ACUPUNCTURE INTAKE & HISTORY

Get Well Family Health & Chiropractic **580 N Hwy 67, Ste 5**
314-524-2580 **Florissant, MO 63031**

Personal Information Todays Date: ___/___/___

Patient Name: _____

Age: _____ Birth Date: ___/___/___ Gender: _____

Address: _____

City: _____ State:_____ Zip: _____

Telephone (Mobile): _____

Email Address: _____

Occupation: _____ Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____ Phone: _____

Main Complaint

Please identify your major health concerns:

1. _____

_____

How long have you had this problem? _____

2. _____

_____

How long have you had this problem? _____

3. _____

_____

How long have you had this problem? _____

Have you been given a diagnosis for these problems? _____

_____

What other treatments have you tried and what were the outcomes? _____

_____

_____

Name: _____ ***DOB:*** _____ ***Today's Date:*** _____

Personal Medical History *(Please include your childhood history)*

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do you have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Other:
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Earaches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

Name: _____ ***DOB:*** _____ ***Today's Date:*** _____

Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Gynecology

Age of Menses _____
Duration of Menses _____
Date of Last Menses _____
# of Pregnancies _____
# of Births _____

- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

Musculo-Skeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain with Weather Changes
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Pain with Activity
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Pain After Waking

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Informed Consent to Acupuncture Treatment

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

I, _____, do hereby give my consent to the performance of procedures which are within the scope of practice of classical Chinese medicine, on myself (or on the patient named below, for whom I am legally responsible) by Dr. Sarah Paunicka, DC.

I understand that classical Chinese medicine procedures may consist of, but are not limited to, acupuncture, moxibustion, cupping, electro-acupuncture, herbology, massage, bodywork, and application of heat lamps.

POSSIBLE RISKS AND COMPLICATIONS ASSOCIATED WITH THESE PROCEDURES
Although Chinese medicine treatments are considered to be some of the safest, most effective forms of therapy for many health conditions, I am aware that there are possible risks and complications associated with these procedures, which include, but are not limited to:

Slight burning * Tingling near the needling sites that may last a few days * Nausea * Infections * Blisters * Fainting * Scarring * Bruising * Minor bleeding * Aggravation of symptoms * Inability to drive * Swelling * Emotional distress * Fatigue

There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider. If I experience any gastrointestinal upset or allergic reaction to the herbs, I will inform my provider immediately. If I experience belabored breathing during or after treatment, I will immediately inform my provider. I do not expect the provider to be able to anticipate and explain all the risks and possible complications, and I wish to rely on the provider to exercise judgment during the course of the procedure, which the provider believes at the time, based upon the facts known, is in my best interest.

TREATMENT RESULTS
I have had an opportunity to discuss with the provider the various types of treatment, including acupuncture, moxibustion, cupping, electro-acupuncture, herbology, massage, bodywork, and application of heat lamps which have been proposed to me for my condition, and the purpose and objectives of these Chinese medicine procedures. I understand that there are beneficial effects associated with these treatment procedures. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my provider.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternatives to these procedures have been explained to me including massage, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. I understand that I may refuse any or all the care that is recommended to me. I have read or have had read to me the above explanation of classical Chinese medicine treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____	_____	_____	_____
Date	Patient Name (Print)	Patient's Signature	
_____	Dr. Sarah Paunicka, DC	_____	
Date	Provider Name (Print)	Provider's Signature	

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Dr. Sarah Paunicka
580 N Hwy 67, Ste 5, Florissant, MO 63031
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Health Care Authorization Form

Patient Name: _____ Date of Birth: _____

The patient identified above authorizes Dr. Sarah Paunicka to use and or disclose protected health information in accordance with the following:

Specific Authorizations:
This form gives permission to Dr. Sarah Paunicka to use your address, phone number, and clinical records to make contact with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

By signing this form, you are giving Dr. Sarah Paunicka permission to use and disclose you protected health information in accordance with the directives listed above.

Expiration:
The Authorization shall expire on the following date: _ongoing_

Right to Revoke Authorization:
You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this Authorization, is not effective to the extent that we have provided services or take action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Dr. Sarah Paunicka, the written notice must contain the following information:

- Your name and Date of Birth
- A clear statement of your intent to revoke this authorization with the date of your request and your signature.

The revocation is not effective until it is received by the Privacy Official.

Acknowledgement of Receipt of Notice of Privacy Practices
I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my heath information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient Signature: _____

Today's Date: _____