PROACTIVE
CHIROPRACTIC AND PHYSICAL THERAPY

Acupuncture Intake Form - Rev 5422

Section 1

Demographic Information

Please check the appropriate box and fill out the information for our records.

Name	
Email	
Phone	Home: Mobile:
Address	
Sex	☐Male ☐Female ☐Non-binary
Date of Birth	
Guardian's Name	
Emergency Contact	
Occupation	
Employer	
Family Doctor	
Name of Referring Professional	
How did you hear about us?	
Who were you referred to?	☐Dr. Pollack ☐Dr. Dispenza ☐Dr. Mullen ☐Dr. Sullivan ☐Bac Dinh

Section 2

Insurance Information

Please note our acupuncturist is only In-Network with Aetna and CareFirst/Blue Cross Blue Shield. All other insurances will be Out of Network. Check the appropriate box and fill out the information.

Insurance	☐**Aetna** ☐**BCBS** ☐**Not using insurance** ☐**Other:**_____
Patient's Name	
Patient's Date of Birth	
Member ID Number	
Group Number (if on card)	
Secondary Insurance Name	
Secondary Member ID	
Secondary Policy Holder's Name	
Secondary Policy Holder's Date of Birth	
Relationship to Policy Holder	☐**Self** ☐**Spouse** ☐**Child** ☐**Other** ☐**Not using insurance**

**If Self is not selected, please fill out information below*

Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's Address	

Section 3

Health History

Have you had acupuncture before? If so for what reason- ***Required***

☐ *Yes*

☐ *No*

Main issues you are seeking treatment for and length of time you have experienced them?

Diagnosis from a medical professional and date of diagnosis: ***Required***

General - *All questions below are required. If a question is not applicable, please check "n/a"*

