JERSEY WELLNESS CENTER
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Denville, NJ 07834

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ACUPUNCTURE NEW PATIENT INTAKE

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Date of Birth: _____ Age: _____ Gender: _____

Occupation: _____ How long at current job: _____ Enjoy work: Yes / No

Marital Status: _____ Spouse's Name: _____

Do you have children: Yes / No If yes, how many: _____ Ages: _____

Name of Emergency Contact Person: _____

Phone Number for Emergency Contact Person: _____

Your Primary Care Physician: _____

Who can we thank for referring you: _____

****

Please describe your chief complaint: _____

How long have you had this condition: _____

How often do you feel this complaint daily: (circle) 0-25% / 25-50% / 51-75% / 76-100%

What makes it: (worse) _____ (better) _____

Is there anything else you would like address today: _____

How are you feeling today: _____

How is your energy level:

_____

Have you had acupuncture before? ☐ Yes ☐ No If yes, when & by whom: _____

Are you afraid of needles: ☐ Yes ☐ No

Have you eaten today: ☐ Yes ☐ No If yes, time: _____ What did you eat:

_____

What are your overall wellness goals? _____

How would you like me to assist with this goal? _____

Do you have expectations for today's visit? _____

_____

Please list any illnesses/diseases that run in your family:

Mother/Grandmother: _____

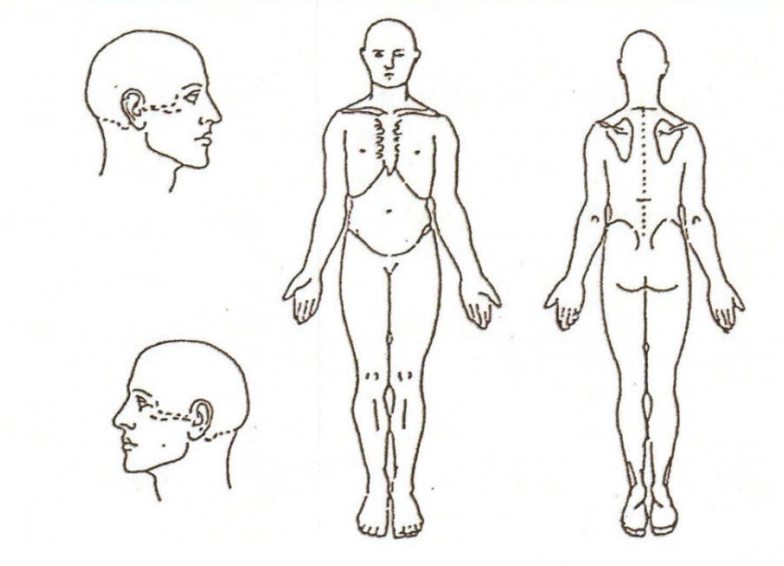
Father/Grandfather: _____

_____

Hospitalization/Surgeries/Accidents: _____

Allergies: _____

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW



Symbol	Reaction
PAIN	
X	little
XX	moderate
XXX	strong
SWELLING	
^	slight
^^	moderate
^^^	severe
PULSING	
O	slight
OO	moderate
OOO	strong
WEAKNESS/TEMP.	
~	weak
+	hot
SKIN PROBLEMS	
*	skin issue

Exercise: ☐ Sedentary (No exercise)

☐ Mild exercise (e.g., climb stairs, walk 3 blocks, golf)

☐ Occasional vigorous exercise (workout/recreation less than 4x/week for 30 min.)

☐ Regular vigorous exercise (workout/recreation 4x/week for 30 min.)

