PremierMD & Medical Acupuncture Intake Form

Patient Name ________________________________ **Gender** ❑M ❑F ____________
Last First Middle Initial Marital Status

Date of Birth (*MM/DD/YYYY*) ______/______/__________ **Social Security Number** _____ - _____ - _______

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why you are completing the form for this patient.

Name__________________________ **Relationship** ____________________ **Reason** ____________________

Patient Address **E-Mail** ______________________________

____________________________________ Home Phone ____________________________

____________________________________ Cell Phone ____________________________

Emergency Contact (Name and Phone #) **Employer:** ____________________________

____ Phone Number ____________________________

Insurance Information

Ins. Name ______________________________________ ID # ____________________________

Subscriber Name_________________________________ Subscriber Date Of Birth ______________________

Secondary Insurance

Ins. Name ______________________________________ ID # ____________________________

Subscriber Name_________________________________ Subscriber Date Of Birth ______________________

Auto Accident or Workmans Compensation Insurance

Ins. Name ____________________________ Claim # __________________________ Incident Date ___________

Insurance Company Address ____

Name of the Case Worker_____________________________ Phone Number ______________________

Please list the name and location of your pharmacy.

____________________________________ ____________________________________

If you prefer for us to send your prescriptions to a mail order pharmacy, please list its information below.

____________________________________ ____________________________________

Reason For Visit ____

Referred by ❑Patient: ____________________ ❑Doctor: ____________________ ❑Self-referral

Discovered the practice myself: ❑online ❑ via an ad ❑via the hospital ❑through the insurance company

If here for Medical Acupuncture, what made you consider this alternative medical treatment?

❑ Insufficient response to conventional medical therapy ❑ Side effects from the conventional medical treatment

❑ Other: ____

Level of education completed

❑<6th grade ❑6th – 8th grade ❑9th grade ❑12th grade ❑1-4 years college ❑>4 years college

PremierMD & Medical Acupuncture Intake Form

Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months)**,** *AND ANY* **Health Care Providers from whom you are obtaining prescriptions.**

____________________________ Contact #__________________________

____________________________ Contact #__________________________

____________________________ Contact #__________________________

____________________________ Contact #__________________________

____________________________ Contact #__________________________

____________________________ Contact #__________________________

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication Name	*Dose*	*Frequency*	*Medication Name*	*Dose*	*Frequency*

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are you allergic to ❑Shellfish ___________ ❑IV Contrast Dye __________ ❑Penicillins ___________

Please list Food, Medication or Insect Allergies	*Reaction*

PremierMD & Medical Acupuncture Intake Form

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)

Occupation	Start Date	Stop Date	Responsibilities

Have you ever been exposed to known cancer causing agents or inhalation hazards? ❑**Yes** ❑**No**
Examples: asbestos, paints, aniline dyes, chemicals, silica, etc.
If yes, please list types of exposure, time period exposed, and health problems experienced at time of exposure

Agent	Start Date	Stop Date	Health problems resulting from exposure

Please describe your hobbies.

______________________ ______________________

______________________ ______________________

Have you traveled, in the past 1 year? ❑**Yes** ❑**No**
If so, please describe where, when, and for how long you were there.

Travel destinations OUTSIDE the United States	Dates spent at this destination

Travel destinations INSIDE the United States	Dates spent at this destination

Have you completed a Living Will OR designated a Durable Power of Attorney for Health Care?❑**Yes**❑**No**
If yes, please provide a copy for your chart here

In the past 12 months, have you fallen? ❑**Yes** ❑**No** If yes, how many times? _______
If yes, have you ever broken bones, or sustained an injury, as a result of falling? ❑**Yes** ❑**No**

PremierMD & Medical Acupuncture Intake Form

Do you exercise? ❑**Yes** ❑**No** If yes, describe how long and how often you exercise on average each week

____

____

Do you have a history of smoking? ❑**Yes** ❑**No** If yes, ______ # packs per day X ______ for # years

Have you ever chewed tobacco? ❑**Yes** ❑ **No**

Have you ever smoked pipes or cigars? ❑**Yes** ❑**No** If yes, how many cigars or bowls _____ per❑Day ❑Week

Have you quit? If so, when. ❑**Yes** ❑**No** ____

Have you considered quitting? ❑**Yes** ❑**No** If yes, have you set a date to quit? ❑**Yes** ❑**No**

Have you tried quitting? ❑**Yes** ❑**No** If yes, what is the longest time period you quit smoking? ________

Do you have a history of alcohol use? ❑**Yes** ❑**No** If yes, specify _______ # drinks per ❑Day ❑Week

1 "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine

Have you ever experienced a blackout, or loss of consciousness due to alcohol intake? ❑**Yes** ❑**No**

