ACUPUNCTURE INTAKE AND MEDICAL INFORMATION

ACUPUNCTURE WELLNESS MOUNT AIRY, 1010 S. Main Street, Mount Airy, NC 27030

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Name: _____ Date of First Visit: _____

Date of Birth: _____ M / F Occupation: _____

Address: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Email Address _____ Preferred method of contact: Home Cell E-Mail

Family Doctor: _____ Phone _____

Emergency Contact Name: _____ Phone: _____

How did you hear of us? _____

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

_____

_____

_____

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: _____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _____

_____

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other _____

Acupuncture Wellness Mount Airy

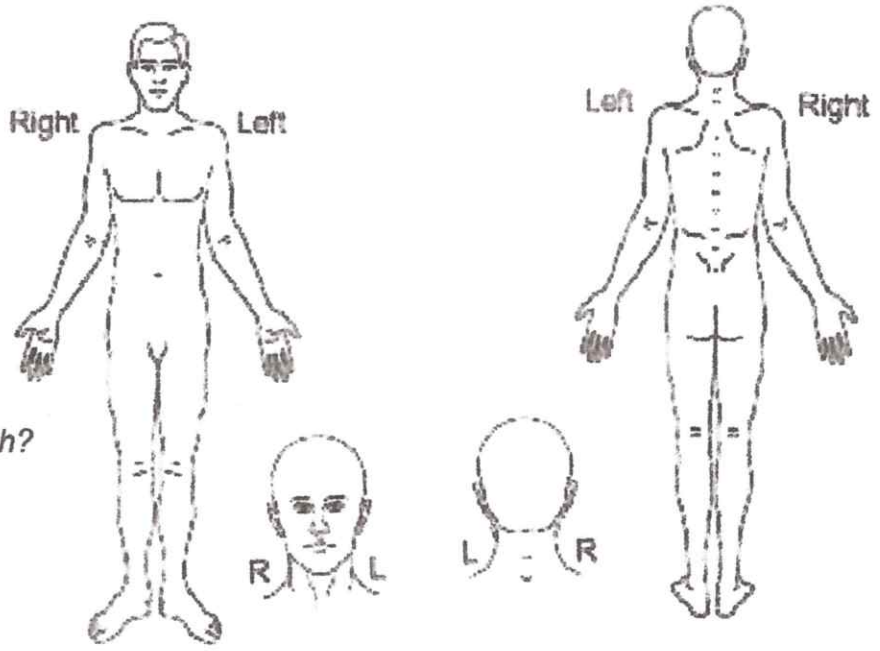
If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

Pain Condition #1 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

1

Nature of the Pain
- O Constant
- O Comes and goes
- O Fixed
- O Moves
- O One side
- O Both sides
- O Sharp
- O Dull
- O Burning
- O Aching
- O Spastic
- O Numb

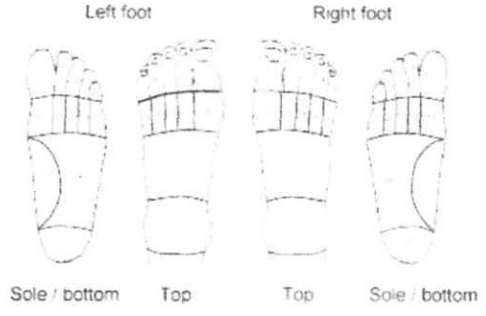
Does the pain get better, or worse with?
- O Heat *better worse*
- O Cold *better worse*
- O Motion *better worse*
- O Rest *better worse*
- O Pressure *better worse*
- O Better in *AM* or *PM*?

