Qi Points Acupuncture, LLC
Jennifer May Lin, L.Ac., MSOM
NCCAOM certified Diplomate of Acupuncture

245 Main Street, Suite 2M
Matawan, NJ 07747
www.qipointsacu.com
732.242.4536
jen@qipointsacu.com

PATIENT INFORMATION

Last Name:	First:	Middle:	[ ] Mr. [ ] Miss [ ] Mrs. [ ] Ms.
Former Name if applicable:	Date of Birth: / /	[ ] Single [ ] Divorced [ ] Married [ ] Widowed	[ ] Male [ ] Other [ ] Female
Street Address:	City:	State:	Zip Code:

Home Phone Number:	Mobile Phone Number:
[ ] Can leave message on machine - [ ] short [ ] detailed [ ] Can leave [ ] short [ ] detailed message with: _____	[ ] Can leave message - [ ] short [ ] detailed [ ] Can text [ ] short [ ] detailed

Occupation:	Employer:	Work Phone Number:
Work Address:	City:	State: Zip Code:

How did you hear about Qi Points Acupuncture, LLC?

[ ] Dr. _____ [ ] Family [ ] Friend [ ] Close to home/work [ ] Other _____

INSURANCE INFORMATION

Primary Insurance Company:

Policy Number:	Group Number:
Policy Holder's Name (if different from Patient):	Policy Holder's Date of Birth: / /

Policy Holder's Address (if different from Patient):

Patient's Relationship to Policy holder: [ ] Self [ ] Spouse [ ] Child [ ] Other _____

Secondary Insurance Company (if applicable):

Policy Number:	Group Number:

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Phone Number:

The above information is true to the best of my knowledge. I authorized my insurance benefits to be paid directly to Qi Points Acupuncture, LLC. I understand that I am financially responsible for any balance. I also authorize Qi Points Acupuncture, LLC to release any information required by the insurance company to process my claims.

_____ Date:_____
Patient/Guardian Signature

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Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Qi Points Acupuncture, LLC (hereafter noted as Qi Points Acupuncture) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Qi Points Acupuncture may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Qi Points Acupuncture is not required to agree to the restrictions that I may request. However, if Qi Points Acupuncture agrees to a restriction that I request, the restriction is binding upon Qi Points Acupuncture.

I have the right to revoke this consent, in writing, at any time except to the extent that Qi Points Acupuncture has acted in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Qi Points Acupuncture's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices Describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Qi Points Acupuncture. The Notice of Privacy Practices is provided at upon request as well as on the organization's website at www.qipointsacu.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Qi Points Acupuncture with respect to my identifiable health information.

Qi Points Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a reviewed Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative Date

Printed Name and Relationship to Patient

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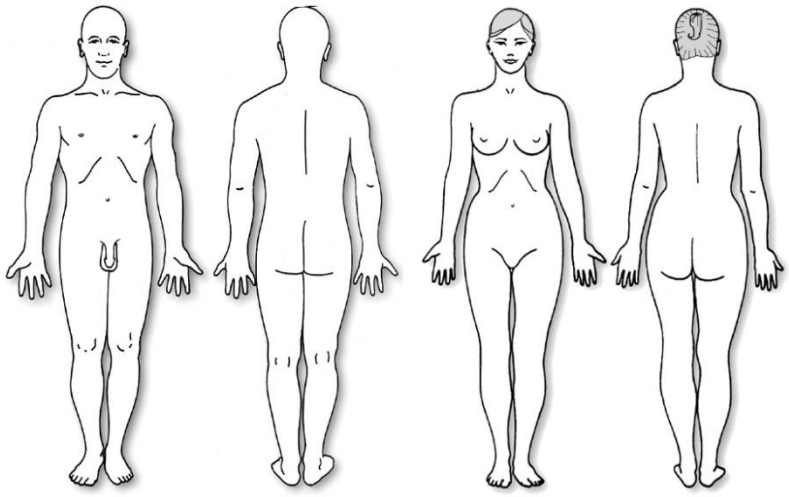
Initial Patient Assessment // Medical History

Name: _____ **Age**: _____ **DOB**: ___/____/_____
Chief Complaint: _____
Onset: _____ **Duration**: _____ **Frequency**:_____
Severity: (minimal) 1 2 3 4 5 6 7 8 9 10 (extreme)
Better when: _____
Worse when: _____
Diagnosed by an M.D.? Y N **Diagnosis**: _____
Been treated? Y N **Effective?** Y N **Treated by**: _____
Treatment: _____
Additional complaints:
_____
_____
_____
_____
Current Medications: _____
Allergies: _____
Past Medical History:
_____
_____

Current Patient Profile

Circle/Mark areas of Body Pain/Discomfort:



Please describe and be specific:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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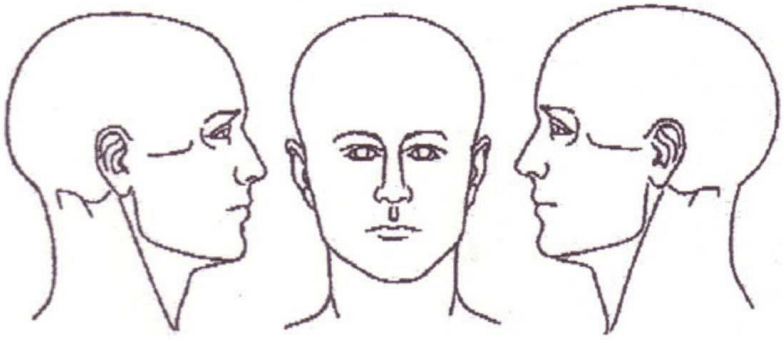
Circle/Mark the areas of Headaches/Face Discomfort:



