Lewinter Acupuncture

404 372-6760
lewintera@aol.com

Patient Information

Last Name: ________________ **First Name:** ________________ **Middle Initial:** ________

Street Address: ____

City: ________________ **State:** ________________ **Zip:** ________________

Contact Information

Home # ____________ **Work #** ____________ **Cell #** ____________ **E-Mail :** ____________

Date of Birth: ____________ **Age:** ________ **Sex:** ________ **Marital Status:** ____________

Who referred you or how did you hear about Lewinter Acupuncture? ________________________

Who is your primary care physician? ________________________

Employer: ________________________ **Position:** ________________

Employer Address: ____

Emergency Contact Information:

First Name: ________________ **Middle Initial:** ________ **Last Name:** ________________

Work # ________________ **Cell:** ________________ **Relationship to Patient** ________________

Payment Information

Person responsible for payment: ________________________________

Address - If different from above: ________________________________

Relationship to Patient: ________________________________

I understand that payment is due at the time of service. Our office will provide you with documentation in order to file with your insurance carrier for reimbursement.

Signed: ________________________________ **Date:** ________________

Patient Name:____

Current and Ongoing Concerns

List below your five (5) main physical complaints in order of importance:

1. ____

2. ____

3. ____

4. ____

5. ____

Life Style

With whom do you live? Include children, parents, relatives and or friends.

Name	Age	Relationship

Do you have any pets or farm animals? Yes_____ No_____
If yes, where do they live? Indoors_____ Outdoors_____ Both-Indoors and Outdoors_____

Have you ever lived outside the United States?
If so, when and where?____

Have you or your family recently experienced any major life change? Yes_____ No_____
If yes, please comment:____

Have you experienced any major losses in life? Yes_____ No_____
If yes, please comment:____

How important is religion or spirituality for you and your family's life?
Not at all important:_____ Somewhat important:_____ Extremely important:_____

How many days have you lost from work or school in the past year?
0-2 days_____ 3-14 days_____ greater than 15 days_____

Patient Name:____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physica, and sexual are leading contributors to chronic stress, illness and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcome.

Please do your best to answer the following questions:
Did you feel safe growing up? Yes______ No______
Have you been involved in an abusive relationship at any time in your live? Yes______ No______
Was alcoholism or substance abuse present in your childhood home, or is it present now? Yes______ No______
Do you currently feel safe in your home? Yes______ No______
Do you feel safe, respected and valued in your current relationship? Yes______ No______
Have you had any violent or otherwise traumatic life experience, or have you witnessed any violence or abuse? Yes______ No______
Would you feel safer discussing any of these issues privately? Yes______ No______

Patient Name:____

Medical History

Primary care physician:			**Phone #**	
Address		**City**	**State**	**Zip**
Last seen	**Reason for visit**			

Are you currently being treated by other health care professionals?			
	Yes	**No**	**Reason for visit**
Medical Doctor			
Other Medical Specialists			
Chiropractor			
Naturopath/Homeopath			
Acupuncturist or Herbalist			
Have you ever had acupuncture?			

Please list all medication that you are currently taking including both prescription and natural medicines (herbs, homeopathies, vitamins, nutritional supplements, etc.).

Medication	**Dosage**	**Reason**	**Began**

Any drug allergies? Yes_____ No_____ If yes, please identify___________________________

How often have you taken antibiotics?

When	**Less than 5 times**	**Greater than 5 times**
Infancy/Childhood		
Adolescents		
Adulthood		

Patient Name:____

How often have you taken oral steroids (e.g. Cortisone, Prednisone, etc.)

When	Less than 5 times	Greater than 5 times
Infancy/Childhood		
Adolescents		
Adulthood		

Please place a check (√) in response to each question as it **currently** applies to you. If you are presently ill or in pain, respond as it applied to your health before this condition occurred.

Yes	No	Energy Level
		Are you fatigued or do you fatigue easily?
		Do you need to take naps?
		Do you generally feel cold?
		Do you have cold hands?
		Do you have cold feet?
		Do you have a low grade fever?
		Do your hands and cheeks warm up easily?
		Do you ever wake up sweating during the night?

Please place a check (√) in response to each question as it **currently** applies to you. If you are presently ill or in pain, respond as it applied to your health before this condition occurred.

