SouthPark Acupuncture

Carolinas HealthCare System

General Intake Form

Date _____/_____/_____Time_____ Practitioner_____**Wenhui Li, L.Ac**_____

Name _____ Gender: Female Male

Parent(s)/Guardian(s) _____ (if under 18 years of age)

Address _____

_____

_____

Daytime Phone ( )_____ Evening Phone ( )_____

Cell Phone ( ) _____ Email: _____

Occupation:_____ DOB_____/_____/_____ Age ____

In case of Emergency, please notify _____

Contact # ( ) _____ Relationship _____

Primary Care Physician _____

Clinic Name _____ Location _____

Other Physicians _____

_____

Diagnoses: _____

Medications currently taking: _____

_____

Allergies:_____

_____

May we send copies of your recommendations to your providers? Yes____ No ____

How did you hear of us?_____

4525 Cameron Valley Parkway, Suite 1600
Charlotte, NC 28211
Phone: (704) 512-6293
Fax: (704) 512-6291

SouthPark Acupuncture
TCM Intake Form

Name:_____ Date:_____/_____/_____

Chief Complaints:_____
_____

Expectation of treatment: _____
_____
_____

Have you seen any other physician for this condition? Yes No
If yes, please list name & clinic. _____
_____

Has your regular daily routine been altered due to your current situation? Yes No
If yes, please explain. _____
_____
_____

Please circle any of the conditions you have a history of:

Cancer	Diabetes	Stroke	Heart attack
Blood clotting	Cosmetic surgery	Herpes/shingles	Paralysis
Epilepsy	Ulcers	Multiple Sclerosis	Parkinson's Disease
Muscular Dystrophy	Chronic pain	Fibromyalgia	Gastrointestinal disorder
Sciatica	HIV/AIDS	Fused vertebrae	Bulging-ruptured discs
Rods/staves	Broken/fractured bones	Strains/sprains	High/low blood pressure
Heart conditions	Asthma	Carpal tunnel	Thoracic outlet
Vericose veins	Menopause	Pregnancy	

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Muscles, Joints, Bones:

Do you have pain or tightness? Where? _____

_____

Frequency of pain? (How often are you in pain?):

- 25%-50% (From time to time)
- 50%-75% (Most of the time)
- 75%-100% (I feel pain <u>All</u> the time)

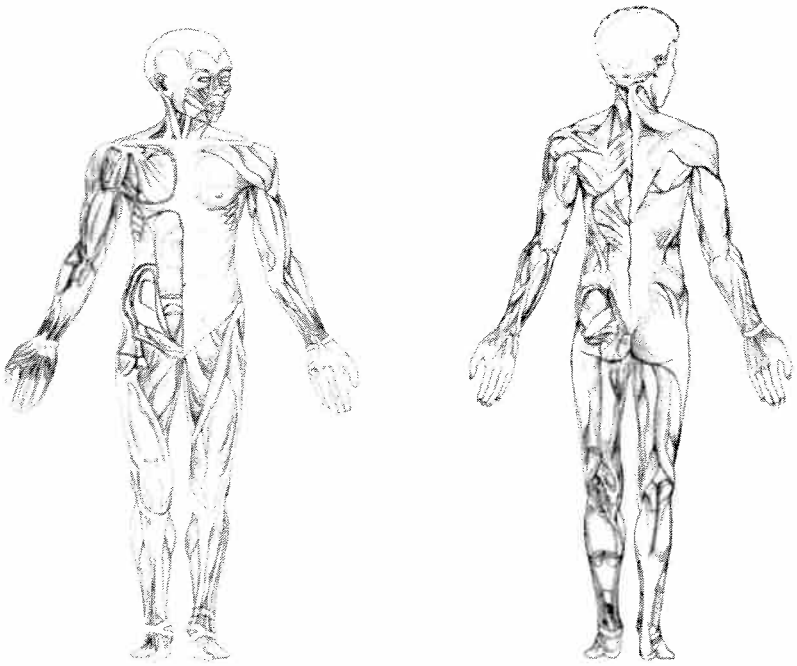
What is the current level of pain, from 1-10? _____
The pain feels worse with:_____
The pain feels better with: _____
The pain is: check all that apply:

- Sharp
- Superficial
- Tingling
- Burning
- Fixed
- Dull
- Deep
- Numb
- Aching
- Moves around
- Other: Please describe:_____

.

On the following diagram, please mark the areas you would like to be addressed using the key below:

A=Ache
B=Burning
P=Pins & Needles
S=Stabbing
N=Numbing
O=Other



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Symptoms: For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if not applicable.