Have you ever needed to drink to prevent yourself from shaking, sweating, and becoming irritable? ❑**Yes** ❑**No**

Have you ever been arrested or ticketed for DUI (Driving Under the Influence)? ❑**Yes** ❑**No**

Have you been involved in any motor vehicle accidents in the past 12 months? ❑**Yes** ❑**No**

Do you use drugs for recreational purposes? ❑**Yes** ❑**No**

If yes, check all that apply ❑Amphetamines ❑Cocaine ❑Marijuana ❑Heroin ❑Inhalants ❑LSD

Method of delivery you chose ❑Ingestion ❑Injection ❑Inhalation

How much would you use ____

How long did you use drugs ____

Have you quit? ❑**Yes** ❑**No** If so, when ____

Have you ever taken drugs to prevent shaking, sweating and becoming irritable? ❑**Yes** ❑**No**

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines? ❑**Yes** ❑**No**

If yes, specify when and which drugs. ____

Are you sexually active? ❑**Yes** ❑**No** **With:** ❑**Men** ❑**Women** ❑**Both**

If so, do you practice birth control of any kind? ❑**Yes** ❑**No** If yes, check below all that apply

❑Condoms ❑Diaphragm ❑IUD (Intrauterine Device) ❑Birth Control Pills, Patches, Implants

How many sexual partners have you had in the past 1 year?________

Have you ever had sex with a person who performs sexual favors in exchange for money or drugs? ❑**Yes** ❑**No**

Have you EVER been diagnosed with a sexually transmitted disease (like syphilis, gonorrhea or HIV), or were you exposed to a sexually transmitted disease during childbirth? ❑**Yes** ❑**No**

Do you have any tattoos or body piercings? ❑**Yes** ❑**No**

Have you received any transfusions of blood or blood products? ❑**Yes** ❑**No**

Describe your seatbelt use when you are driving, or a passenger in a vehicle

❑All the time ❑Most of the time ❑About half the time ❑Rarely ❑Never

Do you keep firearms in your place of residence? ❑**Yes** ❑**No**

If yes, are they kept in locked compartments, or do they have safety locks? ❑**Yes** ❑**No**

Can you perform your own hygiene, dressing, cooking and shopping needs independently? ❑**Yes** ❑**No**

Do you feel safe in your relationship? ❑**Yes** ❑**No**

Have you ever been in a relationship where you were threatened, hurt or afraid? ❑**Yes** ❑**No**

PremierMD & Medical Acupuncture Intake Form

Have you ever had the following exams?
If so describe when and why

Exam	Yes	No	Description
PAP Smear	❑Yes	❑No	______
Prostate Biopsy	❑Yes	❑No	______
Mammogram	❑Yes	❑No	______
Colonoscopy	❑Yes	❑No	______
EGD (Esophageal endoscopy)	❑Yes	❑No	______
EKG	❑Yes	❑No	______
Cardiac stress test	❑Yes	❑No	______
ECHO	❑Yes	❑No	______
Chest x-ray	❑Yes	❑No	______
CT “CAT” scan of chest	❑Yes	❑No	______
Pulmonary function test	❑Yes	❑No	______
EEG	❑Yes	❑No	______
Bone density test	❑Yes	❑No	______

Have you had any of the following vaccinations? Check all that apply, and specify when last received.

Yes	No	Vaccination	When
❑Yes	❑No	Influenza	______
❑Yes	❑No	Pneumonia	______
❑Yes	❑No	Tetanus	______
❑Yes	❑No	BCG	______
❑Yes	❑No	Varicella	______
❑Yes	❑No	HPV (Gardasil)	______

If you are female, have you ever been pregnant? ❑Yes ❑No If yes, please describe

Number of pregnancies? ______ Number of live births? ______ Number of miscarriages or abortions? _____

Age of onset of menstrual cycles? ______ **Age of onset of menopause?** ______ ❑NA

Have you ever taken birth control pills, or used birth control patches or implants? ❑Yes ❑No

If yes, what did you take and for how long? ______________________

Have you ever been on hormone replacement therapy? ❑Yes ❑No

If yes, what did you take and for how long? ______________________

Did you ever have an IUD? ❑Yes ❑No If yes, was it removed? If yes, when __________

PremierMD & Medical Acupuncture Intake Form

Past Medical History Please check all that apply.

