _____

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician _____ Phone _____

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for? _____

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for? _____

Insurance Information

Insurance Company _____ Phone _____ Date Called _____

ID # _____ Co-Pay $ _____ Covered % _____

Visit # _____ Deductible Amount _____

Contact Name _____ Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

☐ Work ☐ Sleep ☐ Walking ☐ Sitting
☐ Standing ☐ Emotional ☐ Relationships ☐ Social Life
☐ Sexually ☐ Recreation ☐ Bending ☐ Stretching
☐ Other _____ _____

What have you done about this? _____

_____

Are you interested in:

☐ Pain Relief ☐ Preventative Care ☐ Oriental Nutrition
☐ Holistic Health ☐ Stretching/Yoga ☐ Maintenance Care
☐ Stress Relief ☐ Herbal Therapy
☐ Other _____ _____

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): _____

List exercise and sport activities you have been or are currently involved in: _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Do you take medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? _____ Do you have a low point during the day? ☐ Yes ☐ No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

Female Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge Other _____

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other _____

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of _____	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: _____
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	_____
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	_____
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	_____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

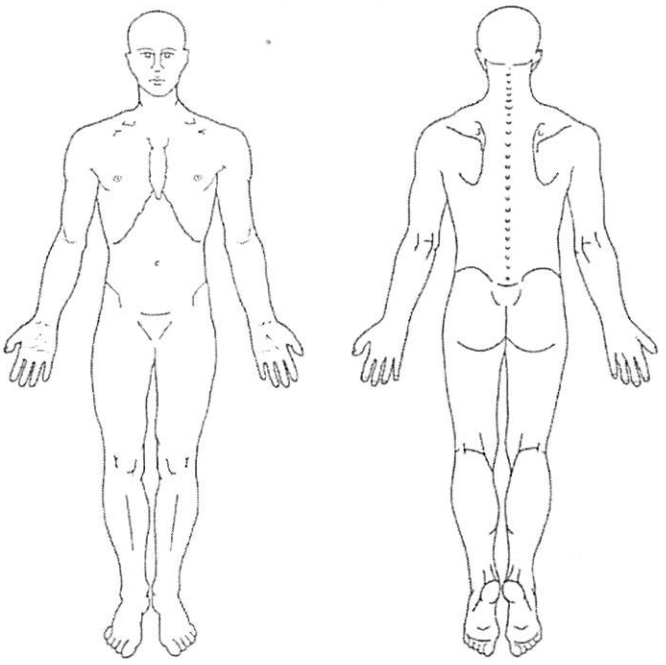
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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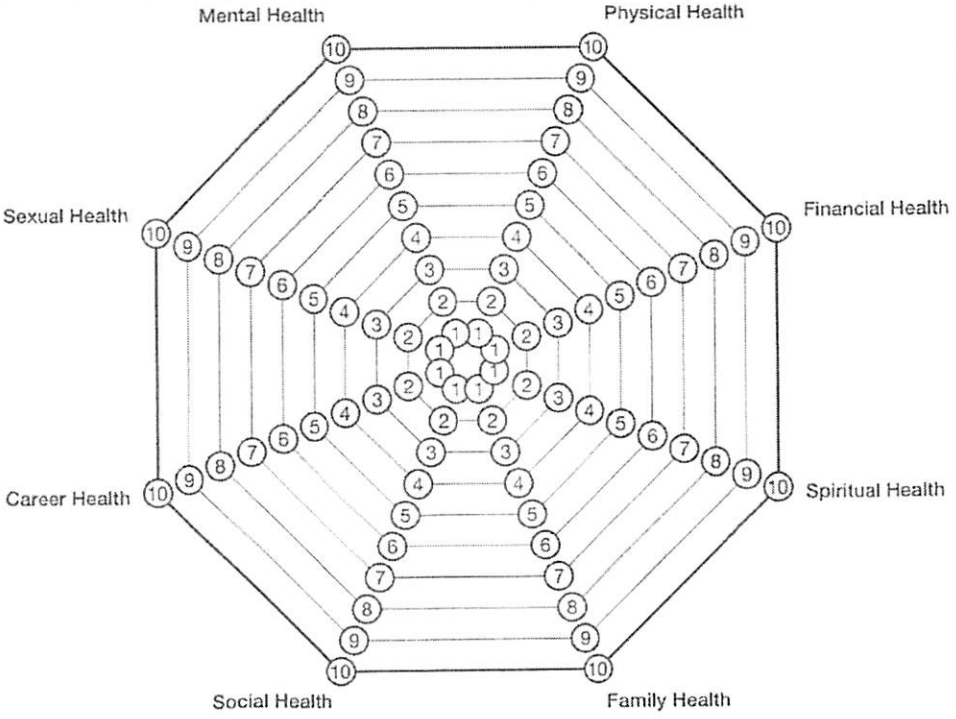
Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

Sheila L. Scott, AP, MSOM, Dipl. Ac.

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Fees:

Our fees are determined by the complexity of each case and different services used.

