Old Bridge Acupuncture & Wellness, LLC

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New Patient Packet

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex ☐ F ☐ M ☐ Other	Date
Date of birth	Age	Occupation	
Main phone #		Mobile phone #	
E-mail address		Opt out email contact by OBA&W: ☐ Yes	
Emergency contact name & phone		Marital status	# of children
Address: Street		City State	Zip
Family physician		Chiropractor	
Do you have health insurance? ☐ Yes ☐ No If yes, name of insurance company			
Does your insurance cover acupuncture? ☐ Yes ☐ No ☐ ? Have you ever been treated by acupuncture before?			
How did you find out about our clinic? ☐ *Friends/Relatives(name)*_____ ☐ *Google* ☐ *Location or walk by* ☐ *Website* ☐ *Referred by*_____ ☐ *Other (please specify)*			

Main problem(s): _____.

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Medical History

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other:		

Surgeries: _____**Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc) _____

Allergies: (drugs, chemicals, foods, environmental):_____

Medicines: taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

_____

Personal: Height_____ Weight now_____ Weight one year ago_____

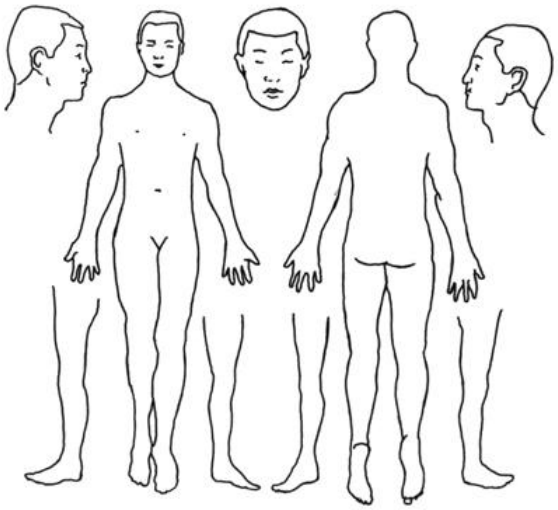
Weight maximum _____@Year _____

Habits: Do you smoke ? □ Yes □ No What? _____ How many per day? _____ Since when? _____

Do you exercise regularly □ Yes □ No Please describe your exercise program: _____

How many hours do you sleep in general? _____ When time do you usually go to bed? _____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General:	□ Poor appetite	□ Poor sleep	□ Fatigue	□ Fevers	□ Chills
□ Night sweats	□ Sweat easily	□ Tremors	□ Cravings	□ Change in appetite	
□ Poor balance	□ Bleed or bruise easily	□ Localized weakness	□ Weight loss	□ Weight gain	
□ Peculiar tastes	□ Desire hot food	□ Desire cold food	□ Strong thirst (cold or hot drinks)		

□ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair:	□ Rashes	□ Ulcerations	□ Hives	□ Itching	□ Eczema
□ Pimples	□ Acne	□ Dandruff	□ Dry skin	□ Recent moles	□ Loss of hair
□ Purpura	□ Change in hair or skin texture		□ Other?		

Musculoskeletal:	□ Joint disorders	□ Muscle weakness	□ Pain/soreness in the muscles		□ Tremors
□ Cold hands/feet	□ Difficulty walking	□ Swelling of hands/feet	□ Spinal curvature	□ Back pain	□ Hernia
□ Numbness	□ Tingling	□ Paralysis	□ Neck tightness	□ Neck pain	□ Shoulder pain
□ Hand/wrist pain	□ Hip pain	□ Knee pain	□ Joint sprain	□ Other-	

Head, eyes, ears, nose, & throat: □ Dizziness □ Concussions □ Migraines □ Glasses/lens

□ Eye strain □ Eye pain □ Color blindness □ Night blindness □ Poor vision □ Cataracts

□ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing □ Spots in front of eyes

□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain

□ Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other?

Cardiovascular: □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting

□ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other?

Respiratory: □ Cough □ Coughing blood □ Wheezing □ Difficulty breathing

□ Bronchitis □ Pneumonia □ Chest pain □ Production of phlegm – What color? _____

Gastrointestinal: □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas

□ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain

□ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological: □ Loss of balance □ Lack of coordination □ Concussion

□ Depression □ Anxiety □ Stress □ Bad temper □ Bi-polar

Genito-urinary: □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate

□ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection

□ Genital pain □ Genital itching □Genital rashes □ STD □ Other?

Female: □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge

□ Fibroids □ Ovarian cysts □ Irregular periods □ Clots □ Pain/cramps prior/during periods

□ Breast tenderness □ Breast Lumps □ Fertility Problems □ Hot flashes □ Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? □ Yes □ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male: □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems

□ Frequent seminal emission □ Fertility problems □ Painful/swollen testicles □ Other

Are there any other health issues you want to discuss with us? Please list dietary supplements if you have not done so already.