Condition	Response
Adrenal Dysfunction	❑Yes ❑No
Alzheimer	❑Yes ❑No
Amyotrophic Lateral Sclerosis	❑Yes ❑No
Anorexia or Bulimia	❑Yes ❑No
Anxiety Disorder	❑Yes ❑No
Arteriovenous Malformations (AVMs)	❑Yes ❑No
Arthritis	❑Yes ❑No
Asthma	❑Yes ❑No
Autoimmune Disease	❑Yes ❑No
Bipolar Disorder	❑Yes ❑No
Bleeding Disorder	❑Yes ❑No
Cataracts	❑Yes ❑No
Cerebrovascular Accident (Stroke)	❑Yes ❑No
Chemotherapy If yes, state when	❑Yes ❑No
Claudication	❑Yes ❑No
Clotting Disorder	❑Yes ❑No
Congenital Heart Defects	❑Yes ❑No
Coronary Artery Disease	❑Yes ❑No
COPD	❑Yes ❑No
Cystic Fibrosis	❑Yes ❑No
Depression	❑Yes ❑No
Diabetes	❑Yes ❑No
Dialysis	❑Yes ❑No
Eclampsia or Pre-eclampsia	❑Yes ❑No
Endocarditis	❑Yes ❑No
Endometriosis	❑Yes ❑No
End Stage Renal Disease	❑Yes ❑No
Erectile Dysfunction	❑Yes ❑No
Esophageal Dysfunction	❑Yes ❑No
Fibromyalgia	❑Yes ❑No
Gallstones	❑Yes ❑No
Gastritis or Gastric Ulcers	❑Yes ❑No
GERD (reflux problems)	❑Yes ❑No
Glaucoma	❑Yes ❑No
Heart or Valve Defects	❑Yes ❑No
Hemochromatosis	❑Yes ❑No
Hemorrhoids	❑Yes ❑No
Hepatitis	❑Yes ❑No
HIV or AIDS	❑Yes ❑No
Hypertension	❑Yes ❑No
Hyperthyroidism	❑Yes ❑No
Hypotension	❑Yes ❑No
Hypothyroidism	❑Yes ❑No
Irritable Bowel Syndrome (IBS)	❑Yes ❑No
Inflammatory Bowel Disease	❑Yes ❑No

Condition	Response
Irregular Heart Rhythm	❑Yes ❑No
Kyphosis	❑Yes ❑No
Liver Dysfunction	❑Yes ❑No
Kidney Failure, or Dysfunction	❑Yes ❑No
Malignancy If yes, describe below	❑Yes ❑No
Mania	❑Yes ❑No
Muscular Dystrophy	❑Yes ❑No
Myocardial Infarction (Heart Attack)	❑Yes ❑No
Narcolepsy	❑Yes ❑No
Obstructive Sleep Apnea	❑Yes ❑No
Organ Transplant If yes, describe	❑Yes ❑No
Osteoporosis	❑Yes ❑No
Pancreatitis	❑Yes ❑No
Periodic Limb Movement Disorder	❑Yes ❑No
Peripheral Artery Disease	❑Yes ❑No
Personality Disorder	❑Yes ❑No
Pituitary Dysfunction	❑Yes ❑No
Polycystic Ovarian Syndrome	❑Yes ❑No
Pulmonary Artery Hypertension	❑Yes ❑No
Pulmonary fibrosis	❑Yes ❑No
Radiation Therapy If yes, explain	❑Yes ❑No
Recurrent Infections	❑Yes ❑No
Restless Leg Syndrome	❑Yes ❑No
Sarcoidosis	❑Yes ❑No
Schizophrenia	❑Yes ❑No
Scleroderma	❑Yes ❑No
Scoliosis	❑Yes ❑No
Seizure Disorder	❑Yes ❑No
Sickle Cell	❑Yes ❑No
Sjogren	❑Yes ❑No
Skin Disorders (Psoriasis, Acne)	❑Yes ❑No
Thalassemia	❑Yes ❑No
Thrombocytopenia	❑Yes ❑No
Thrombophilia	❑Yes ❑No
Transfusions	❑Yes ❑No
Tuberculosis	❑Yes ❑No
If yes, have you been treated?	❑Yes ❑No
Urinary retention or urgency	❑Yes ❑No
Vasculitis	❑Yes ❑No
Visual defects	❑Yes ❑No
Vocal cord dysfunction/paralysis	❑Yes ❑No

PremierMD & Medical Acupuncture Intake Form

Review of Systems In the last 6 months, have you experienced any of the following symptoms? Respond to each.