1. sweating easily during the day

☐ past ☐ current ☐ N/A

2. weight loss/gain

☐ past ☐ current ☐ N/A

3. brain fog or confusion

☐ past ☐ current ☐ N/A

4. dizziness/vertigo

☐ past ☐ current ☐ N/A

5. fatigue during the day

☐ past ☐ current ☐ N/A

6. Fevers

☐ past ☐ current ☐ N/A

7. chills

☐ past ☐ current ☐ N/A

8. loss of appetite

☐ past ☐ current ☐ N/A

9. increased appetite

☐ past ☐ current ☐ N/A

10. trouble falling asleep

☐ past ☐ current ☐ N/A

11. trouble staying asleep

☐ past ☐ current ☐ N/A

12. swollen/sore lymph nodes

☐ past ☐ current ☐ N/A

13. bleed or bruise easily

☐ past ☐ current ☐ N/A

14. autoimmune disease

☐ past ☐ current ☐ N/A

Skin and Hair

1. rashes/hives

☐ past ☐ current ☐ N/A

2. eczema

☐ past ☐ current ☐ N/A

3. dry skin

☐ past ☐ current ☐ N/A

4. oily skin

☐ past ☐ current ☐ N/A

5. psoriasis

☐ past ☐ current ☐ N/A

6. itchy skin

☐ past ☐ current ☐ N/A

7. acne

☐ past ☐ current ☐ N/A

8. loss of hair/thinning hair

☐ past ☐ current ☐ N/A

Head, Ears, Eyes, Nose & Throat

1. earaches/pressure in the ears

☐ past ☐ current ☐ N/A

2. ringing in the ears

☐ past ☐ current ☐ N/A

3. hearing loss

☐ past ☐ current ☐ N/A

4. eye floaters

☐ past ☐ current ☐ N/A

5. itchy eyes

☐ past ☐ current ☐ N/A

6. blurry vision

☐ past ☐ current ☐ N/A

7. vision loss

☐ past ☐ current ☐ N/A

8. headaches/migraines

☐ past ☐ current ☐ N/A

9. sinus pressure

☐ past ☐ current ☐ N/A

10. nose bleeds

☐ past ☐ current ☐ N/A

11. dizziness/vertigo

☐ past ☐ current ☐ N/A

12. teeth/jaw clenching

☐ past ☐ current ☐ N/A

13. sore throat

☐ past ☐ current ☐ N/A

14. swollen throat

☐ past ☐ current ☐ N/A

Cardiovascular and Circulatory

1. chest pain

☐ past ☐ current ☐ N/A

2. fainting

☐ past ☐ current ☐ N/A

3. light headaches

☐ past ☐ current ☐ N/A

4. cold hands and feet

☐ past ☐ current ☐ N/A

5. heart arrhythmia

☐ past ☐ current ☐ N/A

6. shortness of breath

☐ past ☐ current ☐ N/A

7. swelling/edema

☐ past ☐ current ☐ N/A

8. high blood pressure

☐ past ☐ current ☐ N/A

9. low blood pressure

☐ past ☐ current ☐ N/A

10. palpitations

☐ past ☐ current ☐ N/A

11.. heart murmur

☐ past ☐ current ☐ N/A

Respiratory

1. pain upon inhaling

☐ past ☐ current ☐ N/A

2. chest tightness

☐ past ☐ current ☐ N/A

3. Cough

☐ past ☐ current ☐ N/A

4. Asthma

☐ past ☐ current ☐ N/A

5. wheezing

☐ past ☐ current ☐ N/A

6. pain behind the eyes

☐ past ☐ current ☐ N/A

7. sneezing

☐ past ☐ current ☐ N/A

8. seasonal/other allergies

☐ past ☐ current ☐ N/A

9. phlegm production

☐ past ☐ current ☐ N/A

10. nasal congestion

☐ past ☐ current ☐ N/A

11. difficulty swallowing

☐ past ☐ current ☐ N/A

Genito-Urinary

1. difficulty urinating

☐ past ☐ current ☐ N/A

2. blood in urine

☐ past ☐ current ☐ N/A

3. pain upon urination

☐ past ☐ current ☐ N/A

4. STD

☐ past ☐ current ☐ N/A

5. bacterial vaginosis (BV)

☐ past ☐ current ☐ N/A

6. urgent/frequent urination

☐ past ☐ current ☐ N/A

7. sore on genitals

☐ past ☐ current ☐ N/A

8. genital pain

☐ past ☐ current ☐ N/A

9. yeast infection

☐ past ☐ current ☐ N/A

Neurological and Psychological

1. anxiety

☐ past ☐ current ☐ N/A

2. depression

☐ past ☐ current ☐ N/A

3. loss of balance/coordination

☐ past ☐ current ☐ N/A

4. areas of numbness/paralysis

☐ past ☐ current ☐ N/A

5. irritability

☐ past ☐ current ☐ N/A

6. parkinsons

☐ past ☐ current ☐ N/A

7. poor memory

☐ past ☐ current ☐ N/A

8. quick temper

☐ past ☐ current ☐ N/A

9. easily susceptible to stress

☐ past ☐ current ☐ N/A

10. mood swings

☐ past ☐ current ☐ N/A

11. ADD/ADHD

☐ past ☐ current ☐ N/A

12. multiple sclerosis (MS)

☐ past ☐ current ☐ N/A

Digestive

1. heartburn

☐ past ☐ current ☐ N/A

2. belching

☐ past ☐ current ☐ N/A

3. bloating

☐ past ☐ current ☐ N/A

4. nausea

☐ past ☐ current ☐ N/A

5. vomiting

☐ past ☐ current ☐ N/A

6. chronic bad breath

☐ past ☐ current ☐ N/A

7. sores of lips/tongue

☐ past ☐ current ☐ N/A

8. gas

☐ past ☐ current ☐ N/A

9. diarrhea

☐ past ☐ current ☐ N/A

10. constipation

☐ past ☐ current ☐ N/A

11. abdominal pain/cramps

☐ past ☐ current ☐ N/A

12. mucus in stool

☐ past ☐ current ☐ N/A

13. blood in stool

☐ past ☐ current ☐ N/A

14. hemorrhoids

☐ past ☐ current ☐ N/A

For Women Only

1. irregular periods

☐ past ☐ current ☐ N/A

2. painful periods

☐ past ☐ current ☐ N/A

3. bleeding between periods

☐ past ☐ current ☐ N/A

4. period clots

☐ past ☐ current ☐ N/A

5. menstrual cramping

☐ past ☐ current ☐ N/A

6. breast pain

☐ past ☐ current ☐ N/A

7. vaginal discharge

☐ past ☐ current ☐ N/A

8. vaginal soreness

☐ past ☐ current ☐ N/A

9. hot flashes

☐ past ☐ current ☐ N/A

10. night sweating

☐ past ☐ current ☐ N/A

What was the age of your first menstrual period and what is the typical duration of your period?

What is the duration of your typical cycle and the date of your last PAP?