Appetite and Taste	Yes	No
Has your appetite altered recently?		
Do you have a poor appetite?		
Do you have poor digestion?		
Do you experience acid reflux?		
Do you have difficult swallowing?		
Do you experience dry mouth?		
Do you have a sores in mouth or tongue?		
Do you have periodontal disease?		
Do you experience upper abdominal pain?		
Do you experience lower abdominal pain?		
Do you have epigastric (stomach) distention?		
Do you have abdominal (large intestine) distention?		
Are you experiencing belching?		
Do you tend to binge eat and/or purge?		
Do you exhibit symptoms of anorexia nervosa?		
Do you have flatulence?		
Do you have a preferred taste? **Please circle:** Salty Sweet Sour Bitter Spicy		
Do you have cravings? **Please list:**		
What is your favorite food(s)? **Please list:**		

Patient Name:____

What percentage of your diet is of the following?

0-100%	Categories
	Animal protein (eggs, meat, poultry, fish, wild meats or birds, etc.)
	Dairy products (cheese, milk, cream, etc.)
	Vegetables
	Fruit
	Carbohydrates (whole grains – wheat, rice, barley, millet, etc.)
	Refined carbohydrates (processed grains, flours)
	Legumes (beans, lentils, peas)
	Sweets (cakes, cookies, candies, etc.)
	Snacks (potato chips, pretzels, nuts, etc.)
	Processed foods (Fast food, pre-packaged, etc)

List any food sensitivities or allergies.

Food	Reaction
Lactose (Dairy)	
Gluten (Wheat)	
Corn	
Eggs	
Fatty foods	
Yeast	
Other:	

Patient Name:____

Please place a check (√) in response to each question as it **currently** applies to you.

Yes	No	**Thirst and Dryness**
		Do you have dry:
		eyes?
		nose?
		lips?
		skin?
		hair?
		cracking or peeling feet?
		cracking or peeling hands?
		scalp?
		Do you have excessive itching? If yes, where?____
		Excessive thirst?
		Don't experience thirst?

Approximately how many glasses of water or fluids do you drink daily? _________________

Stools and Urine		
Stools – Are your stools:	**Yes**	**No**
Normal (daily with same shape and size)?		
Unusually hard (small or large pellet like)?		
Unusually loose (with undigested food)?		
Erratic (sometimes hard, sometimes loose)?		
Do you have bowel movements less than 5 times per week?		
Do you experience chronic constipation?		
Do you experience chronic diarrhea?		
Do you experience urgency before a bowel movement?		
Is there blood or pus in your stool?		
Do you experience anal spasms?		
Do you have hemorrhoids?		
Urine – Is your urine:	**Yes**	**No**
Unusually dark and scanty (deep coloration and small volume)?		
Unusually clear (very light coloration and large volume based on intake)?		
Do you wake more than once a night to urinate?		
Do you experience any leaking (incontinence) of urine?		
Kidney disease or stones?		
Scanty urination?		
Do you have urgency to urinate?		
Do you experience burning with urination?		
Is there blood or pus in your urine?		

Patient Name:____

Yes	No	Sleep
		Upon waking do you feel refreshed?
		Do you experience difficulty falling asleep?
		Do you experience difficulty staying asleep?
		Is your sleep disrupted by vivid dreams?
		Do you remember your dreams?
		Do you experience night terrors?
		Would you describe your sleep as restless?
		Do you have restless legs?
		Do you eat within 2 hours of going to bed?
		Do you drink within 2 hours of going to bed?
		Do you read in bed?

What do you do to facilitate a good night's rest? ________________________________

Emotions		
	Yes	**No**
Do you have or had agoraphobia?		
Do you experience:		
Irritability?		
Auditory hallucinations?		
Visual hallucinations?		
Black-outs?		
Do you have difficulty:	**Yes**	**No**
Concentrating?		
Balance?		
Thinking?		
Judgment?		
Speech?		
Memory		
Do you experience **excessive:**	**Yes**	**No**
Anger?		
Sadness?		
Worry?		
Fear?		
Anxiety?		
Do you experience mood swings?		
Are your mood swings related to eating or not eating?		
Do you have light-headedness?		
Do you have numbness?		
Do you experience:	**Yes**	**No**
Paranoia?		
Seizures?		
Suicidal thoughts?		
Tremors or trembling?		
Panic attacks?		
Do you experience dizziness?		
Do you have fainting spells?		
Do you take medications or other chemicals to modulate your moods?		