Constitutional

- Weight Loss or Gain ☐ Yes ☐ No
- Appetite changes (increased or decreased) ☐ Yes ☐ No
- Fatigue, profound and impairs daily function ☐ Yes ☐ No
- Fever ☐ Yes ☐ No
- Shakes/sweats from lack of alcohol or drug ☐ Yes ☐ No

Eyes

- Eye pain or drainage ☐ Yes ☐ No
- Visual changes ☐ Yes ☐ No
- Dry, irritated eyes ☐ Yes ☐ No

ENT/Mouth

- Ear pain or drainage ☐ Yes ☐ No
- Frequent sinus infections ☐ Yes ☐ No
- Hearing changes or loss ☐ Yes ☐ No
- Nosebleeds ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No

Respiratory

- Blood in your sputum ☐ Yes ☐ No
- Chest tightness ☐ Yes ☐ No
- Cough lasting >1 month, productive or not ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Chest pain with inhalation or coughing ☐ Yes ☐ No

Cardiovascular

- Chest pain or heaviness ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Fainting or near fainting spells ☐ Yes ☐ No
- Swelling of feet or legs ☐ Yes ☐ No
- Shortness of breath lying flat in bed ☐ Yes ☐ No

Gastrointestinal

- Abdominal pain ☐ Yes ☐ No
- Blood in your stool ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Diarrhea or Food Intolerance ☐ Yes ☐ No
- Heartburn or Indigestion ☐ Yes ☐ No
- Vomiting or nausea lasting for >1 day ☐ Yes ☐ No
- Swallowing difficulty ☐ Yes ☐ No

Psych

- Anxiety without clear explanation ☐ Yes ☐ No
- Sadness lasting for days or weeks ☐ Yes ☐ No
- Hearing voices ☐ Yes ☐ No
- Thoughts of hurting yourself ☐ Yes ☐ No
- Thought of hurting others ☐ Yes ☐ No
- Fear of people, places or things ☐ Yes ☐ No

Genitourinary

- Blood in your urine ☐ Yes ☐ No
- Menstrual changes ☐ Yes ☐ No
- Urinating that is painful or difficult ☐ Yes ☐ No
- Erection problems ☐ Yes ☐ No
- Vaginal discharge or bleeding ☐ Yes ☐ No

Musculoskeletal

- Broken bones ☐ Yes ☐ No
- Joint pain or swelling ☐ Yes ☐ No
- Muscle aches ☐ Yes ☐ No
- Muscle weakness ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No

Skin/Breasts

- Masses or lumps ☐ Yes ☐ No
- Nipple discharge ☐ Yes ☐ No
- Rashes or nonhealing ulcers ☐ Yes ☐ No

Neurologic

- Seizures ☐ Yes ☐ No
- Coughing or choking with swallowing ☐ Yes ☐ No
- Excessive daytime sleepiness ☐ Yes ☐ No
- Extremity pain or burning sensations ☐ Yes ☐ No
- Hallucinations ☐ Yes ☐ No
- Numbness or tingling ☐ Yes ☐ No
- Difficulty falling asleep, staying asleep ☐ Yes ☐ No

Endocrinologic

- Hair loss ☐ Yes ☐ No
- Frequent urination ☐ Yes ☐ No
- Increased thirst ☐ Yes ☐ No
- Heat or cold intolerance ☐ Yes ☐ No

Heme/Lymph

- Bleeding from gums or nose ☐ Yes ☐ No
- Unexplained bruising ☐ Yes ☐ No
- Night Sweats ☐ Yes ☐ No
- Swollen, painful lymph nodes ☐ Yes ☐ No

Allergy/Immun

- Watery eyes ☐ Yes ☐ No
- Runny nose ☐ Yes ☐ No
- Food intolerance ☐ Yes ☐ No
- Frequent skin sores ☐ Yes ☐ No

PremierMD & Medical Acupuncture Intake Form

Please list all surgical procedures you have had. Please include surgeon and date of procedure.

Family Medical History Please list all known medical problems in your immediate family.
(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Additional Information that you feel may be helpful for your health care provider to know.

PremierMD & Medical Acupuncture Intake Form

Patient Name:______________________________

Advance Beneficiary Notice (ABN)

NOTE: *You need to make a choice about receiving these health care services.*

Your insurance may not cover acupuncture costs. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

Please ask us to explain, if you don't understand why your insurance may not pay for your treatment. Please ask us how much these services will cost you in case you have to pay for them yourself.

PLEASE CHECK OFF ONE OF THE OPTIONS BELOW, SIGN AND DATE.

☐ **YES, I want to receive these services.**

I understand that my insurance company will not decide whether to pay unless I receive these services. Please submit my claim to my insurance company. I understand that you may bill me for the services and that I may have to pay the bill while my insurance company is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally out of pocket.

☐ **NO, I have decided not to receive these services.**

I will not receive acupuncture services. I understand that you will not be able to submit a claim to the insurance company and that I will not be able to appeal your opinion that my insurance company won't pay.

Date　　　　　　　　　　Signature of Patient or person acting on patient's behalf

NOTE: ***Your health information will be kept confidential****. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company your health information on this form may be shared with your insurance company.*