Regarding Insurance:

We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document, you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Usual and Customary Rates UCR:

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. All payments are due at the time of service.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to improve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns.

I have read the financial policy and I agree to this financial policy.

_____ _____

PATIENT'S SIGNATURE DATE

Sheila L. Scott, AP, MSOM, Dipl. Ac.

INFORMED CONSENT AND WAIVER

I, _____, do hereby voluntarily request to receive clinical services from _____. I voluntarily consent that these services may include examination using Traditional Chinese Methods, differential diagnosis based in Chinese Medicine theory and Five Element Stimulation, Therapeutic Massage, Manual Therapy, Lifestyle Counseling, Hot and Cold Packs, biofeedback, Kinetic Therapies and Qi Gong therapeutic breathing techniques. I acknowledge that no guarantees have been made to me as to the effect of such examinations, treatments, therapy or care of my condition.

I further acknowledge that none of the above services are meant to be considered by me as the WESTERN diagnosis or treatment of disease. Such treatment and examinations are used as an aid to help my body produce varied physiologic effects to heal itself. Several examples of physiologic effects are stimulation of various gates within the Central Nervous System, production of serotonin, endorphins, norepinephrine and acetylcholine, B-endorphins and regulation of the autonomic nervous system to name a few.

I understand that prior to the beginning of any treatment procedure, I will receive an explanation of the nature and purpose of the treatment and any probable risks involved. I understand that I may refuse service at anytime. I recognize that I am responsible for my health and well-being. It is my duty to stay informed of my assessment and treatment.

I understand that payment by cash, check or credit card is due at the time of service.

I understand that all the clinical information will be kept confidential.

_____

Witness

_____

Patient's Signature

_____

Date

Sheila L. Scott, AP, MSOM, Dipl. Ac.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we chance our Notice, you may obtain a revised copy by contacting our offices.

You do have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we are, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such revocation shall not affect any disclosures we may have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

WITNESS DATE

Neal Wieder, DC, DCBCN
Chiropractic Physician
1045 Primera Blvd., Ste. 1017
Telephone: 407-682-4454
Cell: 407-388-5825

Sheila L. Scott, AP, MSOM
Acupuncture Physician
Lake Mary, Florida 32746
Fax: 407-915-6853
Cell: 407-484-2183

PATIENT HIPAA QUESTIONNAIRE

1. Please list the family members, medical professionals, attorneys or other persons, if any, whom we may inform about your general medical condition and your diagnosis(es) (including treatment, payment and health care procedures or surgeries):

   _____

   _____

2. Please list the family members, medical professionals, attorneys or significant others, if any, whom we may inform about your medical condition **IN THE EVENT OF AN EMERGENCY:**

Name _____ **Phone** _____ **Fax:**_____
Name _____ **Phone** _____ **Fax:**_____
Name _____ **Phone** _____ **Fax:**_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if ***other than your home.***

   _____

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL". YES** _____ **NO** _____

5. I authorize this office to transmit my health information by either facsimile or email: **YES**_____ **NO**_____

6. Please print the telephone number you prefer to receive calls/texts about your appointments, lab, tests and x-ray results, or other health care information, **Cell:** _____ **Home:** _____

7. I authorize this office, it's physicians or employees to either text me, email me or phone & leave me confidential messages on my cell phone or home answering machine, voicemail or email address: _____
   YES _____ **NO**_____

   **** I AM FULLY AWARE THAT A CELL PHONE, THE INTERNET OR EMAIL IS NOT 100% SECURE AND PRIVATE.**

Email: _____**Fax:**_____

(Cell)_____ **(Home)**_____ **(Work)**_____

PATIENT NAME: _____ _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

Sheila L. Scott, AP, MSOM, Dipl. Ac.

AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS

Date of Request:	
Patient's Name:	Date of Birth:
Patient Phone:	

1. Information may be disclosed: TO ☐ FROM ☐

Sheila L. Scott, AP, MSOM, Dipl. AC
1045 Primera Blvd., Suite 1017, Lake Mary, Fl 32746
Phone: 407-682-4454 **Fax: 407-915-6853**

2. Information may be disclosed: TO ☐ FROM ☐

Name of Person / Practice:	
Address:	
Phone:	Fax:

3. Purpose of Disclosure

	Changing Physicians		Continuity of Medical Care
	Personal Use		Others:

4. Information to be disclosed:

	All Medical Records		Progress Notes
	History and Physical		Laboratory Results
	Radiology Results		Consultations
Other:			

I understand that the information in my health records may include information relating to sexually transmitted disease, required immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by State / Federal Law.

I understand that I may revoke this authorization in writing anytime and further understand that I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 90 days from the date initiated above.

Our notice of Privacy Practices provides information about our use of a patient's Protected Health Information (PHI). The notice contains a Patient's Rights section describing your rights under the law. Patients have the right to access, inspect and copy protected health care information used to make decisions about them.

Patient Signature: _____ Date: _____

Witness: _____