Patient Name:____

Physical Structure	
Do you suffer from:	**Describe**
Chronic or occasional back or neck aches?	
Chronic or occasional joint pain?	
Muscle aches or cramping?	
Numbness of limbs, hands or feet?	
Do you have a pacemaker, hearing aid, breast implants or prosthesis?	

Musculoskeletal		
Do you experience	**Yes**	**No**
Back muscle spasms?		
Calf cramps?		
Chest tightness?		
Foot cramps?		
Joint deformity?		
Joint pain?		
Joint redness?		
Joint stiffness?		
Muscle pain?		
Muscle spasms?		
Muscle stiffness?		
Muscle twitches around eyes?		
Muscle twitches of arms or legs?		
Muscle weakness?		
Neck muscle spasm?		
Tendonitis?		
Tension headaches?		
TMJ problems?		
Head, Eyes, and Ears		
Do you have	**Yes**	**No**
Conjunctivitis?		
Distorted sense of smell?		
Distorted taste?		
Ear fullness?		
Ear noise?		
Ear pain?		
Ear ringing/buzzing?		
Hearing loss?		
Hearing problems?		
Sensitivity to loud noises?		
Eye crusting?		
Eye pain?		
Lid margin redness?		
Headaches?		
Migraine?		

Patient Name:____

Respiration		
Do you experience	**Yes**	**No**
Bad breath?		
Bad odor in nose?		
Cough – dry?		
Cough – productive?		
Hay fever?		
Spring		
Summer		
Fall		
Change of season		
Hoarseness?		
Nasal stuffiness?		
Nose bleeds?		
Post nasal drip?		
Sinus fullness?		
Sinus infection?		
Snoring?		
Sore throat?		
Wheezing?		
Winter stuffiness?		
Cardiovascular		
Do you have	**Yes**	**No**
Angina/chest pain		
Breathlessness?		
Heart attacks?		
Heart Murmur?		
High blood pressure?		
Irregular pulse?		
Mitral valve prolapse?		
Palpitations?		
Phlebitis?		
Swollen ankles/feet		
Varicose veins?		

Patient Name:____

Diagnostic Studies	When	Results
Barium Enema		
Bone Scan		
CAT Scan of Abdomen		
CAT Scan of Brain		
CAT Scan of Spine		
Chest X-ray		
Colonoscopy		
EKG		
Liver Scan		
EKG		
Neck X-ray		
NMR/MRI		
Sigmoidoscopy		
Upper GI Series		
Other:		

Accidents			
Please list all major accidents, including fractures, deep cuts and wounds, serious sprains, etc.			
Injury	**Date**	**Age**	**Description**

Please list all surgeries, elective or necessary, and any consequence from procedure.

Surgery			
Surgery	**Date**	**Age**	**Outcome**
Appendectomy			
Dental Surgery			
Gall Bladder			
Hernia			
Hysterectomy			
Tonsillectomy			
Tubal Ligation			
Vasectomy			

Patient Name:____

Please list all hospitalizations and reason for treatment.

Hospitalizations	
When	**Reason**

Exercise	
In what type of exercise do you engage?	
How many days a week do you exercise?	
How do you feel after you exercise?	
Do you feel compelled to exercise? Yes_______ No_______	

Drug History			
Please indicate with check (√) current or previous use of the following.			
Now	**Past**		**Years used**
		Anti-depressants	
		Antibiotics	
		Estrogen	
		Birth control	
		Pain medication/Narcotics	
		Steroids	
		Antacids	
		Thyroid medication	
		Sedatives or mood modifiers	
		Alcohol	
		Cigarettes	
		Amphetamines	
		Cocaine	
		Heroin	
		Marijuana	