I have completed this form correctly to the best of my knowledge and affirm my signature below.

Signature: **Date:**

I am a (check one) : □ Adult Patient □ Parent or Guardian □ Spouse

Old Bridge Acupuncture and Wellness, LLC
Consent to Treatment & Informed Consent

Please take time to read this form, which will provide you with some basic knowledge about acupuncture and Oriental Medicine.

Acupuncture is performed by the insertion of pre-sterilized, disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to certain points on the body. Your acupuncture treatment may be combined with with tui-na/acupressure, Chinese herbs, moxibustion, cupping, electric stimulation, infrared heat lamp, and/or therapeutic exercises based on the fundamentals of Chinese Medicine. Your practitioner will explain the nature of each type of treatment as needed.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing.
- Maintain good personal hygiene.
- Avoid treatment when excessively fatigued, hungry, full, or emotionally upset.
- We are unable to treat patients who are intoxicated and /or are abusing substances.

Acupuncture is generally very safe. Although rare, certain side effects may result from acupuncture and each procedure or treatment has specific risks and benefits. While receiving acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness. Other potential risks from acupuncture are very rare. These risks include infection, bleeding, or pneumothorax (e.g. collapsed lung). We only use sterile needles one time, so the risk of infection is minimal and extremely rare. It is important that you advise the acupuncturist if you are on any blood thinning medication.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.
Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I agree to suspend administration and contact Old Bridge Acupuncture and Wellness, LLC as soon as possible.*
Acupressure/Tui-Na Massage/Cupping: I understand that I may also be given acupressure/tui-na massage or cupping as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from these treatments. These could include, but are not limited to: bruising, sore

muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Please inform your practitioner if you have any of the following conditions:

- If you are pregnant and/or breastfeeding
- If you have ever experienced seizures, fainting or panic attacks
- If you have a pacemaker or any other electrical implants
- If you have HIV/AIDS, hepatitis or a sexually transmitted disease (STD)

Everyone responds to treatment differently therefore, we cannot guarantee the outcome. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visit(s), so that your treatment plan can be adjusted accordingly. Depending on your condition and your goal for treatment, we may require a physician referral in order for you to continue treatment in our clinic. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change, or if any new condition(s) arise.

The Notice of Privacy Practice, which describes how we may use and disclose your protected health information, is available upon request.

By signing this informed consent, you (the patient) acknowledge that you have read the information above carefully and are giving consent for treatment.

_____Date_____
Signature of Patient *or Guardian if patient is a minor/unable to affirm signature*
I have read and understand the above statement and freely give my consent to treatment.

_____Date_____
Signature of Witness

Old Bridge Acupuncture and Wellness, LLC
Authorization & Agreement

Please read carefully the paragraphs below which contain several agreements with **Old Bridge Acupuncture & Wellness, LLC.**

MEDICAL INSURANCE: Old Bridge Acupuncture & Wellness, LLC is an acupuncture provider with Horizon BCBS of New Jersey, Cigna and United Healthcare. We will verify coverage for acupuncture services. Upon verification of coverage, you, the patient, will be responsible for any up front payment or copay. **By signing below, you agree to assign all benefits Horizon BCBS of NJ, Cigna and or United Healthcare may assign to you for services rendered to Old Bridge Acupuncture and Wellness, LLC.** If you are an out of network patient, or otherwise do not have coverage for acupuncture services you will designated as self-pay and therefore responsible for all treatment costs at Old Bridge Acupuncture and Wellness, LLC.

FINANCIAL RESPONSIBILITY: Fees for Outpatient Services must be paid at the time services are rendered. In other words, payment is due at the time of your treatment appointment.

I understand that both I and/or the person who signs below are responsible for all fees incurred. Furthermore, I understand that I may not be eligible for reimbursement from my insurance company.

Appointments: Treatments are by appointment only. If you find that you need to cancel an appointment, it is important that we receive twenty-four (24) hours notice. This enables us to fill the time slot. **We reserve the right to charge a $75 fee for appointments canceled with less than twenty-four hours notice or for "no show" appointments**.

RELEASE OF INFORMATION: I authorize **Old Bridge Acupuncture & Wellness, LLC** to release medical or other information about me to the medical insurance company, insurance billing agent and/or referring physician or other medical provider. This authorization will end if I give written instructions to **Old Bridge Acupuncture & Wellness, LLC**, which I may do at any time.

DISCLAIMER: In an attempt to provide quality customer service to our patients, any verification of your insurance is only an estimate and is not a guarantee of payment by your insurance company. **Any insurance approval implied or otherwise is subject to all plan provisions in force at the time services are rendered. As a result, you, the patient will be held responsible for all fees incurred.**

_____ _____

Patient or Guardian Signature Date

In order to provide a peaceful and healing atmosphere…
PLEASE
SPEAK SOFTLY
TURN PHONE OFF/VIBRATE
DO NOT WEAR STRONG PERFUME/COLOGNE