

Metro Acupuncture 6255 Barfield Road, Suite 175 Atlanta, GA 30328 404 255-8388 www.metroacupuncture.com

Patient Information

Last Name:	Firs	st Name:	Middle Initial:	
Street Address:				
City:		State:	Zip:	
Preferred Contact #		Email:	<u>-</u>	
Date of Birth:	Age:	Sex:	Marital Status:	
Who referred you or how did yo	ou hear about Metro	Acupuncture?		
Who is your primary care phys	ician?			
	P	ayment Information	on	
Person responsible for payment	:			
Address - If different from above	/e:			
Relationship to Patient:				
I understand that payment is do your insurance carrier for reim		ce. Our office will	provide you with documentation in (order to file with
Signed:		D	ite:	



Patient Name:_

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Medication	Dosage	Reason	Began
	200.90		
allergies? Yes No	If was please identify		
allergies? Yes No	If yes, please identify		
allergies? Yes No			
	If yes, please identify Concerns or health concerns in order of im		
	Concerns		
st main physical complaints o	Concerns		
st main physical complaints o	Concerns		
st main physical complaints o	Concerns		

Patient Name:			

		Ac	cidents			
Please list all major accid	dents, including	fractures, dee	p cuts and wounds, serious sprains, etc.			
Injury	Injury Date Age Description		Date	Age	Age	Description
			rgeries			
Please list all surgeries, e	elective or nece	essary, and any	consequence from procedure.			
Surgery	Date	Age	Outcome			

List any allergies or food sensitivities.

Substance	Reaction

Patient Name:	:	

low	Past		Now	Past	
		Allergies			Heart murmur
		Anemia			Heart palpitations
		Anxiety			Hepatitis – Type:
		Arthritis			Herpes
		Asthma			Hypertension
		Bruising			Hypotension
		Cancer			Hyperthyroidism
		Candida			Hypothyroidism
		Cholesterol, high			Kidney stones
		Chronic fatigue			Low sex drive
		Constipation			Mental illness
		Depression			Mononucleosis
		Diabetes			Nose bleeds
		Diarrhea			Numbness
		Digestive problems			Prostate issues
		Dizziness, vertigo			Sciatic pain
		Edema			Skin problems
		Epilepsy			TMJ
		Food allergies			Ulcers
		Frequent colds			Venereal disease
		Frequent gas			Vision issues
		Gallstones			- near sighted
		Hay fever			- far sighted
		Head injury			- use reading glasses
		Headache			

Other symptoms or diseases (please list):		

Women Only		
Menstrual History		
Onset of menstruation? Date or age:		
Length of cycle? (number of days from onset of first day to onset of next cycle)		
Please place a check ($\sqrt{\ }$) 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?		
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?		
Other		

Gynecological History	Please place a check ($\sqrt{\ }$) in response to each question.			
Are you presently pregnant?	Do you have a history of:		No	
Yes No If Yes, Due date:	Amenorrhea (long time spans without a period)			
Previous pregnancies?	Chronic vaginal or yeast infections			
Number of Live births:	Ectopic pregnancy			
Full term: Preterm:	Endometriosis			
Number of miscarriages:	Insulin resistance			
Did you have difficulty getting pregnant?	Irregular periods			
Yes No	Urinary tract infections (UTI)			
Did you have difficulty after childbirth?	Menstrual cramps			
Yes No	Painful intercourse			
Have you experienced postpartum depression? Yes No	Ovarian cyst			
If yes, please indicate date(s):	Pelvic Inflammatory Disease (PID)			
Are you presently experiencing perimenopausal symptoms?	you presently experiencing perimenopausal symptoms? Polycystic Ovarian Disease (PCOD)			
Yes No If Yes, describe:	Endometrial thickness (lining) problem			
Have you completed menopause?	Uterine fibroids			
If yes, please indicate # of years:	Excessive vaginal discharge			
Have you had a hysterectomy?				
If yes, please indicate date:				

Patient Name:	
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Please answer the following questions if you are undergoing assisted reproductive technologies.

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:
Hysteroscopy date:
Laparoscopic surgery date:
Reason:
Previous abdominal surgeries:
Date:Reason:
Date:Reason:
Date:Reason:
Date: Reason:
Pertinent Lab Information:
FSH:
AMH:
Other:



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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 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 you via the E-mail address you have 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		



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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Metro 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 Metro 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. Metro 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 Metro Acupuncture at 6255 Barfield Road, Suite 175, Atlanta, GA 30328.

With my consent, Metro 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, Metro 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, Metro 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 Metro Acupuncture restricts how it uses or discloses my Protected Health Information (PHI) to carry out TPO.

By signing this form, I am consenting to Metro 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, Metro Acupuncture may decline to provide treatment to me.

Signature of Patient or Legal Guardian		
Patient's Name	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 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. We at Metro 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 mail or sending an E-mail from our website at www.metroacupuncture.com.

Thank you for choosing Metro Acupuncture to support your health and wellness.