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?_____

Employer: _____ Position: _____

Employer Address: _____

Spouse/Parent Information:

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

Date of Birth: _____ Occupation:_____ Employer: _____

Employer Address:_____

Cell:_____

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

Primary care physician:		**Phone #**	
Address	**City**	**State**	**Zip**

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 below your five 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:	**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?	

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 chemicals 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 your 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

(If you are being treated for pain, please complete.)

Patient Name:_____ Date:_____

Location of pain:_____

Duration of pain:_____

Last Imaging Study:

X-ray:_____

MRI:_____

CT Scan:_____

Other: _____

List of MD's consulted:

Orthopedic:_____

Neurologist:_____

Neurosurgeon:_____

Other:_____

Previous surgeries for pain:

Type _____ Date _____

_____ _____

_____ _____

Previous procedures to address pain: (epidural steroid injections/facet injections/radiofrequency ablations/other)

_____

_____

Medications for pain:

Current:_____

Past:_____

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:_____	Etopic pregnancy		
Full term:_____	Endometriosis		
Preterm:_____	Insulin resistance		
… Number of miscarriages:_____	Irregular periods		
Did you have difficulty getting pregnant?	Urinary tract infections (UTI)		
Yes_____ No_____	Menstrual cramps		
Did you have difficulty after childbirth?	Painful intercourse		
Yes_____ No_____	Ovarian cyst		
Have you experienced postpartum depression? Yes_____ No_____	Pelvic Inflammatory Disease (PID)		
If yes, please indicate date(s):_____ _____ _____ _____	Polycystic Ovarian Syndrome (PCOS)		
Are you presently experiencing peri-menopausal symptoms?	Endometrial thickness (lining) problem		
Yes_____ No_____ If Yes, describe:_____	Uterine fibroids		
Have you completed menopause?	Excessive vaginal discharge		
If yes, please indicate # of years:_____			
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 night-time 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?		
Leg nervousness at night?		
Please list any other urinary and/or genital issues:		

Patient Name:

Self-Assessment Profile

Check the qualities that apply to you

Hun

- ☐ Feel confident, act assertively
- ☐ Ambitious and enjoy being competitive
- ☐ Openly discuss my abilities and achievements
- ☐ Comfortable with challenges, conflict or pressure
- ☐ Intolerant and impatient
- ☐ Enjoy being first, best, unique, even outlandish
- ☐ Feel right, even if others disagree or disapprove
- ☐ Tend to be pushy or provocative
- ☐ Volatile emotions
- ☐ Take pleasure in public recognition
- ☐ Comfortable directing or leading others
- ☐ Love action, movement and adventure
- ☐ Tend to work best under pressure
- ☐ Comfortable acting boldly and decisively
- ☐ Tend to reject or argue with other peoples opinions, especially of me

Shen

- ☐ Enjoy the pleasure of my senses
- ☐ Easily know what another thinks and feels
- ☐ Anxious, agitated and frenzied
- ☐ Enjoy physical contact and emotional intimacy
- ☐ Easily share my innermost feelings and desires
- ☐ Keenly intuitive and passionately empathetic
- ☐ Tend to live in the here-and-now
- ☐ Tend to abuse mind altering substances
- ☐ Love physical stimulation, drama and sentiment
- ☐ See the humorous side of life
- ☐ Thoroughly enjoy getting what I want
- ☐ Get involved easily and enjoy being moved emotionally
- ☐ Optimistic and hopeful despite what others may say
- ☐ Unabashed in showing affection, enthusiasm and excitement
- ☐ Enjoy being attractive and magnetic

Yi

- ☐ Agreeable and accommodating
- ☐ Nurturing and supportive, putting other's needs first
- ☐ Enjoy frequent socializing with friends and family
- ☐ Enjoy being relied upon for reassurance and help
- ☐ Unrealistic expectations and easily disappointed
- ☐ The hub of my life is social and family networks
- ☐ Enjoy settling disputes so that all parties are satisfied
- ☐ Involved in other peoples' lives
- ☐ Like to create a relaxed and comfortable environment for others
- ☐ Worry, obsess and have self-doubt
- ☐ Loyal and accessible to friends, family and co-workers
- ☐ Tend to be diplomatic and tactful, a consensus builder
- ☐ Happy to rely on the skill and intelligence of others
- ☐ Like getting close and being needed
- ☐ Comfortable and open even with people I don't know well or have just met

Po

- ☐ Prefer a neat and orderly lifestyle
- ☐ Enjoy a convivial but undemanding social life
- ☐ Committed to high moral principles and conduct
- ☐ Comfortable when proper procedures are followed
- ☐ Enjoy tasks that require logical and systematic approached to problem solving
- ☐ Meticulous, tasteful and discriminating
- ☐ Self righteous and/or disillusioned
- ☐ Self-contained, not overly involved in other's affairs
- ☐ Work effectively in situations where goals and guidelines are well defined
- ☐ Indifferent and inhibited
- ☐ Willing to accept the authority of those with more competencies
- ☐ Enjoy solving puzzles and mysteries
- ☐ Put virtue and principle before pleasure and fulfillment
- ☐ Tactless, unforgiving and suspicious
- ☐ Like things to run calmly and smoothly

Zhi

- ☐ Cautious and sensible
- ☐ Particularly enjoy solitude
- ☐ Curious and imaginative
- ☐ Tend to keep feelings, thoughts and opinions to myself
- ☐ Content being anonymous, a "fly on the wall"
- ☐ Doesn't mind being considered unusual or eccentric
- ☐ Excited by intellectual pursuits
- ☐ Content figuring things out for myself
- ☐ Careful about what I reveal to other people
- ☐ Stubborn defender of the truth as I see it
- ☐ Patient and persevering, in spite of defeats or dead ends
- ☐ Objective and fair, regardless of what others think
- ☐ Preferably self-sufficient and independent
- ☐ Cherishing privacy and a few good friends
- ☐ Like to reflect upon my place in the grand scheme of things

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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. 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. 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.

5. 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.

Patient Signature: _____ Date: _____

Office Initials: _____