Patient Name:____

Please indicate with check (√) if you now or have had any of the following symptoms or diseases.					
Now	**Past**		**Now**	**Past**	
		Allergies			Heart attack
		Anemia			Hepatitis – Type:_____
		Anxiety			Herpes
		Arthritis			Hypertension
		Asthma			Hypotension
		Bruising			Hyperthyroidism
		Cancer			Hypothyroidism
		Candida			Kidney stones
		Cholesterol, high			Low sex drive
		Chronic fatigue			Mental illness
		Crohn's Disease or Ulcerative Colitis			Mononucleosis
		Constipation			Nose bleeds
		Diabetes			Numbness
		Diarrhea			Pneumonia
		Digestive problems			Rheumatic fever
		Dizziness, vertigo			Sciatic pain
		Edema			Skin problems
		Emphysema			Sleep apnea
		Epilepsy			Stroke
		Food allergies			Thyroid disease
		Frequent colds			TMJ
		Frequent gas			Ulcers
		Gallstones			Venereal disease
		Gout			Vision issues
		Hay fever			- near sighted
		Head injury			- far sighted
		Headache			- use reading glasses
		Heart murmur			

Patient Name:____

Family History		
	Maternal	**Paternal**
Do your parents have any unusual health problems? Please list		
If deceased, please list cause and date.		
Family history of mental illness? Please list		
Family history of substance abuse		
During your mother's pregnancy with you, did she:	**Yes**	**No**
• Drink alcohol		
• Smoke cigarettes		
• Take medication		
• Have a sudden and serious illness		
• Suffer emotionally or physically		

How would you rate you current level of health?
(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?
(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

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Patient Name: ______________________________

Women Only

Menstrual History

Onset of menstruation?	Date or age:	Date last cycle began	Date:

Length of cycle? (number of days from onset of first day to onset of next cycle)		
Please place a check (√) in response to each question as it currently applies to you.	**Yes**	**No**
Is your period regular?		
Is your ovulation painful?		
Are your periods painful?		
Does your period last for more than 5 days?		
Does your period last for less than 3 days?		
Do you bleed excessively?		
Is your flow scanty?		
Spotting between menstrual cycle?		
Do you discharge clots?		
Do you get headaches during menstruation or ovulation?		
Do you experience pre-menstrual syndrome (PMS)? **If yes, please indicate:**		
Breast distention and tenderness?		
Irritability?		
Headache?		
Water retention?		
Bloating?		
Constipation?		
Diarrhea?		
Fatigue?		
Increased sleep?		
Decreased sleep?		
Carbohydrate craving?		
Chocolate craving?		
Other		

Patient Name:____

Gynecological History	Please place a check (√) in response to each question.		
Are you presently pregnant? Yes_____ No_____ If Yes, Due date:____________________________	**Do you have a history of:**	**Yes**	**No**
	Amenorrhea (long time spans without a period)		
Previous pregnancies? … Number of Live births:_________ Full term:_________ Preterm:_________ … Number of miscarriages:_______	Chronic vaginal or yeast infections		
	Etopic pregnancy		
	Endometriosis		
	Insulin resistance		
Did you have difficulty getting pregnant? Yes_____ No_____	Irregular periods		
	Male sub-fertility		
Did you have difficulty after childbirth? Yes_____ No_____	Menstrual cramps		
	Miscarriage		
Have you experienced postpartum depression? Yes_____ No_____ If yes, please indicate date(s):_______ _______ _______ _______	Ovarian cyst		
	Pelvic Inflammatory Disease (PID)		
Have you ever developed toxemia? Yes_____ No_____ If Yes, describe:____________________________	Polycystic Ovarian Disease (PCOD)		
	Endometrial thickness (lining) problem		
Any other problems during pregnancy? If yes, describe:____	Uterine fibroids		
	Excessive vaginal discharge		
Have you had a hysterectomy? If yes, please indicate date:_______	Painful intercourse		
	Urinary tract infections (UTI)		

Gynecological History	
Have you ever used birth control pills? Yes_____ No_____ If yes, When:____________________________ If Yes, How long?:____________________________	
Are you taking the pill now? Yes_____ No_____ Did taking the pill agree with you? Yes_____ No_____	Do you currently use contraception? Yes_____ No_____ If yes, what type of contraception do you use? Type:____
Are you presently experiencing peri-menopausal symptoms? Yes_____ No_____ If Yes, describe:____________________________	
Are you in menopause? Yes_____ No_____ If yes, age of last period_____________________	Have you completed menopause? If yes, please indicate # of years:_______
Please check what you are taking? Estrogen?_____ Ogen?_____ Estrace?_____ Premarin?_____ Other?_____________________ Progesterone?_____ Provera?_____ Other?_____________________	

Patient Name:____

Please answer the following questions if you are undergoing assisted reproductive technologies (ART).

