LEWIS HEALING INSTITUTE Dr. Lisa Lewis, ND, LAc

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Acupuncture Patient Intake Form

This information is confidential.

Name:____ Date:____________________
(Last) (First) (MI)

Address:____
(number, street, apt number)

City______________________________ State___________________ Zip Code: _____________

Phone: h_____________ w _____________ c _____________ Email: _________________________

Birthdate: ___/___/______ Birthplace: _________________ Age:_______ Gender(Sex): M F

Social Security # _______ - _____-________ Occupation: _______________________________

Employer's Name and Address: ____

____

Name of Emergency Contact: _________________________ Relationship to self:______________

Address: ____

Phone: h _______________ w_______________ c_______________ Email: _______________________

Primary Care Physician: ____Phone:______________

Please circle those that apply: single married significant other

Do you have children? YES NO How many?___________ Ages:_________________

Who can I thank for referring you to me? ____

A note to patients: Please take the time to carefully complete this health history questionnaire. Acupuncture and Naturopathic medicine involves providing a complete picture of the patient (physically, mentally & emotionally). This is a confidential record of your medical history and will not be released except when you have authorized me to do so.

Present Health Concerns: Please list your most important health concerns in their order of significance.

1.) ____________________________________ 3.) ____________________________________

2.) ____________________________________ 4.) ____________________________________

What goals do you have for your visit today?

____

____

Have you ever consulted an Acupuncturist? Yes ____________________________ No

What other treatments have you tried? ____

____

Personal/Social History:

Please list the medications that you are currently taking, with dosages:

1.) ________________________________ 4.) ________________________________
2.) ________________________________ 5.) ________________________________
3.) ________________________________ 6.) ________________________________

Please list supplements, vitamins, herbs or homeopathic remedies that you are presently taking:

1.) ________________________________ 5.) ________________________________
2.) ________________________________ 6.) ________________________________
3.) ________________________________ 7.) ________________________________
4.) ________________________________ 8.) ________________________________

Please list any allergies/Intolerances that you have to any of the following:

Foods: ____

Animals:________________________________ Drugs:________________________________

Environmental Sources: (ex. Pollen, grasses, etc…) ________________________________

Food Cravings?____

Do you follow any particular dietary regimens or restrictions? ________________________

How many glasses do you drink of each of the following per day?

Water__________ Soda____________ Coffee __________ Tea ___________ Alcohol_________

Medical History (Check all that apply)

	Aids/HIV		Heart Disease		Pacemaker
	Alcoholism/Substance Abuse		Hepatitis A / B / C		Polio
	Cancer		Herpes		Seizures
	Diabetes		Lyme Disease		Tuberculosis
	Emphysema		Multiple Sclerosis		Varicose Veins

Past History:

Hospitalizations or Surgeries: (Please list reason and dates)

____

____

Serious Illnesses, Injuries or Accidents:

____

____

Date of last complete physical exam: ____________________

Family History:
Please fill in the boxes below for each condition that applies to one of you family members.

	YES	WHO	Comments		YES	WHO	Comments
Alcoholism				Hay Fever, Hives			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other:			

Do you perspire during the day? ____________
Do you perspire at night? ________________
Are you always thirsty? Yes / No
Do you prefer drinks that are Hot or Cold? _________
Taste preferences on a scale of 1 to 5. 1 being *most liked* to 5 *disliked*:

	Salty		Sour		Bitter		Sweet		Spicy

Gastrointestinal:
Do you have currently or have you had a major incidence in the past?

