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

Patient Information

Last Name: _____ **First Name:** _____**Middle Initial:** _____

Street Address: _____

City: _____**State:** _____**Zip:** _____

Contact Information

Home #_____ **Cell #**_____**Email:**_____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:**_____

Who referred you or how did you hear about Metro Acupuncture? _____

Who is your primary care physician?_____

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:**_____

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Patient Name:_____
First Middle Initial Last

Medical History

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 _____

_____

Patient Name:_____

Concerns
List main physical complaints or health concerns in order of importance:
1.
2.
3.
4.
5.

Accidents			
Please list all major accidents, including fractures, deep cuts and wounds, serious sprains, etc.			
Injury	**Date**	**Age**	**Description**
Surgeries			
Please list all surgeries, elective or necessary, and any consequence from procedure.			
Surgery	**Date**	**Age**	**Outcome**

Physical Structure	
Do you suffer from:	**Description**
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?	

Patient Name:_____

List any allergies or food sensitivities.

Substance	Reaction

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 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		
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 take medications or other substances to modulate your moods?		

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 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):

_____

_____

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)

Do you drink coffee? Yes No
Do you smoke cigarettes? Yes No
Do you drink alcohol? Yes No

Patient Name: _____

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 (√) 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 (√) in response to each question.**		
Are you presently pregnant?	**Do you have a history of:**	**Yes**	**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:_____	Endometriosis		
Preterm:_____	Insulin resistance		
… Number of miscarriages:_____			
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?	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:_____

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: _____ _____

Patient Name:_____

Men Only		
Please place a check (√) in response to each question as it current applies to you.	**Yes**	**No**
Prostate issues?		
Difficulty urinating?		
Dribbling after urination?		
Frequent nighttime urination?		
Diminished libido?		
Excess libido?		
Difficulty achieving an erection?		
Difficulty maintaining an erection?		
Morning erection?		
Premature ejaculation?		
Nocturnal emission?		
Infertility?		
Pain on the inside of legs or heels?		
Feeling of incomplete bowel evacuation?		
Lack of energy?		
Migrating aches and pains?		
Tire too easily?		
Avoid activity?		
Restless leg syndrome?		
Please list any other urinary and/or genital issues:		

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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 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.