Assisted Reproduction

Are you working with a Reproductive Endocrinologist? Yes:____ No:____

If Yes – Name of Group:____

Name of physician:____

Number of IUI's _______
Dates:_______ _______ _______ _______

Number of IVF's _______
Dates:_______ _______ _______ _______

Upcoming procedure:___________________
Date:_______

Hysterosopy date:_______

Laparoscopic surgery date:_______
Reason:_____________________________

Previous abdominal surgeries:
Date:_______Reason:____
Date:_______Reason:____
Date:_______Reason:____
Date:_______Reason:____
____
____
____

Pertinent Lab Information:
FSH:___________

For Office Use

Notes____
____
____

Western Diagnosis____

Oriental Diagnosis____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Lewinter Acupuncture** may use and disclose health information [treatment, payment or healthcare operations (TPO)] about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Lewinter Acupuncture's** Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Lewinter Acupuncture** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Lewinter Acupuncture at 6700 Roswell Road, NE, 30-D, Atlanta, GA 30328.**

With my consent, **Lewinter Acupuncture** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Lewinter Acupuncture** may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, **Lewinter Acupuncture** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Lewinter Acupuncture** restricts how it uses or discloses my Protected Health Information (PHI) to carry out TPO.

By signing this form, I am consenting to **Lewinter Acupuncture** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Lewinter Acupuncture** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

.

________________________________ ____________________________
Print Patient's Name Date

Lewinter Acupuncture

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To protect the privacies of our patients please respond to the following questions.

Please indicate your answer with a check to the right of each question.	**Yes**	**No**
Do we have your permission to contact or leave a message on your home phone?		
Do we have your permission to contact or leave a message on your work phone?		
Do we have your permission to correspond with you through the USPS mail at home or work? (Examples include: sending appointment reminders, birthday wishes, or a thank you notes when you have made a referral to us)		
Do we have your permission to correspond with and send credit card receipts to you via the e-mail address provided?		
Do we have permission to contact your doctor(s)?		
If photographed for the purpose to training or teaching, do we have your permission to use the photograph(s) to share, publish or use in a presentation?		

_______________________________________ _______________________________

Signature of Patient or Legal Guardian Date

Consent to Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

____

Patient Signature Date

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POST-ACUPUNCTURE INSTRUCTIONS
(Please read before your treatment)

1. Immediately after your acupuncture session it is possible that you may become euphoric or light-headed. Please be sure you are properly oriented before leaving. We offer water and juice upon request and you are welcome to stay in the treatment room or in the lobby until you are capable of walking or driving safely from our office.

2. For 8-12 hours following your treatment:
   - Engage in your normal daily activities, however, wait 24 hours before performing any strenuous physical activities.
   - Refrain from alcohol or other mind/mood altering substances.
     - If you choose to consume these substances, be aware their effect will be magnified.
   - Eat moderately sized and satisfying meals (avoid spicy foods).
   - If you feel sleepy or tired following your treatment, please honor those feelings by resting as needed.

3. During the first 24 to 48 hours after an acupuncture treatment you may feel that the very condition you were seeking relief from has worsened. This experience is a perfectly normal and a common treatment reaction; in fact, this type of response frequently indicates the treatment is working. If you are concerned by such an occurrence, please do not hesitate to contact us and do discuss this event with your acupuncturist at your next appointment.

4. You may be sent home with ear needles and instructions to be removed at a specific time; please follow the practitioner's instructions for removal and proper disposal.

5. In the rare event a needle has been unintentionally left in an acupoint, remain calm, and simply grasp the handle of the needle pulling slowly in an outward direction until the needle is released from the site. Please do not cut the handle of the needle or attempt to push it in further. Return the needle to the office for proper disposal. If you are concerned regarding self-removal of the needle, please contact our office and we will gladly assist you.

6. We at Lewinter Acupuncture are dedicated to providing the highest possible level of care and strive for constant improvement; therefore, we welcome and encourage you to share your experience with us. Please feel comfortable offering us your opinion(s) in the form of a suggestion, comment, and or concern by discussing these matters with your practitioner, writing to us directly via E-mail using lewintera@aol.com. Thank you for choosing Lewinter Acupuncture to support your health and wellness.

Patient Signature:____ Date:_____________________

Witness Signature:____ Date:_____________________