GENERAL INFORMATION

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Work Phone _____ Occupation _____

Email _____

Emergency Contact _____ Contact Number _____

Family Physician _____ Physician Phone _____

Referred By _____

Have you had Acupuncture or Oriental Medicine before? ___ Yes ___ No

Are you presently under a doctor's care? ___ Yes ___ No

Who and for what? _____

Are there any other therapies, which you are involved in? ___ Yes ___ No

Who and for what? _____

FOCUS

What is your primary reason for seeking care at our office? _____

_____

What was the initial cause? _____

When did it begin? _____

What makes it better? _____

What makes it worse? _____

How does the problem interfere with your daily activities?

___ Work ___ Sleep ___ Walking ___ Sitting ___ Standing ___ Bending

___ Stretching ___ Emotional ___ Relationships ___ Social Life ___ Sexually ___ Recreation

___ Other (list to the right) _____

What have you done about this?

_____

Are you interested in?

___ Pain Relief ___ Performance Care ___ Maintenance Care

___ Preventative Care ___ Holistic Health ___ Stress Relief

___ Oriental Nutrition ___ Meridian Yoga ___ Herbal Therapy

___ Other (list to the right) _____

FOCUS (Continued)

What are your health goals? _____

List any past or future surgeries _____

List any significant traumas? When did it occur? (Auto accident, falls, emotional, sexual, etc.) _____

List exercise and sport activities you have been in or are currently involved in _____

SIGNS/SYMPTOMS

___ Abdominal pain/distention
___ Abuse survivor
___ Acid regurgitation
___ Acne
___ Asthma
___ Bad breath
___ Blood in stools
___ Blood in urine
___ Blurry vision
___ Breast lump/pain
___ Bruise easily
___ Chest pains
___ Chills
___ Cold hands/feet
___ Concussion
___ Confusion
___ Constipation
___ Cough
___ Coughing blood
___ Dark stools
___ Decreased libido
___ Depression
___ Diarrhea
___ Dizziness/vertigo
___ Dry throat/mouth
___ Ear aches
___ Enlarged thyroid
___ Eye pain/strain/tension
___ Excessive phlegm color of
___ Excessive saliva
___ Fatigue
___ Fever
___ Frequent urination
___ Gas/belching
___ Grinding teeth
___ Headache
___ Hemorrhoids
___ Heart palpitations
___ Hiccup
___ High blood pressure
___ Impotence
___ Increased libido
___ Indigestion
___ Intestinal pain/cramps
___ Irritable
___ Itchy eyes
___ Itchy skin
___ Joint pain
___ Kidney stones
___ Laxative use
___ Limited range of motion
___ Loss of hair
___ Low back pain
___ Migraine
___ Mouth sores
___ Mucous in stools
___ Muscle cramps/pain
___ Nasal congestion
___ Neck/shoulder pain
___ Night sweat
___ Nocturnal emission
___ Nose bleeds
___ Numbness
___ Odorous stools
___ Pain upon urination
___ Peculiar tastes
___ Poor appetite
___ Poor circulation
___ Poor memory
___ Poor sleep
___ Premature ejaculation
___ Psoriasis
___ Rash
___ Redness of eyes
___ Seizures
___ Seeing a therapist
___ Short temper
___ Shortness of breath
___ Sinus pressure
___ Skin fungal infection
___ Spots in eyes
___ Sweat easily
___ Sore throat
___ Sudden energy drop
___ Swollen glands
___ Teeth/gum problems
___ Ulcerations
___ Upper back pain
___ Urgent urination
___ Vomiting
___ Wake to urinate
___ Weight loss/gain
___ Wheezing

FEMALE CONCERNS

Date of last menstruation? _____ Is your cycle regular? ___ Yes ___ No

Is your cycle painful? ___ Yes ___ No Have you ever been pregnant? ___ Yes ___ No

Birth control? ___ Yes ___ No How long? _____

___ PMS ___ Clotting ___ Vaginal sores ___ Vaginal pain ___ Discharge

MEDICAL HISTORY

Do you have any allergies? ___ Yes ___ No If so, to what? _____

Do you take medication? ___ Yes ___ No If so, what types and how often? _____

Do you take supplements? ___ Yes ___ No If so, what types and how often? _____

Please indicate if you or any family members have or have had any of the following conditions:

___ Pneumonia	___ Blood transfusion	___ Mumps	___ Mental illness
___ Tuberculosis	___ Anemia	___ Syphilis	___ Hypo/hyper thyroid
___ Hepatitis	___ Arthritis	___ Gonorrhea/Herpes	___ Premature graying
___ Diabetes	___ Obesity	___ HIV/AIDS	___ Seizures
___ Epilepsy	___ Mental breakdown	___ High/low blood pressure	___ Multiple Sclerosis
___ Kidney stones	___ Jaundice	___ Heart disease	
___ Drug reaction	___ Parasites	___ Gout	
___ Heart attack	___ Measles	___ Cancer	

Do you sleep well? ___ Yes ___ No Do you dream? ___ Yes ___ No

Do you have a high point during the day? ___ Yes ___ No When? _____

Do you have a low point during the day? ___ Yes ___ No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

TYPES OF CARE

According to your signs and symptoms, please indicate where your current state of health falls along this Types of Care time line.