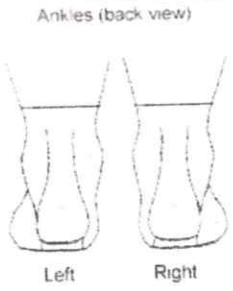


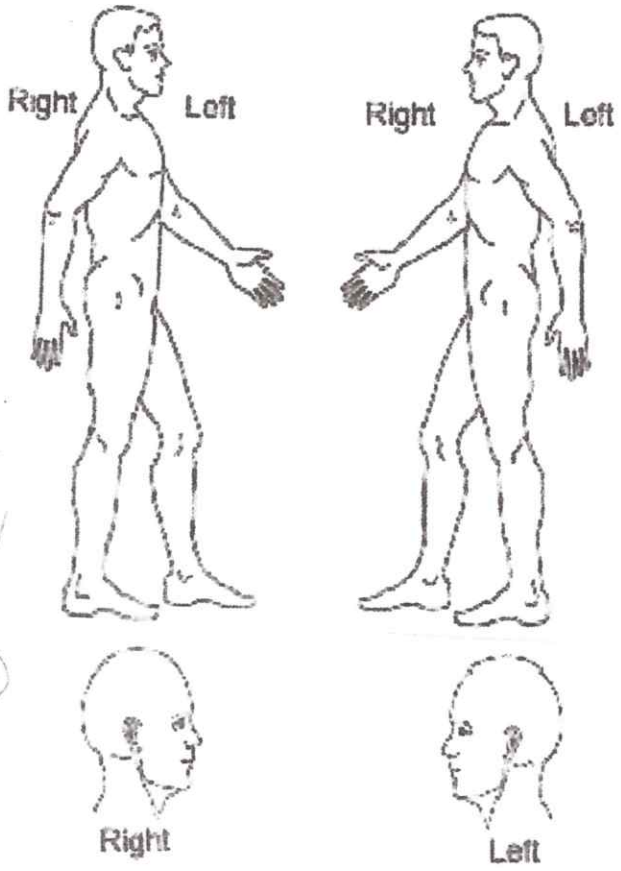
Pain Condition #2 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain
- O Constant
- O Comes and goes
- O Fixed
- O Moves
- O One side
- O Both sides
- O Sharp
- O Dull
- O Burning
- O Aching
- O Spastic
- O Numb

Does the pain get better, or worse with?
- O Heat *better worse*
- O Cold *better worse*
- O Motion *better worse*
- O Rest *better worse*
- O Pressure *better worse*
- O Better in *AM* or *PM*







Do you suffer from needle sen vity resulting in light-headedness, nausea or fainting? Yes No

How do you sleep? (Trouble falling or staying asleep, dreams, wake often - at specific times, etc?)

How is your digestion? (Appetite, bowel movements, bloating, nausea, heart burn, etc?)

Body Temperature

Not necessarily in degrees, but how you feel relative to others - needing to wear more layers, over-heating regularly, etc.

COLD 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 HOT

☐ Cold hands & feet ☐ Thirst but no desire to drink ☐ Hot hands & feet ☐ Numbness
☐ Easily chilled ☐ Never thirsty ☐ Always thirsty *location*_____

Energy Level

LOW 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 HIGH

☐ Drop in energy ☐ Shortness of breath ☐ Difficulty focusing ☐ Energy drop after meals
*time of day?*_____ ☐ Body weakness/heaviness ☐ Poor memory ☐ Dizziness
☐ High or low blood pressure ☐ Need caffeine or stimulants ☐ Bleed or bruise easily ☐ Heart Palpitations

Women Only Are you currently or potentially pregnant? Yes No If yes, how many weeks? _____
How many pregnancies have you had? _____ Natural births: _____ Cesarian: _____
Please check if any apply. ☐ PMS ☐ Heavy menses ☐ Long menses ☐ Cramping ☐ Spotting
☐ Yeast Infection ☐ UTI ☐ Birth Control ☐ Infertility ☐ Trying to conceive ☐ Miscarriage
☐ Menopause ☐ Hot Flashes/Night Sweats ☐ Weight gain ☐ Vaginal dryness ☐ Mood Swings

Frequent Emotions ☐ Anger ☐ Irritability ☐ Anxiety ☐ Fear ☐ Sadness/Grief
☐ Depression ☐ Hyperactivity ☐ Timid/Shy ☐ Indecision ☐ Obsessive thoughts

Eyes, Ears, Nose & Throat	☐ Vision loss	☐ Red eyes	☐ Itchy eyes	☐ Floaters or spots in eyes
	☐ Night blindness	☐ Tinnitus	☐ Hearing loss	☐ Sleep apnea
	☐ Phlegm	☐ Dental issues	☐ Sore throat	☐ Seasonal allergies
	☐ Cold sores, cankers	☐ Lingering cough	☐ Sinus congestion	☐ Asthma
	☐ Sinusitis	☐Rhinitis	☐ Dry eyes	☐ Dry nose, mouth, throat

Lifestyle Do you exercise? Yes No If yes, how often? _____ times per week.
List your physical activities: _____
What is your stress level like? ☐ Low ☐ Moderate ☐ High ☐ Off & on
Do you have stress management habits? Yes No If yes, please list: _____
Please describe your diet: _____
Please list any foods you restrict: _____

Please give any other information you feel may be of importance: _____

Allergies

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Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to

Medication Name	Allergic Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity ☐Malaise ☐Unexplained weight gain ☐Unexplained weight loss ☐Low sex drive ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Blood clots ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Suicidal thoughts ☐Hallucinations ☐Stress problems ☐Suicidal planning ☐Thoughts of harming others

Mark all appropriate diagnoses as they pertain to your parents siblings:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

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☐Other Medical Problems: _____

☐ I have no significant family medical history

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	Dose	Frequency
1)			
2)			
3)			
4)			
5)			

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.

