Community Acupuncture of Mt. Airy Intake Form

(to be filled out on the first visit)

Name:_____Date:_____

Address:_____

Phone No._____

Email (not shared & used only to transmit info related to your health)_____

Physician's name & location of practice:_____

Permission to contact your physician to share info: ____Yes ____No

In Emergency contact (provide name & phone #):_____

Have you had acupuncture before? No____ If yes, was it helpful?_____

How did you hear about the Acupuncture Center?_____

Main health concern you'd like to address:

Have you seen a physician about your concern?

When did it first begin?

What treatments have you tried? Were they helpful?

What makes it better?

What makes it worse?

What do you think is the cause of the problem?

Clinician's Notes from first visit:

Clinician's Treatment from first visit:

Pulse: Tongue:

Practitioner's Diagnosis/Assessment:

Initial Points on Body:

Ear Points: Practitioner's Initials_____

Community Acupuncture of Mt. Airy

Brief Health History Form
(to be filled out on your first visit)

Patient Name: Birth Date: Age:

Western diagnosis, if known:

Is there any procedure or surgery scheduled for you? ☐ Yes ☐ No If yes, when?_____

Medical History:

☐ Asthma ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Chronic Pulmonary Disease ☐ COVID-19

☐ Vaccinated for Covid-19 ☐ Kidney Disease ☐ Liver Disease ☐ Bleeding disorder

☐ Thyroid Disease ☐ Seizures ☐ Hepatitis ☐ Depression ☐ Anxiety ☐ High Stress Level ☐ Alcoholism

☐ AIDS ☐ Cancer – what kind?_____ ☐ Other (specify)_____

Any other info you would like us to know about your health history:

Allergies: ☐ None ☐ Yes If yes, please specify_____

Current Medications: ☐ None ☐ Yes If yes, please specify_____

_____

Social History: ☐ Alcohol ☐ Tobacco

Significant Trauma (auto accidents, falls, etc.)_____

_____

Significant Surgical History: ☐ None ☐ Yes If yes, please specify_____

CAMA
COMMUNITY ACUPUNCTURE OF MOUNT AIRY

Consent to Treatment

I hereby authorize licensed acupuncturists at CAMA to administer any style of Asian medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of acupuncture needles into my body at various depths and locations. Rarely, but on occasion, a small bruise can occur from needling which will resolve as bruises normally do.

2. Far Infrared Heat treatments known to expand capillaries to increase blood flow and detoxifies the body by enabling the elimination of toxins, lactic acid and heavy metals.

3. A technique call "gua sha" or “cupping” that eases the pain of aching muscles. This treatment leaves redness on the skin that can last for 1-5 days and is essential for the treatment to be effective. Slight tenderness may occur after the treatment and resolves shortly thereafter.

Furthermore:

- I understand that I may feel extremely relaxed following treatment and therefore I am welcome to remain in the waiting room until I feel comfortable departing.
- I know I have the right to refuse any form of treatment, and that I can ask questions pertaining to the treatment at any time.
- I also understand that while acupuncture is considered extremely safe, there is always a small possibility of an unexpected complication and that no guarantees can be made concerning the results of treatment.

Please sign below to indicate that you understand both the cancellation policy and consent to treatment:

_____ Date:_____

Signature

_____

Name (please print)

CAMA
COMMUNITY ACUPUNCTURE OF MOUNT AIRY

HIPAA Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Community Acupuncture of Mt. Airy (CAMA) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for my diagnosis and diagnosis codes to any receipt I may request
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

If desired, I can request a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the CAMA is not required to agree to the restrictions requested if required by law.

I understand that I may revoke this consent in writing, except to the extent that the CAMA has already take action in reliance thereon, and am aware that upon request at reception, I can be provided with a HIPAA Compliance Assurance Notification to review.

At this time, I request the following restrictions to the use or disclosure of my health information: (write your request here)

Signature of Patient or Legal Representative:

Print Name: _____

Signature_____ Date: _____