Please describe your exercise regimen: _____

Please list drugs, herbs and supplements you currently take: _____

_____

General: ☐ Poor appetite ☐ Insomnia ☐ Disturbed sleep ☐ Localized weakness

☐ Cravings ☐ Strong thirst ☐ Weight gain ☐ Weight loss ☐ Sweating easily

☐ Bleeding/bruising ☐ Tremors ☐ Night sweats ☐ Fever ☐ Chills

☐ Sudden energy drop ☐ Poor Balance

Skin & Hair: ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema ☐ Pimples/Acne
☐ Dandruff ☐ Recent moles ☐ Changes in hair texture ☐ Hair loss

Head, Eyes, Ears, Nose, Throat: ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses

☐ Spots in front of eyes ☐ Eye pain ☐ Poor vision ☐ Night blindness ☐ Photophobia

☐ Color blindness ☐ Cataracts ☐ Blurry vision/Glaucoma ☐ Earaches ☐ Ringing in the ears

☐ Poor hearing ☐ Eye strain ☐ Sinus problems ☐ TMJ ☐ Recurrent sore throats

☐ Nose bleeds ☐ Grinding teeth ☐ Sores on lips or tongue ☐ Facial pain ☐ Teeth problems

☐ Headaches ☐ Jaw clicks ☐ Gum/teeth problems

Cardiovascular: ☐ Dizziness ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat

☐ Tightening in chest ☐ High blood pressure ☐ Fainting ☐ Cold hands or feet

☐ Swelling of hands ☐ Palpitations ☐ Swelling of feet ☐ Blood clots ☐ Difficulty in breathing

☐ Phlebitis ☐ Stroke Do you have a pacemaker? ☐ Yes ☐ No

Respiratory: ☐ Cough ☐ Asthma/Allergies ☐ Bronchitis ☐ Shortness of breath

☐ Frequent colds or flu ☐ Excessive phlegm

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas/bloating

☐ Parasites ☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath

☐ Diverticulitis ☐ Rectal pain ☐ Hemorrhoids ☐ Abdominal pain/cramps

☐ Chronic laxative use ☐ Crohn's ☐ Colitis

Do you follow a special diet tailored to your needs? ☐ Yes ☐ No

Genitourinary: ☐ Pain on urination ☐ Low to no sex drive ☐ Blood in urine ☐ Incontinence

☐ Decrease in flow ☐ Kidney stones ☐ Sores on genitals ☐ Impotence/frigidity

Musculoskeletal: ☐ Neck pain ☐ Muscle pain ☐ Knee pain ☐ Sciatica ☐ Migraines

☐ Back pain ☐ Muscle weakness ☐ Foot/ankle pain ☐ Tinnitus ☐ Varicose veins

☐ Hand/wrist pain ☐ Shoulder pain ☐ Hip pain ☐ Arthritis

Neuro/Psych: ☐ Seizures ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Poor memory

☐ Depression ☐ Concussion ☐ Anxiety ☐ Bad temper ☐ Frequent mood swings

Other Illness: ☐ HIV positive ☐ AIDS ☐ Epstein-Barr/Mono ☐ Herpes 1 or 2

☐ Rheumatic fever ☐ Hypoglycemia ☐ Diabetes ☐ Lupus ☐ Eating disorder ☐ Jaundice

☐ Hepatitis ☐ Under/Overweight

Diet: Are you dieting: ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet: ☐ Yes ☐

