Red Poppy Healing and Acupuncture

Intake Form

# **Personal Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Gender: MALE or FEMALE

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Status: Single Married Divorced Separated Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Who is your primary health care provider/MD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Insurance Information**

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Responsible Party**

 Name of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 AUTHORIZATION TO RELEASE PATIENT INFORMATION AND AUTHORIZATION TO PAY

I hereby authorize Red Poppy Healing & Acupuncture to release any personal health information (PHI) required in the course of my treatment to the above stated insurance company, or their affiliates and hereby authorize insurance payment directly to Red Poppy Healing & Acupuncture, for medical services rendered.

I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Complaint:**

Please identify your major health concerns

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Illnesses |  |
| Surgeries |  |
| Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.) |  |
| Do 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) |  |

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

**General** (Please check all that apply)

 Poor Appetite  Weakness  Sudden Energy drops  Hearing Loss  Fevers

 Chills  Sweats easily  Easy to bleed or bruise  Fatigue  Strong Thirst

 Poor sleep  Tremors  Puffiness or swelling  Poor Balance  Weight Loss

 Night sweats  Cravings  Changes in Appetite  Weight Gain  Other

**Skin & Hair**

 Rashes  Itching  Dandruff  Skin Ulcers  Eczema

 Hair Loss  Hives  Pimples  Recent Moles

**Head, Eyes, Ears, Nose & Throat**

Dizziness  Toothache  Blurry Vision  Cataracts  Ear Ringing

 Headaches  Concussions  Taste/Smell Problems  Sinus Problems  TMJ pain

 Eye Strain/Pain  Nose Bleeds  Night Blindness  Poor Hearing  Migraines

 Ear Aches  Facial Pain  Spots in front of eyes  Ear Aches  Floaters

 Lip or Tongue Sores  Recurrent Sore Throat

**Cardiovascular**

Phlebitis  Fainting  High Blood Pressure  Palpitations  Faintheadedness

 Blood Clots  Chest Pain  Cold hands or Feet  Swelling Feet  Swelling Hands

 Low Blood Pressure  Irregular Heartbeat

**Respiratory**

Cough  Bronchitis  Difficulty Breathing  Pneumonia  Easily Winded

 Phlegm  Asthma  Coughing up Blood  Painful Breathing

**Gastro-Intestinal**

Nausea  Ulcers  Chronic Laxative Use  Bad Breath  Intestinal Gas

Diarrhea  Belching  Abdominal Pain  Hemorrhoids  Rectal Pain

Vomiting  Indigestion  Blood in Stool  Constipation

**Urology**

 Cloudy Urine  Blood in Urine  Frequent Night Urination  Decrease in Flow  Pain in Groin

 Kidney Stones  STD  Unable to Hold Urine  Painful Urination  Urgency

* Frequent Urination

**Musculo-Skeletal**

 Arthritis  Scoliosis  Pain After Waking  Pain with Activity  Weak Joints

 Muscle Spasms  Muscle Cramps  Muscle Weakness  Pain with Weather Changes

**Neuro-Psychological**

 Seizures  Twitches  Lack of Coordination  Depression

 Concussion  Irritability  Areas of Numbness  Mood Swings

 Anxiety  Tremors  Loss of Balance  Poor Memory

  Stress

**Gynecological**

**­­­­­­**\_\_\_\_\_\_ Age of Menses  Irregular Periods  Fertility Problems  Breast Lumps

\_\_\_\_\_\_ Duration of Menses  Painful Periods  Vaginal Discharge  Spotting

\_\_\_\_\_\_ Date of Last Menses  Yeast Infections  Menopausal  PMS

\_\_\_\_\_\_ # of Pregnancies  Clots

\_\_\_\_\_\_ # of Births

**Men’s Issues**

* Erectile Dysfunction  Prostatitis  Frequent Urination  Slow Flow
* Impotence  Benign Prostatic Hyperplasia  Infertility

 **Fee Schedule**

 Acupuncture Initial Visit $128

 Acupuncture Follow-Up Visits $70

 Cosmetic Acupuncture $95

 Cupping $25

 Herbal Consult $25

Consult (15 min) FREE

 **Acupuncture Packages**

 4 pack $260 ($65 ea)

 6 pack $380 ($63 ea)

 8 pack $500 ($62 ea)

 10 pack $600 ($60 ea)

 Cosmetic 10 pack $900 ($90 ea)

Insurance billing will NOT take place. An itemized statement or superbill is offered every 30 days which you may request in the event you would like to submit it to your insurance company for possible reimbursement.

I understand and will compensate Red Poppy Healing & Acupuncture according to the individual treatment price of $128 for the first treatment & $70 for follow up treatments. I understand I can also purchase a multiple treatment package at the prices listed above. Package visits never expire.

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Red Poppy Healing & Acupuncture

 ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of them

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bums and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

 understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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, although some may be toxic in large doses- I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest- I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my Written consent-

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

|  |  |
| --- | --- |
| ACUPUNCTURIST NAME:  | CYNTHIA L. POPPE, LAC. |
| PATIENT SIGNATURE:(Or Patient Representative) | DATE: |
| PRINT NAME: |  |

(Indicate relationship if signing for patient)