Number of pregnancies? Number of live births and age of children?

Number of Miscarriages? Number of Abortions?

Are you currently pregnant and/or breastfeeding? If pregnant, how far along?

☐ Yes

☐ No

Have you been through menopause? If yes, at what age?

☐ Yes

☐ No

Did you experience a difficult menopause? Please elaborate

Have you ever taken birth control pills? If yes, when and for how long?

☐ Yes

☐ No

Other premenstrual and menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

For Men Only

1. erectile dysfunction/impotence (ED)

☐ past ☐ current ☐ N/A

2. varicocele

☐ past ☐ current ☐ N/A

3. ejaculatory pain

☐ past ☐ current ☐ N/A

4. BPH (Benign Prostatic Hypertrophy)

☐ past ☐ current ☐ N/A

Lifestyle - Men and women please answer the following

Current medications/herbs/supplements (include dosage and frequency)

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

☐ Yes

☐ No

How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

Have you used antibiotics in the past? If so, when and how often?

☐ Yes

☐ No

Current exercise routine:

Do you have or have you ever used tobacco? If so, how often?

☐ Yes

☐ No

Do you or have you ever drank alcohol heavily? If so, how many drinks per week?

☐ Yes

☐ No

Do you or have you ever taken recreational drugs? If so, how often?

☐ Yes

☐ No

Are you currently taking any of the following medications? How often?

☐ Advil/Motrin/Ibuprofen

☐ Celebrex/Celecoxib

☐ Aleve/Naproxen

☐ Bayer/Aspirin

☐ Prednisone/Prednisolone

☐ Acetaminophen/Tylenol

☐ N/A

Do you have any allergies? (medications/foods/chemicals/etc.)

Have you had a seizure? If yes, indicate the date of the last one.

☐ Yes

☐ No

Have you had any of the following significant illnesses? Please indicate the date. If you have a family history of any of the illnesses please indicate which family member (mother, grandfather).

☐ **Cancer**	
☐ **High Blood Pressure**	
☐ **Stroke**	
☐ **Colon Polyps**	
☐ **Hepatitis**	
☐ **Epilepsy**	
☐ **Ulcer Disease**	
☐ **Diabetes**	
☐ **Heart Attack**	
☐ **Liver Disease**	
☐ **Asthma**	
☐ **Other**	

Please list any major surgeries/hospitalizations and approximate dates:

What are your goals for your health?

Please indicate any other relevant information or issues you would like to discuss:

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- ☐ I would like email notifications of new, canceled, and rescheduled appointments
- ☐ Email 24 hours before appointment
- ☐ Text Message (SMS) 1 hour before appointment
- ☐ Text Message (SMS) 24 hours before appointment
- ☐ Text Message (SMS) 36 hours before appointment

News and Special Promotions

☐ Yes, I would like to receive news and special promotions by email. Including information about our hours of operation, staff changes, new services, office events, and special discounts.

—---- Consents—----

Accuracy of Information

☐ *I certify that the above medical information is correct to the best of my knowledge.* Required

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ *I agree* Required

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a $50 cancellation fee.

☐ *I am aware of the Cancellation Policy.* Required

Insurance and Payment Policy

Proactive will do their best to work with your insurance company. We will try to look up your benefits before your appointment and let you know what your out of pocket expenses will be for treatment here if the forms are received in adequate time before your appointment. Please also look up your benefits so that we are on the same page. Proactive will securely hold your credit card information to help with payment. For acupuncture, you will never pay more than $120 for follow up visits and $200 for an initial exam. Proactive's no-show fee is a standard $50.

To check your insurance benefits, we utilize the provider portal to see the information online and/or contact the provider service number for the information via a live representative. Please note that the benefit information given to us is not a guarantee of benefits and insurance may or may not cover everything. If for any reason your insurance does not cover your visit, you will be responsible to pay the out of pocket cost of services.

☐ *I understand the Insurance and Payment Policy* Required

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named on Page 1, for whom I am legally responsible) by Bac Dinh LAC, LMT.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriages and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been prescribed are traditionally considered safe in the practice of Chinese Medicine. Any herbs and nutritional supplements prescribed by the provider are a separate and out of pocket expense from the treatment cost. Prices of herbs and supplements range from $60 to $90 depending on the product. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the fates then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent.. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

☐ *By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.*

Signature

_____ Date: _____

Please print First and Last name