Number of meals you eat on an average day: _____

Describe daily diet: _____

Caffeine: ☐ Coffee ☐ Tea ☐ Cola ☐ Energy Drinks # of cups/day: _____

Tobacco: ☐ Yes ☐ No Tobacco Type: _____

How much per day: _____ # of years: _____ If you quite, when: _____

Alcohol: Do you drink alcohol? ☐ Yes ☐ No If so, how many drinks per week? _____

Mental Health

Is stress a major problem for you: ☐ Yes ☐ No

Do you feel depressed: ☐ Yes ☐ No

Do you panic when stressed: ☐ Yes ☐ No

Do you have problems with eating or your appetite: ☐ Yes ☐ No

Do you cry frequently: ☐ Yes ☐ No

Have you ever attempted suicide or is there family history: ☐ Yes ☐ No

Have you ever seriously thought about hurting yourself: ☐ Yes ☐ No

Do you have trouble sleeping: ☐ Yes ☐ No Is it dream disturbed: ☐ Yes ☐ No

Have you ever been to a counselor: ☐ Yes ☐ No

Do you have a history of alcohol/drug abuse: ☐ Yes ☐ No

If so, please explain: _____

Is there a family history of alcohol/drug abuse: _____

For Women Only

Age at onset of menstruation: _____

Are you in menopause: ☐ Yes ☐ No

Date of last period: _____ Period occurs every: _____ days How many days on period: ____

Do you have heavy periods, irregularity, spotting, pain, or discharge: ☐ Yes ☐ No

Number of pregnancies _____ live births _____ miscarriages _____ abortions _____

Is there a chance you may be pregnant: ☐ Yes ☐ No

Do you or have you breastfed your children: ☐ Yes ☐ No

Have you had a D&C, hysterectomy, or Cesarean: ☐ Yes ☐ No

Any urinary tract, bladder, or kidney infections within the last year: ☐ Yes ☐ No

Do you get yeast infections often or at all: ☐ Yes ☐ No

Any hot flashes or sweating at night: ☐ Yes ☐ No

Experience menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period: ☐ Yes ☐ No

Experienced any recent breast tenderness, lumps, or nipple discharge: ☐ Yes ☐ No

For Men Only

Do you urinate often: ☐ Yes ☐ No If so, is it clear, copious, dark, yellow, scanty: _____

Do you usually get up to urinate during the night: ☐ Yes ☐ No

Do you feel burning discharge from penis: ☐ Yes ☐ No

Has the force of your urination decreased: ☐ Yes ☐

No Have you had any kidney, bladder, or prostate infections within the last year: ☐ Yes ☐ No

Do you have any problems emptying your bladder completely: ☐ Yes ☐ No

Any difficulty with erection or ejaculation: ☐ Yes ☐ No

Any testicle pain or swelling: ☐ Yes ☐ No

Have you been diagnosed to be sterile: ☐ Yes ☐ No

Have you had a vasectomy: ☐ Yes ☐ No

PRIVACY PRACTICES

A copy of our Privacy Practices is available for viewing on our website: www.jerseywellnesscenter.com. In addition, a hard copy is visible in our office. You may request a copy of our Privacy Practices at any time from our front desk.

I have been provided with my options to review a copy of Jersey Wellness Center, LLC Notice of Privacy Practices, which describes Jersey Wellness Center, LLC use and disclosure of my Protected Health Information (PHI).

Patient name (print): _____

Patient signature/parent or guardian: _____ Date: _____

ASSIGNMENT OF BENEFITS TO OUR OFFICE

I hereby authorize direct payment of my insurance reimbursements to Jersey Wellness Center.

I am herein noticed that an insurance company, based on its own policies and guidelines, may make different determinations of the medical necessity of my treatments received at Jersey Wellness Center. This insurance company determination may result in decreased payment or non-payment of some or all services from my insurance company. I acknowledge that I understand the above statement and agree to be personally responsible for payment of any service/s rendered to me (or my child) by Jersey Wellness Center that is NOT reimbursed by my Insurance Company.

I hereby authorize the office of Jersey Wellness Center to release any healthcare information in compliance with HIPAA, to my insurance company, utilization review company or attorney that may be requested.

Patient name (print): _____

Patient signature/parent or guardian: _____ Date: _____

INSURANCE INFORMATION

Medical Insurance Carrier: _____ Member ID: _____

Policy holder name: _____ Policy holder dob: _____

Relationship to policy holder: _____

AUTHORIZATION TO TREAT & EXAMINE

I hereby authorize consultation, examination and treatment by Kim Summitt, LAC at Jersey Wellness Center as determined appropriate for my medical care and health concerns.

Patient name (print): _____

Patient signature/parent or guardian: _____ Date: _____