ACUTE CARE
(Obvious symptoms and signs)

Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. *Acute Care* helps to ease your initial problem(s) quickly.

MAINTENANCE CARE
(Symptom and signs disappear)

Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

WELLNESS & PREVENTATIVE CARE
(You feel great)

Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. *Wellness Care* is your best choice.

PAIN

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describes)

___ No pain ___ Moderate pain ___ Severe pain ___ Terrible pain

Sleeping

___ No problem ___ Mildly disturbed ___ Greatly disturbed ___ Cannot sleep

Work – Can do:

___ Usual work ___ 25% of work ___ 50% of work ___ No work

Frequency of pain

___ 25% of time ___ 50% of time ___ 75% of time ___ 100% of time

Travel

___ No problem on long trips ___ Moderate pain on trips ___ Severe pain on trips

Recreation – Can do:

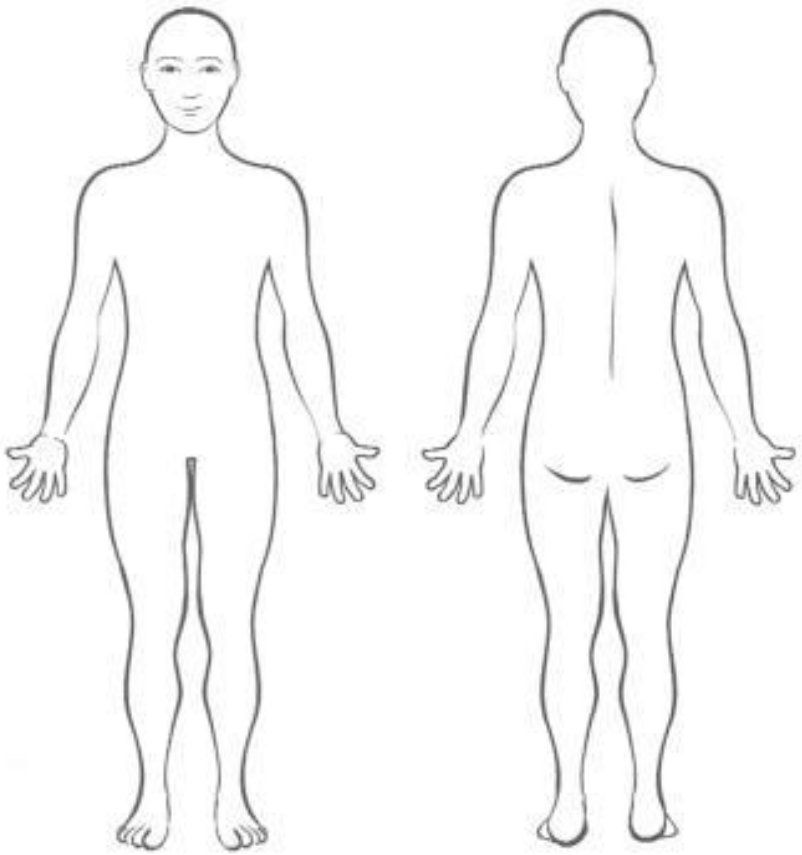
___ All activities ___ Some activities ___ No activities

Walking

___ Can walk any distance ___ Pain after 1/2 mile ___ Cannot walk

Sitting

___ No pain sitting ___ Some pain while sitting ___ Cannot sit



GENERAL QUESTIONS

How did you hear about Modern Point Acupuncture? _____

Would you like to receive our free monthly newsletter? ___ Yes ___ No

May we contact you by:

Mobile Phone ___ Yes ___ No

Home Phone ___ Yes ___ No

Work Phone ___ Yes ___ No

Email ___ Yes ___ No

Mail (home address) ___ Yes ___ No

Cancellation Policy and Treatment Package Agreement

At least a twenty-four hour notice of cancellation of any appointment is requested by Modern Point. I understand that if I arrive more than fifteen minutes late for a scheduled appointment or do not give twenty-four hours' notice of a missed appointment that the amount of the entire treatment may be deducted from my prepaid acupuncture package or I may be charged for the entire amount of the missed appointment.

I consent Modern Point to take payment for and to track the number of visits used for my prepaid acupuncture treatment package. I understand that acupuncture treatment packages are non-transferrable, non-refundable*, and expire one year from the date of purchase. This policy is designed for the benefit of both patients and practitioners so that appointments are available to those in need of treatment.

I have read and I understand the above information:

Patient name printed

Patient Signature | Date

Office signature | Date

*In the rare circumstance that a refund is given for a partially used treatment package the regular treatment price (not the discounted package treatment price) is deducted from the total amount paid for the package for each treatment used.

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for hour medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:
Limited access to facilities where information is stored.

Policies and procedures for handling information.

Requirements for third parties to contractually comply with privacy laws.

All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:
In administering your health care, we gather and maintain information that may include non-public personal information:

About your financial transactions with us (billing transactions).

From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you – e.g. your name, address, Social Security Number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 763-494-9500.

I have read and understand this privacy policy.

X: _____ Date: _____