Please describe and be specific:

_____
_____
_____
_____
_____
_____
_____

For the following sections, please put "A" for always, "S" for sometimes, and leave blank for never in the boxes preceding the symptom:

Body Temperature KD

[ ] Cold hands	[ ] Often feels hot	Hot Flashes (Dry)	With Sweating
[ ] Cold feet	[ ] Often feels cold	[ ] Morning flashes	[ ] Morning flashes
[ ] Sweaty hands	[ ] Easily sweats	[ ] Afternoon flashes	[ ] Afternoon flashes
[ ] Sweaty feet	[ ] Never sweats	[ ] Night flashes	[ ] Night flashes

Overall Energy LU, KD

[ ] Shortness of breath	[ ] General Weakness	[ ] Fatigue
[ ] Frequent colds	[ ] Low Energy	[ ] Worse after exercise

Heart/Chest HT

[ ] Palpitations	[ ] Low blood pressure	Insomnia
[ ] Chest pain	[ ] High blood pressure	[ ] Trouble falling asleep
[ ] Chest tightness	[ ] Anxiety	[ ] Trouble staying asleep

Respiratory System/Skin LU

Nasal Discharge	[ ] Wheeze	[ ] Acne
[ ] White	[ ] Difficulty breathing	[ ] Skin rash
[ ] Yellow	[ ] Sinus congestion	[ ] Stiff neck
[ ] Thick	[ ] Nosebleeds	[ ] Stiff shoulders
[ ] Thin	[ ] Dry nose	[ ] Sadness
Cough	[ ] Dry mouth	[ ] Depression
[ ] Dry	[ ] Dry skin	
[ ] Productive	[ ] Dry/sore throat	

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Gastrointestinal Issues ST, SP, LI, SI

[ ] Low appetite
[ ] Ravenous appetite
[ ] Weight gain
[ ] Weight loss
[ ] Bloating/gas
[ ] Nasua/vomiting
[ ] Loose stools
[ ] Constipation
[ ] Diarrhea
[ ] Blood in stools
[ ] Undigested food
[ ] Strong odor from stool
[ ] Bleeding gums
[ ] Bad breath
[ ] Acid reflux
[ ] Stomach pains
[ ] Stomach ulcers
[ ] Hemorrhoids
[ ] Pensiveness
[ ] Constant worry
[ ] Constant stress
[ ] Easily bruised

Dampness in Body SP

[ ] Overall sensation of heaviness
[ ] General edema
[ ] Swollen hands
[ ] Swollen feet
[ ] Swollen joints
[ ] Chest congestion
[ ] Nasal discharge
[ ] Excessive sweating
[ ] Mental sluggishness
[ ] Mental fogginess

Eyes LV

[ ] Itchy
[ ] Bloodshot
[ ] Hot/burning
[ ] Dry
[ ] Watery
[ ] Gritty
[ ] Blurry vision
[ ] Nighttime blindness
[ ] Nearsighted/farsighted

Urinary System KD, BL

[ ] Frequent urination
[ ] Infrequent urination
[ ] Burning/painful urination
[ ] Incontinence
[ ] Strong odor
[ ] Kidney stones
[ ] Bladder stones
[ ] Bedwetting
Abnormal color urine
[ ] Dark yellow
[ ] Reddish/blood tinged
[ ] Cloudy

Other LV, GB

[ ] Pain below ribs
[ ] Distention below ribs
[ ] Pain in flanks
[ ] Muscle spasms/cramping
[ ] Tingling sensation
[ ] Numbness
[ ] Seizures/tremors
[ ] Tinnitus
[ ] Easily angered
[ ] Easily frustrated
[ ] Irritability
[ ] Bitter taste in mouth

Reproductive System - MALE

[ ] Noctural emissions
[ ] Penile Discharge
[ ] Testicular pain/swelling
[ ] Prostate problems
[ ] Impotence
[ ] Premature Ejaculation

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Reproductive System - FEMALE

Age of first menses: _____ # Days of Menses: _____ Length of Cycle: _____
Age of Menopause: _____ Currently Pregnant? **[ ]** Yes **[ ]** No Birth Control: **[ ]** Yes **[ ]** No
# of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: ____ # of Terminations: ____

[ ] Irregular cycles	**[ ]** Vaginal discharge	**[ ]** Menopausal symptoms
[ ] Heavy periods	**[ ]** Clots	**[ ]** Infertility concerns
[ ] Light periods	**[ ]** Cramps	**[ ]** Breast lumps
[ ] Spotting	**[ ]** PMS	**[ ]** Breast tenderness

Additional Symptoms/Concerns:

_____
_____
_____
_____

I hereby declare that I have filled out this intake form honestly and to the best of my ability and will update my acupuncturist if there are any changes as my treatment continues.

Signed: _____ **Date:**_____