Misty Nault L.Ac.

INFORMATION FORM Today's Date:_____

Name: _____Sex: M_____ F_____

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

Home Phone: (____)_____ Cell Phone: (___)_____Work Phone: (____)_____

Email **:**_____

Birth date: ___/___/_____ Age:_____ Marital Status: _____

EMERGENCY CONTACT:

Name: _____Telephone: (____) _____

PRIMARY CARE PHYSICAN:

Name: _____Telephone: (____) _____

Medical Questionnaire

Have you had acupuncture before? Yes _____ No_____
How did you hear about us? _____
Reason(s) for today's visit: _____
How long have you had this condition? _____
Does it bother your: o Sleep o Work o Other (Please explain) _____
What seemed to make it better/worse? _____
What other therapies are you currently using? _____
Current Medications: _____
Current Vitamins/Supplements: _____
Allergies: _____
Height: _____ **Weight**_____

Family Medical History

o Allergies	o Arteriosclerosis	o Cancer	o Diabetes	o Seizures
o Asthma	o Heart Disease	o Stroke	o Alcoholism	o High Blood Pressure

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are significant part of your medical history.)

oAIDs/HIV	o Epilepsy	o Pacemaker	o Thyroid Disorders	o Other (Specify)
o Alcoholism	o Heart Disease	o Seizure	o Major Trauma	_____
o Allergies	o Hepatitis	o Stroke		
o Asthma	o Herpes	o Surgery (List)	_____	
o Cancer	o High Blood Pressure	oTuberculosis		
o Diabetes	o Multiple Sclerosis	o Whooping Cough		

YOUR LIFESTYLE

o Alcohol o Marijuana o Stress o Tobacco o Drugs
oOccupational Hazards **(Specify)** _____
o Regular Exercise **(Specify)** _____

GENERAL SYMPTOMS

o Poor appetite o Poor / Heavy sleep o Lack of strength o Shortness of breath o Bleed or bruise easily
o Excessive appetite o Dream disturbed sleepo Body heaviness o Fever o Peculiar taste (describe)
o Prefer cold / hot drinks o Vertigo or dizziness o Cold hands or feet o Chills
o Sweat easily o Weight gain or loss o Fatigue o Poor circulation o Night sweats
o Muscle cramps

HEAD/EYES/EARS/NOSE/THROAT

oGlasses o Night blindness o Facial pain o Excessive phlegm o Ringing in ears
o Eye pain/strain o Glaucoma o Color or phlegm oPoor hearing o Red eyes
oCataracts o Dry mouth o Sore throat o Earaches o Itchy eyes
o Teeth problems o Excessive saliva oLumps in throat oHeadaches o Spots in vision
o Grinding teeth o Sinus problems o Enlarged thyroid o Concussions o Poor / Blurry vision
oTMJ o Gum problems o Nose bleeds o Sores on lips or tongue

RESPIRATORY

o Tightness in chest o Bronchitis o Pneumonia o Shortness of breath o Asthma/wheezing
o Cough Color of phlegm: _____
Productive?_____ Wet or dry?_____

CARDIOVASCULAR

o High blood pressure oLow blood pressure o Chest pain o Tachycardia o Palpitations
o Blood clots o Fainting o Difficult breathing o Irregular heartbeat

GASTROINTESTINAL

o Nausea o Diarrhea o Intestinal pain/cramp Bowel movements:
o Vomiting o Constipation o Itchy / Burning anus
o Acid regurgitation o Laxative use o Rectal pain Frequency _____per day /week
o Gas o Black stools o Hemorrhoid o Hiccup o Bloody stools
o Anal fissures o Bloating o Mucous in stools o Bad breath

MUSCULOSKELETAL

o Neck/shoulder pain o Upper back pain o Joint pain o Muscle pain o Low back pain
o Rib pain o Limited range of motion_____ o Limited use _____
o Other (Please describe)_____

SKIN/HAIR

o Rashes o Eczema o Dandruff o Change in hair o Hives
o Psoriasis o Itching o Fungal infection o Ulcerations o Acne
o Hair loss o Change in skin texture o Other (Please describe) _____

NEUROPSYCHOLOGICAL

o Seizures o Poor memory o Irritability o Considered suicide o Numbness
o Depression o Easily stressed o Attempted suicide o Tics o Anxiety
o Abuse survivor o Seeing therapist o Other (Please describe) _____

GENITO-URINARY

o Pain on urination o Blood in urine o Venereal disease o Increased libido o Impotence
o Frequent urination o Unable to hold urine o Bedwetting o Decreased libido o Premature ejaculation
o Urgent urination o Incomplete urination o Wake to urinate o Kidney stone o Nocturnal emission

GYNECOLOGY

o Age menses began _____ oDuration of flow _____ o Vaginal sores
oLength of cycle _____ o Vaginal discharge(color?) _____ o Painful periods
o Date last period began_____ oIrregular periods o PMS
o Clots o Breast Lumps oVaginal odor
oAge at Menopause_____ oDate of last PAP _____
o#Pregnancies_____ o# births_____ o Premature births_____

GUARANTOR: Party Responsible for Payment if not self
Name: (please print) _____ Birth date: ___/___/_____

Address: _____ City: _____State: _____ Zip Code: _____

Relationship to Patient: _____ Relationship to Insured:_____

INSURANCE INFORMATION

Name of Policy Holder:_____ Birth date: ___/___/_____ SSN#:_____

Insurance Name: _____ Phone Number:_____

Policy Number:_____ Group Number:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my insurance benefits be directly paid to Smith Chriopractic, for the treatment of _____.

I understand that I am financially responsible to the charges not covered by this assignment. I also authorize the doctor, attorney, or insurance company to release any information required for this claim.

Signature:_____ Date:_____
Person Authorized to Consent

Last Updated 2/28/10

Office Policies and Authorization for Treatment

I, _____, understand that acupuncture is an energetic form of therapy based on the regulation of energy, and is not intended to replace conventional medical treatment. I assume full responsibility for consulting with appropriate physician since I understand that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Misty Nault L.Ac., to perform the following specific procedures:

Acupuncture procedures involving insertion of special needles through the skin into the underlying tissue at specific points on the surface of the body, as well as other techniques as specifically described in the Washington State Law for Licensed Acupuncturists, such as moxibustion, cupping, electro acupuncture, acupressure, and herbal consultation.

I recognized the potential benefits and risks of the above procedures included reactions as described below:

> Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention, or elimination of the presenting problem.
> Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruised, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given me by Misty Nault L.Ac., regarding cure or improvement of my condition.

I hereby release Misty Nault L.Ac.,, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

FEE:

I understand that fee for treatment is payable at the time of service unless I am receiving treatment via a medical plan which recognizes Misty Nault L.Ac.,, as a Preferred provider. In such an event, payment shall be provided as per the terms of the plan. If it is found I am not eligible for coverage of treatment by my medical plan, I assume full responsibility for paying Misty Nault L.Ac., any money owed for treatment.

MISSED APPOINTMENT:

I will give 24 hours notice if I need to cancel an appointment. I understand without that advance notice, the time reserved for me is my responsibility and will be charged to me as a missed appointment. Missed appointments are charged at the same rates as regular appointment. Insurance companies do not pay for missed appointments so I understand that any appointments missed are my financial responsibility. Exceptional circumstances will be considered regarding this policy.

_____ _____

Signature of Patient Date