Liver/Gallbladder Balance
____Irritability/Anger
____Depression/Stress
____Headaches/Migraines
____Visual Problems
____Red/Dry/Itchy Eyes
____Gall Stones
____Dizziness
____Blurred Vision
____Clenching of Teeth at Night
____Muscle Cramping/Twitching
____Tension
____Joints/Neck/Shoulder Pain
____Poor Circulation
____Soft/Brittle Nails
____Emotional Eater
____Bad Taste
____Bad Breath

Kidney/Urinary Bladder Balance
____Urinary Problems
____Bladder Infection
____Dropped Bladder
____Lack of Bladder Control
____Weakness/Pain in Lower Back
____Decreased Bone Density
____Cold Hands
____Cold Feet
____Poor Memory
____Loss of Hair
____Hearing Problems
____Cavities
____Fear
____Hot Flash/Night Sweats

Heart/Small Intestine Balance
____Heart Problems
____Chest Pain
____Insomnia/Sleep Problems
____Easily Startled
____Restlessness/Agitation
____Vivid Dreams

Lung/Large Intestine
____Bloody Cough
____Dry Cough
____Cough with Sputum
____Nasal Discharge
____Post Nasal Drip
____Sinus Infection/Congestion
____Itchy, Red, or Painful Throat
____Dry Mouth/Throat/Nose
____Skin Rashes/Hives
____Snoring
____Grief/Sadness
____Shortness of Breath
____Allergies/Asthma
____Sneezing
____Mild Fever Comes and Goes
____Smokes Cigarettes
____Emphysema
____Bronchitis
____Black/Blood in Stools
____Constipation
____IBS
____Colitis/Spastic Colon
____Diarrhea

Spleen/Stomach Balance
____Heaviness Anywhere in the stomach
____Fatigue on a Scale of 1-10 (10 being the highest)
____Hard to get up in the morning
____Muscles Feel Tired Often
____Edema (Swelling) hands or feet
____Easily Bruising & Bleeding
____Bad Breath
____Nausea/Vomiting
____Gas/Belching
____Hemorrhoids
____Constipation
____Diarrhea
____Abdominal Pain
____Indigestion/Heartburn
____Over-thinking
____Tendency to Gain Weight
____Brain Foggy

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Informed Consent

I understand that SouthPark Acupuncture offers consultative services only, and that I should seek or continue to secure the services of a primary care physician to oversee and coordinate my daily healthcare needs.

I have been advised that the recommendations for treatment at SouthPark Acupuncture may differ from conventional "Western" treatment for my condition(s) and further, that some of the recommended treatment methods may be considered "experimental". I have been further advised that the possible treatments recommended by my SouthPark Acupuncture professional including, but not limited to, supplements and botanical remedies, complementary therapies, and referral to community practitioners, are based on unique clinical experience as well as knowledge gleaned from specialized training in complementary and alternative medicine. I understand that any prescription, whether a plant or pharmaceutical drug, or treatment may cause allergic, idiosyncratic (unique to the individual), or other adverse reactions including but not limited to rash, gastrointestinal upset, headaches, mood changes, or dysfunction in any organ or system of the body. I agree to promptly notify the acupuncturist of any adverse effects of treatment.

By signing this statement I acknowledge that I have read or have had read to me and agreed to the foregoing. I further acknowledge that the nature, purpose and possible consequences of each treatment recommended or rendered by the professionals of SouthPark Acupuncture has been carefully explained to me, including potential benefits, significant risks involved, and possible alternative methods of treatment. I understand that the explanation I have received is not exhaustive and, as with any medical intervention, that there may be other, more remote risks and consequences. I have had ample opportunity to ask questions and to gain additional information. The proposed treatment has been satisfactorily explained to me and I have all the information I need to move forward with treatment. I have received no guarantees from anyone of the results that may be obtained and I understand that I may discontinue treatment at any time.

I voluntarily consent to the following:

- ❑ Chinese medicine including acupuncture, acupressure, cupping, and moxabustion.

_____ _____

Patient or legally responsible person (signature) Date and Time

Witness _____

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FINANCIAL RESPONSIBILITY FORM

Patient understands and agrees that payment is due at the time services are rendered. SouthPark Acupuncture makes no representations regarding whether or not the patient's insurance company will cover any of the services provided at SouthPark Acupuncture. SouthPark Acupuncture does not accept insurance assignment or assignment of Medicare or Medicaid benefits except as required by law. If patient must cancel or change an appointment, SouthPark Acupuncture must be notified of such change at least 24 hours prior to the time of such appointment or patient will be charged for the services that were to have been rendered.

_____

Patient Signature

Date:_____

CHS NOTICE OF PRIVACY ACKNOWLEDGMENT FORM

We are requires by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

____ I have been provided a copy of CHS' Notice of Privacy Practices

Signature_____ **Date**_____/_____/_____

(Patient or Authorized Representative)

Relationship to Patient_____

Reason Patient is Unable/Unwilling to Sign _____