MISSION WELLNESS
CHIROPRACTIC
ACUPUNCTURE ◆ MASSAGE THERAPY

Acupuncture Intake Form

First Name: _____ Last Name: _____ M.I. _____

Nickname: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____Work: _____

Social Security Number: _____ Email: _____

Gender: Male Female **Marital Status:** Single Married Divorced Partnered Widowed

Occupation:_____ Employer: _____

Emergency Contact Name: _____ Phone Number: _____

How were you referred to this office? _____

Acknowledgment of receipt of Notice of Patient Privacy Practices

I, _____ give consent to Mission Chiropractic & Wellness to use and disclose my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Mission Chiropractic's general healthcare operation purposes. Healthcare operations shall include, but are not limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Mission Chiropractic's diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

Information will not be shared with any third party without patient's consent. Under extreme circumstances, information may be shared without patient's consent with sole purpose of best regards towards patient's treatment. A full expansion of these circumstances is available upon request.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition: the provision of health care services to me; and either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time except to the extent that the physician or Practice has acted in reliance on this consent.

Mission Chiropractic & Wellness reserves the right to change the privacy practices that are described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time. The most current copy of this notice will be posted in the clinic.

_____ _____

Signature of Patient or Personal Representative **Date**

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at **Mission Wellness.** I understand that acupuncturists practicing in the state of Kansas are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

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 should suspend taking them and call your clinic as soon as possible.*

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.
I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all the above information and am fully aware of what I am signing.
I understand that I may ask my practitioner for a more detailed explanation.

I give my permission and consent to treatment.

Printed Name: _____

Signature: _____ Date: _____

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Patient Health History

Successful health care and preventative medicine are both only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally.

Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark.

1.When and where did you last receive health care? _____

For what reason? _____

2.Has your case been referred to an attorney? Y N

3.Please identify the health concerns that have brought you to our clinic, in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

4.If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

5.Please list any medications prescribed and over the counter, vitamins, and supplements you are currently taking:

_____

_____

6.Do you have any reason to believe you may be pregnant? Y N **If so, how far along are you? _____**

7.Do you have any infectious diseases? Y N **If yes, please identify: _____**

8. Family History

	Father	Mother	Brothers	Sisters	Spouse	Children
Check those that apply:						
Age (if living)						
Health G=Good P=Poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay Fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

9.Height_____ Current Weight: _____ Past Max Weight: _____ When?_____

10. Blood Pressure: What is your most recent blood pressure reading? _____/_____Date:_____

11. Hospitalizations and Surgeries:

Reason **When**

_____

_____

_____

12. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason **When**

_____

_____

13. Emotional (Please circle any that now you experience and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Major Trauma

14. Energy and Immunity
(Please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

15. Head, Eye, Ear, Nose, and Throat
(Please circle any that you experience now and underline any that you have experienced in the past):

Impaired VisionEye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

ImpairedHearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding Hay Fever

TMJ/Jaw Problems

16. Respiratory
(Please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath **Other Respiratory Problems:** _____

17. Cardiovascular
(Please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

18. Gastrointestinal
(Please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

19. Genito-Urinary Tract
(Please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Kidney Stones Painful Urination Impaired Urination Frequent UTI Blood in Urine Frequent Urination Urination at Night Heavy Flow Frequent

20. Female Reproductive/Breasts
(Please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

21. Menstrual/Birthing History

Age of First Menses:_____ Birth Control Type:_____ Number of Abortions:_____

# of Days of Menses:_____ Number of Pregnancies:_____ Number of Live Births:_____

Length of Cycle:_____ Number of Miscarriages:_____

22. Male Reproductive
(Please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

23. Musculoskeletal
(Please circle any thatyou experience now and derline anx- that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?):_____

24. Neurologic
(Please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. Endocrine
(Please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

26. Other
(Please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?

_____

_____

27. Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed:

f. Occupation: _____ Employer: _____ Hours/ Week: _____

Do you enjoy work? Y N Please Explain: _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____