On average, how often do you have a bowel movement?
(Please check one)

☐ **More than 3 times per day**
☐ **Once per day**
☐ **Less than once per week**
☐ **2 to 3 times per day**
☐ **2 to 3 times per week**

Think back to when you started pain medicine. Did your bowel habits change? If so how?

_____

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology
- ☐ Cancer – Type _____
- ☐ Cancer – Type _____
- ☐ Cancer – Type _____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Presence of stent/pacemaker/ defibrillator

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ IBS/Crohns Disease

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neurological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines

ENT
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ PTSD

Endocrinology
- ☐ Diabetes – Type _____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____

Please list any surgical procedures you have had done in the past including date:

1) _____ Date? _____
2) _____ Date? _____
3) _____ Date? _____
4) _____ Date? _____
5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

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HIPAA Authorization for Release of Health Information

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Purpose of Release:

I, _____, authorize the release of my health information to the individuals listed below for the purpose of sharing information related to my medical care, including diagnosis, making appointments, treatment, prognosis, and other relevant details.

Individuals Authorized to Receive Information:

1. Name: _____
   Relationship: _____
   Phone: _____
2. Name: _____
   Relationship: _____
   Phone: _____
3. Name: _____
   Relationship: _____
   Phone: _____

This authorization permits the release of the following health information (select or specify applicable information):

- [ ] Entire medical record
- [ ] Specific medical conditions, treatments, or procedures:
  _____
- [ ] Mental health records
- [ ] Substance abuse treatment records
- [ ] HIV/AIDS information
- [ ] Billing and payment information

Expiration of Authorization:

This authorization shall expire (check one):

- [ ] Upon termination of treatment with [Health Care Provider/Organization Name]
- [ ] One year from the date of signature
- [ ] Other (Specify): _____

Revocation:

I understand that I may revoke this authorization at any time by submitting a written request to the health care provider or organization listed below. The revocation will not apply to any information already disclosed under this authorization.

I hereby authorize the release of my health information as described above.

Signature of Patient (or Legal Representative): _____

Date: _____

Printed Name of Patient (or Legal Representative): _____

Witness Signature (Optional): _____

Date: _____

Health Care Provider/Organization Receiving this Authorization

Name: _____ ACUPUNCTURE WELLNESS MOUNT AIRY

Contact Information: ____ 1010 S. MAIN STREET Mount Airy NC 27030

DR. DIANE MILHAN AND EVAN MAGEE
ACUPUNCTURE WELLNESS MOUNT AIRY
NPI#1588966824 NPI#1417704545
GRP NPI# 1073925566

ACUPUNCTURE WELLNESS MOUNT AIRY

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Consent for Treatment

_____ ACUPUNCTURE–is a healing art that involves the stimulation of specific points on the body. It has the effect of normalizing physiological functions, modifying the perception of pain, and treating certain patterns of disease in the body. Acupuncture is considered a safe method of treatment but occasionally there can be bruising or tingling near needling sites that can last for a few days. Rare instances of fainting, a spontaneous miscarriage, or a pneumothorax have been reported.

_____INDIRECT MOXABUSTION–is the application of a moxa roll to the end of a placed needle, which is then burned. There may be a slight warming perceivable to the patient. The burning adds a frequency treatment to the needles used.

_____ ELECTRICAL ACUPUNCTURE–is the addition of a very small amount of electrical current by wires to the needles in the areas where the practitioner desires an additional effect to the body. The current is microcurrent as opposed to millicurrent, which is used in TENS equipment. There may be small side effects, such as electrical sensation or discomfort in the needles. Tell your practitioner if this occurs, and the current will be altered.

____ DIRECT MOXABUSTION- Some acupuncture points that would benefit from the effects of moxabustion are more easily and less painfully treated with direct moxibustion. The moxa is on the end of a cardboard tube which keeps the heat 1/2 inch away from the skin. Side effects may include a blister or darkening of the skin at the site.Please tell your attendant if the moxa feels too hot and the moxa will be removed immediately.

