

# 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 <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other	Date
Date of birth	Age	Occupation
Main phone #	Mobile phone #	
E-mail address	Opt out email contact by OBA&W: <input type="checkbox"/> Yes	
Emergency contact name & phone	Marital status	# of children
Address: Street	City	State Zip
Family physician	Chiropractor	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of insurance company _____		
Does your insurance cover acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? Have you ever been treated by acupuncture before? _____		
How did you find out about our clinic? <input type="checkbox"/> Friends/Relatives(name) _____		
<input type="checkbox"/> Google <input type="checkbox"/> Location or walk by <input type="checkbox"/> Website <input type="checkbox"/> Referred by _____		
<input type="checkbox"/> 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	Diagnosis	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/Dietary Supplements:** taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

\_\_\_\_\_  
\_\_\_\_\_

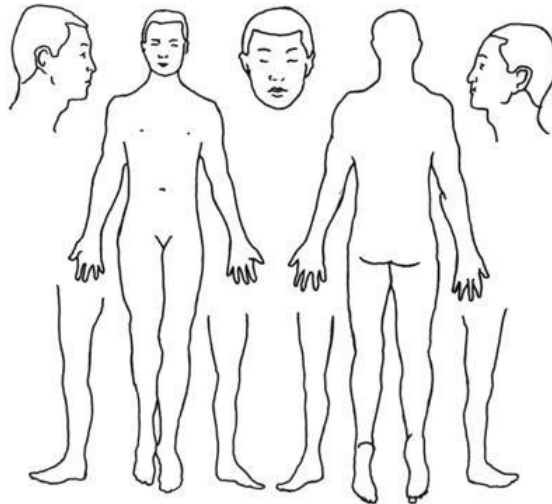
**Personal:** Height \_\_\_\_\_ Weight now \_\_\_\_\_ Weight one year ago \_\_\_\_\_

**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) \_\_\_\_\_

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**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?

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**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  **PACEMAKER**

**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

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

<b>Signature:</b>	<b>Date:</b>
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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, dietary therapy, 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, if you have an implanted pacemaker, if you are pregnant and/or you have a history of epilepsy/seizure.** Initial:

**Indirect and or Direct Moxibustion:** I understand that if I receive indirect and or direct moxibustion as a part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse

this therapy.

**Chinese Herbs/ Herbal Medicines/ Dietary Supplements:** I understand that substances from the Oriental Materia Medica or otherwise 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 effects 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 Bodywork/Cupping:** I understand that I may also be given acupressure/tui-na bodywork 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 or online at [www.oldbridgeacupuncture.com](http://www.oldbridgeacupuncture.com).

**By signing this informed consent, you (the patient) acknowledge that you have read the information above carefully and are freely 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 contracted with Horizon BCBS of New Jersey 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 and 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 be designated as self-pay and therefore responsible for all up front 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 advance 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...

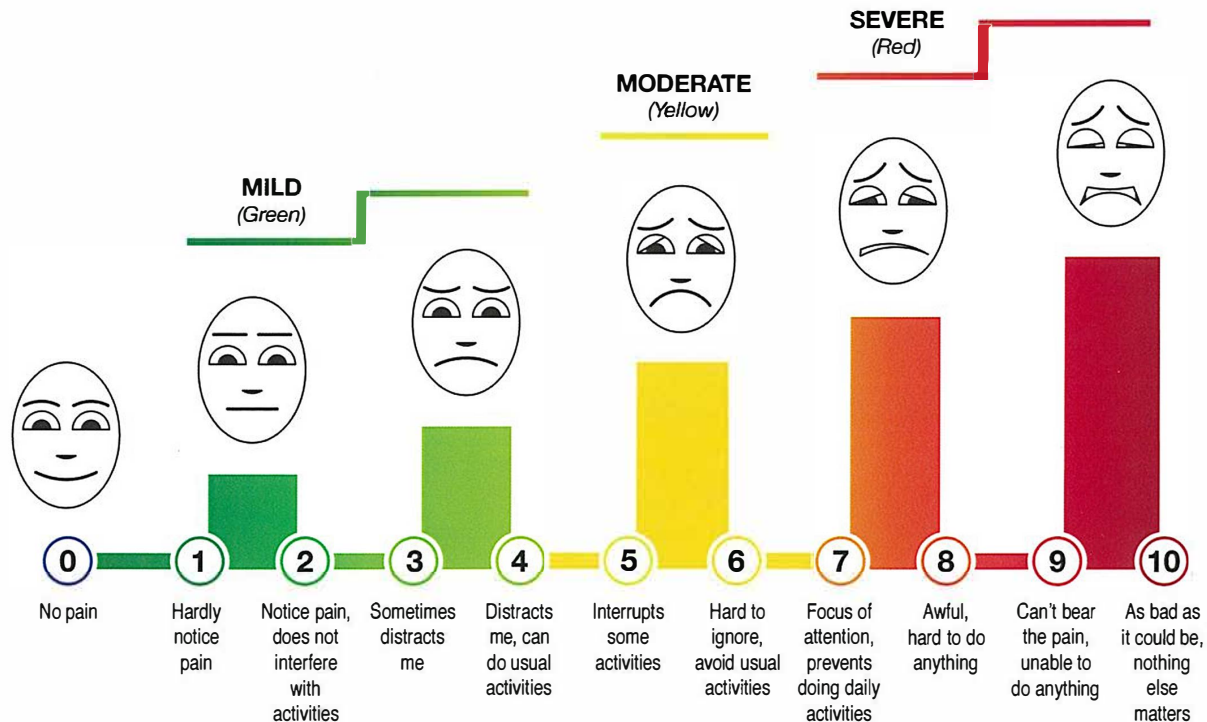
PLEASE

SPEAK SOFTLY

TURN PHONE OFF/VIBRATE

DO NOT WEAR STRONG PERFUME/COLOGNE

# Standardized (VA) Pain Rating Scale



# DoD/VA PAIN SUPPLEMENTAL QUESTIONS

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For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual **ACTIVITY**:



2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**:



3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**:



4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**:

