

Acupuncture Wellness Center

Patient Information

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Balance Acupuncture and Wellness Center considers this information privileged physician / patient communication and will hold it in confidence.

Name (LAST, FIRST, MIDDLE)			Date
Age	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Home Phone		Email	
Home Address			
City		State	Zip Code
Occupation		Business Phone	
Employed By			
Employers Address			
City		State	Zip Code
Spouse's Name			
Contact in case of an emergency		Relationship	Phone
Addition Information / Notes			

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Balance Acupuncture and Wellness Center is based on Traditional Chinese medical principals and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, If I am concurrently undergoing western medical treatment, it is my responsibility to advise my physician of any herbal supplements that I am concurrently taking.

Signature

Date

Name (LAST, FIRST, MIDDLE)	Date
Major Complaint / Health Problem	

How did this condition develop?

How long has this condition persisted?

Is there any thing that makes it better?

Is there anything that makes it worse?

Have you ever received treatment for this condition? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, When?
Where?	By Whom?
What was the diagnosis?	What kind(s) of treatment?
What were the results of the treatment	

List any substances that you are allergic to:

Medication	Strength	How many per day?	For how long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Significant trauma (Auto accidents, falls, etc.)

Significant Illnesses (Please check all that apply:)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Ruptured Appendix
<input type="checkbox"/> Aids	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid Disease

Please check any symptoms you currently have or have had in the past

General

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

Head and Neck

- Blurred vision
- Heaviness in the head
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache
- Ear discharge
- Eye pain / strain
- Corrected vision
- Nasal obstruction
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nose bleeds
- Recurrent sore throat
- Red / inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems
- Vision—see halos

Respiratory

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production

- Difficulty inhaling
- Difficulty exhaling

Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea / loose stools
- Bloody stools
- Black stools
- Difficulty swallowing
- Poor appetite
- Heartburn
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

Diet / Lifestyle

- Vegetarian
- Healthy diet
- Eat a lot of fried foods
- Eat a lot of meat
- Smoke cigarettes
- Drink alcohol
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly
- Exercise excessively

Weight

- Underweight
- Normal for height
- Overweight
- Very overweight

Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Musculoskeletal

Pain weakness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

Skin

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruises easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarms
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out

Neurologic

- Fainting
- Convulsions
- Paralysis
- Stroke

- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

Emotional

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Fearful
- Unrestrained joy
- Terrors
- Difficulty expressing emotion

Men Only

- Genital pain
- Impotence
- Lumps in testicle
- Penile discharge
- Nocturnal emissions
- Low libido

Women Only

- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy periods
- > 25 day cycle
- < 25 day cycle
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitals
- Low libido
- Vaginal discharge
- Menopausal
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant

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 below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treats me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office or clinic.

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

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

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 miscarriage 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 recommended are traditionally considered safe in the practice of Chinese Medicine. 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 facts then known, is in my best interests.

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 written 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.

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(s) for which I seek treatment.

Patient's Name: _____
Signature: _____
Date: _____

Catherine Allen Markovsky, L.Ac.

Linda Greenwood, L.Ac.

PAYMENT FOR SERVICE

The best care can be provided with open communication and mutual understanding. We, therefore, invite early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc.

Patients are expected to pay at the time services are rendered. Because some PPO or Auto Insurance plans will cover your office visits I encourage you to let us verify your eligibility and benefits.

INSURANCE: Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. **WE CANNOT GUARANTEE PAYMENT FOR YOUR CLAIMS.** If your insurance company pays only a portion of the bill, or rejects your claim, or applies it toward your deductible, an explanation of benefits will be sent to you the policyholder. Please advise the office when you receive this information.

Patients having PPO and Company benefits will be required to pay the normal co-payment, which typically ranges from \$5 to \$35.

PATIENTS ARE REQUIRED TO REIMBURSE BALANCE ACUPUNCTURAND WELLNESS CENTER FOR ANY AMOUNT PAID DIRECTLY TO THE PATIENT.

I hope that this information has been helpful in clarifying our financial policy.

Catherine Allen Markovsky, L.Ac.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PRIVATE, GROUP, ACCIDENT, AND HEALTH INSURANCE

PATIENT: _____ Date of Birth: _____

INSURANCE COMPANY: _____

CLAIM/GROUP: _____

SS# OR ID#: _____

I hereby instruct and direct that the above Insurance Company pay by check made out and mailed to:
Balance Acupuncture and Wellness Center, 2299 Woodbury Avenue, Newington, NH 03801

If my current policy prohibits direct payment to physician, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Balance Acupuncture and Wellness Center, 2299 Woodbury Avenue, Newington, NH 03801

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. ***THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY.***

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature of Policyholder _____ Date: _____

Office Signature _____