	Belching		Indigestion		Ulcers
	Hernia		Nausea		Vomiting
	Bloating		Acid Reflux		Hemorrhoids

Bowel movements: How often? __________day/week

	Irregularity		Constipation		Diarrhea		Gas

Exercise and Energy:
What kind of exercise do you do? _______________How often?_____________________
How is your general energy level?____
Are you sedentary or active? ____

Emotions and Sleep:

	Panic Attacks		Depression		Anxiety		Nervous
	Fearful		Poor Memory		Difficulty Concentrating		

Do you take antidepressants? ___________________What kind? ________________________
Do you take sleeping pills? ______________________What kind? ________________________

	Difficulty falling asleep		Restless		Disturbed Sleep
	Dreams		Waking up in the night		

Urination:
How many times a day? _______ Light or Dark in Color____________

	Frequent Urination		Incontinence		Burning
	Wake up at night to urinate		Pain during urination		Bladder Infections

Gynecology:
Are you still menstruating? _________

	Heavy flow		Light flow		No flow
	Blood clots		PMS		Painful periods
	Uterine fibroids		Cystic breasts		

Respiratory:
Do you smoke? Y / N __________ times/day for ______ years Tobacco Cigars Other

	Frequent Colds		Asthma		Cough		Cold Sores
	Bleeding Gums		Dry mouth		Ear pain		Migraine
	Ringing in Ears		Sinusitis		Excessive Phlegm		

Cardiovascular:

	Palpitations		Varicose Veins		Cold hands/feet
	Poor circulation		Dizziness		Chest pain
	Irregular heart beat		High blood pressure		Low blood pressure
	Blood clots				

Skin and Hair:

	Dry skin		Skin rashes		Itching
	Acne		Eczema		Hair loss

Musculoskeletal:

	Joint pain		Arthritis		Muscle tightness		Numbness
	Tendonitis		Osteoporosis		Swelling		

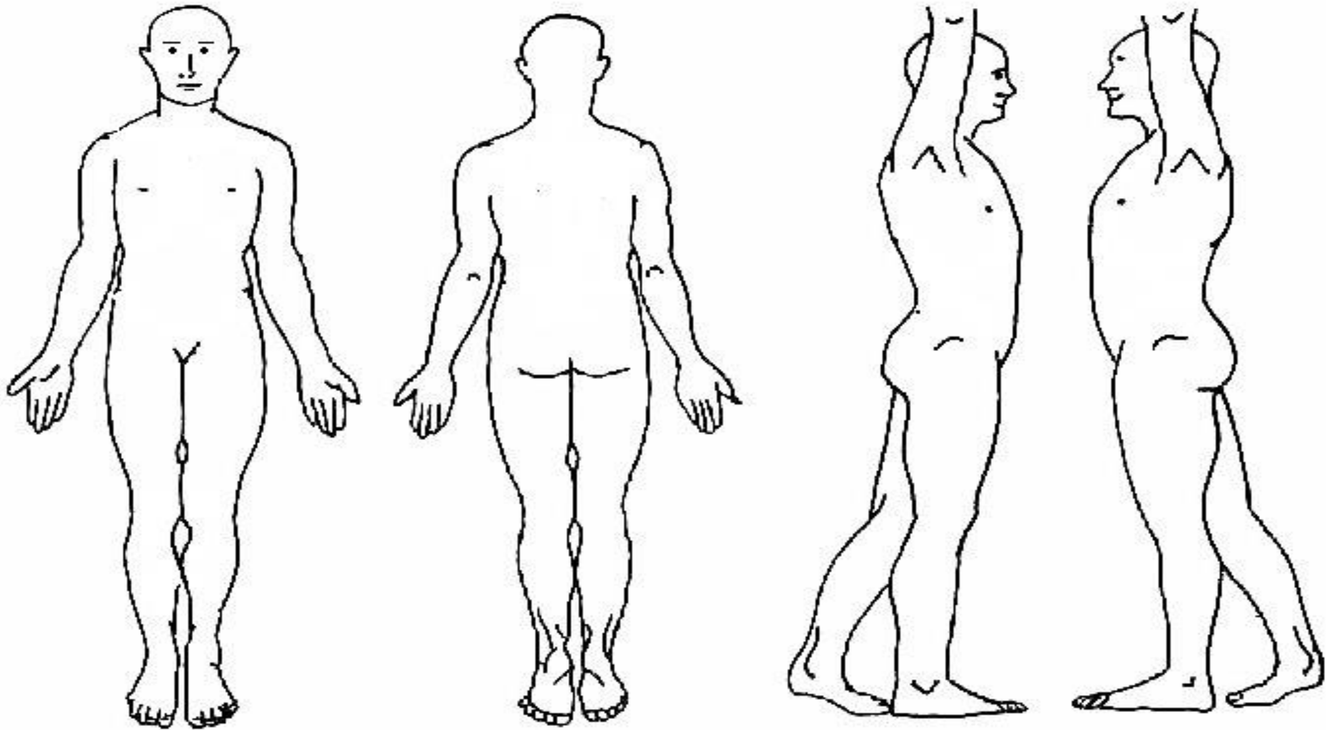
Where is the general area that you are feeling any discomfort? ___________________________