_____ CUPPING–Cupping is the application of plastic cups to the surface of the body to modify pain. The tissue lifted up into the suction allows an increased blood flow to the tissues below the cup and can increase the delivery of oxygen and glucose into the area of pain. Cupping can leave marks in circles or oval following the shape of the cups.The color of the marks should fade in less than a week depending on the vitality of your vascular system. These marks are not "bruises" because blood vessels are not broken in the process so no blood leaks out of vessels.

_____ GUA SHA- also called Instrument Assisted Soft Tissue Mobilization--Gua Sha is an ancient technique that uses a tool that is rubbed against the surface of the skin in the areas of pain. The rubbing may leave "color" in the areas of treatment and while this may be considered unsightly, the color is not painful and does not represent leaking of blood vessels. The color will last several days to a week and generally fades similarly to sunburn. Pictures of typical colors are seen in a book in the front of the office so that you can anticipate the color you might produce.

_____ ERCHONIA AND THOR LASER -Class 3-B laser- When appropriate, the acupuncturist may decide to use laser's healing light on a painful or injured area. The red and blue light of the laser modifies pain responses. Because these lasers are "cold" burns are not possible. Laser therapy has been used for forty years to reduce pain, swelling, and inflammation, prevent tissue damage, heal wounds, and treat deeper tissues and nerves. When lasers are used for surgery (which our lasers ARE NOT), there can be additional problems which you may know about.

_____ INFRARED LIGHT- We use several different instrumsnt in the first room to increase blood flow into your areas of pain and dysfunction. These "red light" instruments contain both infrared and far infrared light. Because heat is a potential side effect of light treatment, please tell us is your instrument feels too warm or hot.

_____ FREQUENCY SPECIFIC MICROCURRENT- AND MICROCURRENT (ITO 130 and 160 and Alpha-Stim)
The side effects of FSM treatments are very rare and mild. If you do experience side effects, these can be nausea, fatigue, drowsiness, a temporary increase in pain, and a flu-like feeling. Side effects usually start during or about 90 minutes after treatment, and may last from 4 to 24 hours. There have been no lasting adverse reactions reported. FSM and microcurrent have a history of being very safe.There are people who shouldn't receive FSM treatment including pacemakers, implanted pumps, pregnancy, uncontrolled seizures, metal plates and pins, too much metal bridgework, cancer within the last two years, or history of thrombosis.

By signing below, I do voluntarily consent to be treated by this practice, Dr. Diane Milhan, and understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that having a regular primary care physician is an important part of my healthcare. No guarantee of results has been made.

I do not expect Dr. Milhan to be able to anticipate or explain all the possible risks of treatment. I understand that I may withdraw my consent to any part of this document at any time with a verbal request.

_____

PRINT and Sign Name and Relationship if Personal Representative: _____

_____ Date: _____

ITEMS TO ACKNOWLEDGE AND UNDERSTAND TO HELP US SERVE YOU BETTER

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Patient Signature Date

☐ **I am NOT here for treatment related to a motor vehicle accident.**

I am NOT here to support a disability application.

We expect that you will identify any plan to use these treatments to support a claim involving motor vehicle accident, no-fault or disability at the initial visit.

If you fail to inform us of any potential claims, we will proceed with your primary complaints in treatment unrelated to and separate from any additional claim you may make in the future for third-party involvement. We will not later say that we were treating you for an unidentified complication/symptom/injury when you have failed to tell us.

☐ **Appointments- I understand that appointments can be made in the office at the scheduling book. I also know that I can call and make appointment.**

☐ **Communication Sheets- Upon coming into the practice, you will be asked to fill out a communication sheet. These sheets give us informationto start the day's treatment. We invite you to make your concerns as complete as possible in the communication sheet and tell us any changes, good or bad, that have occurred to you since your last visit.**

☐ **Missed or Late Cancellations- We do understand. We are all human. But we ask for a minimum of 24 hour cancellation when you find it necessary to reschedule your appointment. Failure to follow this prevents us from scheduling another patient in your place. We ask for a $25 fee to be paid on your next visit following a no show or a late cancellation.**

Thank you for your understanding of this policy.

☐ **RECEIPTS- We are happy to provide you with a receipt for the day. Please request receipts upon your arrival in our office. If you will require one on each visit, please let us prepare the note ahead of time and we will have one ready for you as you arrive. This may apply to patients with flexible spending accounts. Please note that we are not able to reproduce the receipt that you took with you. We can give to you a letter stating payment was made.**