Chronic or Acute? _____________________

What number best describes your pain now?

No pain 1 2 3 4 5 6 7 8 9 10 Worst pain

Mark with an (X) where you are feeling any discomfort or pain.



If pain, please describe: Sharp Dull Stabbing (please circle)

What makes the pain better? (Circle all that apply)
Heat Cold Movement Massage/Pressure Rest

Do you have any additional health conditions? ____

____

____

____

Print Name ____

Patient Signature ____

Practitioner Signature____

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame and in the cause and prevention of disease." -Thomas A. Edison

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of 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 listed below or any other office or clinic, whether signatures 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 the herbs.

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. Burns 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 (pneumonthorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I 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 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 clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to 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 the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and labs, 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 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 conditions(s) foe which I seek treatment.

______________________________________ _______________
Patient Name (Please Print) Date

____
Patient Signature

______________________________________ _______________
Dr. Lisa Lewis, ND, LAc. Date

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or physically or legally incapactited.

Patient Name: ___________________________________

Patient Representative: _____________________________

Relationship of authority: ______________________________

Witness:____

Credit Card Authorization Form
Lewis Healing Institute
Dr. Lisa Lewis, P.C.

____
Name (as it appears on the card)

____
Billing Address
____

_______________________ _______________________ ________
City State Zip Code

____
Telephone Number

____
Email Address

____
Card Type (Visa, Mastercard, American Express, Discover)

____
Number of card

____
Expiration Date:

____
3 digit security code

Notice to Cardholder: (Please read before signing)
Cardholder agrees that his/her signature on this form constitutes his/her signature on file and becomes his/her agreement to pay all charges, fees related to services provided lab tests, supplements, shipping and handling, etc. as signed by the cardholder and that Dr. Lisa Lewis is authorized to charge the indentified account of Cardholder.

I, _________________________ (Patient Name), hereby authorize, as signature below represents, the above credit card to be charged each and every time services or products are rendered. The authorization allows Dr. Lisa Lewis to continue to use this information and such information shall remain in full force and effect unless I revoke such authorization in writing.

____
Legal Patient Name (Please Print)

_________________________________ _____________

Patient Signature Date

Authorization to Bill Third-Party Payer

SECTION 1: Patient Information

Last Name: ____ First Name: __________________________________ Middle Initial: ________

DOB: ___________________ SS#: ______________________________________ Daytime Phone: (_________)____________________

SECTION 2: Benefits and Billing Information

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. _______________________________________ Clinic Phone #: (_______)_________________

Clinic Address: ____ City:___________________ State: ______ Zip Code: ____________

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:____

II. Primary Insurance Company & Plan Name: ____

ID Number: ____ Group/Policy Number: ______________________________________

Name of Policy Holder: ____ Policy Holder's Date of Birth: __________________________

The policy holder is my: ___________________________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): __________

III. Secondary Insurance Company & Plan Name: ____

ID Number: ____ Group/Policy Number:______________________________________

Name of Policy Holder: ____ Policy Holder's Date of Birth: __________________________

The policy holder is my: ___________________________ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): __________

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: ______________________________________ First Name: ______________________________________ Middle Initial: _________

Address: ____________________________________ City: _______________ State: _______ Zip: ___________ Phone: (_______)____________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X____ _____________________

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 30 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Lisa Lewis, ND, LAc. to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X ____ ______________________

Patient's Signature Date

X ____ ______________________

Guardian/Representative's Signature Date

____

Relationship to Patient/Representative Authority