Welcome to
Schmidt Chiropractic Center
320 Hill Street Norwood Young America, MN 55368

Acupuncture Confidential Patient Intake Form

Name: ____ Date: ______________
(First) (MI) (Last)

Address: ____
(Street Address) (City) (State) (Zip Code)

Home Phone #: ________________________ Cell Phone #: ________________________

Email Address: ________________________________ Marital Status: M S D W

Date of Birth: ________________ Age: _______

Parent/Guardian Name(s) if patient is a Minor: ____

How did you hear about our office? ◯ Family ◯ Friend ◯ Newspaper ◯ Facebook

◯ Waconia Business Newsletter ◯ Community Event ◯ Other ______________________

Whom can we thank for referring you? ____

Employment Information

Occupation: ______________________ Employer: ___________________________

Please mark if your situation is the result of…

- ❑ Work Injury
- ❑ Auto Accident
- ❑ Farm Injury/Accident
- ❑ Other:________________________ Date of Injury:_____________________

Healthcare Providers

Emergency Contact: _____________________ Contact #:_______________________

Relationship: ______________________

Name of your Primary Medical Doctor and Clinic: ___________________________________

Last seen: __________________ Reason for visit: ____________________________

Medical History

Surgeries, injuries, hospitalizations:

____

____

____

Do you have any infectious diseases: ◯ Yes ◯ No Type: ______________________________

Autoimmune disease? : ◯Yes ◯No Type: ____

Cancer: ◯ You ◯Family member Year: ______________ Type: ______________________________

Are you in recovery? ____

Any recent major life change ____

Diabetes	___You	____Family member	Year: ______________
Hepatitis	___You	____Family member	Year: ______________
Heart disease	___You	____Family member	Year: ______________
Stroke	___You	____Family member	Year: ______________
Pacemaker	___You	____Family member	Year: ______________
Seizure disorder	___You	____Family member	Year: ______________
Thyroid disease	___You	____Family member	Year: ______________
Osteoporosis	___You	____Family member	Year: ______________
Kidney Disease	___You	____Family member	Year: ______________
Anemia	___You	____Family member	Year: ______________
Rheumatic Fever	___You	____Family member	Year: ______________
Alcoholism	___You	____Family member	Year: ______________
Recreation drug use	___You	____Family member	Year: ______________

Would you like support cutting back on any addictive habits? _____ Yes ____ No Type? __________________

Allergies: ____

____

Medications/ Supplements: ____

____

____

Your Height: _______________ Weight: _________________ Age: __________________

Number of Children: _______________________ Ages of children: ______________________

Health History

Please check all that apply:

<table>
<tr>
<td>Cardiovascular
__ Heart Disease
__ Pacemaker
__ High BP
__ Low BP
__ Chest Pain
__ Palpitations
__ Stroke
__ Varicose Veins
__ Edema</td>
<td>Emotional/ Mental
__ Clinical Depression
__ Mild Depression
__ Add or ADHD
__ Schizophrenia
__ Mood Swings
__ Panic Attacks
__ Nervousness
__ Anxiety
__ Alzheimer’s
__ Dementia</td>
<td>Energy & Immunity
__ Chronic Fatigue
__ General Fatigue
__ Slow Wound Healing
__ Easy Bruising
__ Chronic Infections
__ Frequent Allergies</td>
<td>Respiratory
__ Pneumonia
__ Asthma
__ Frequent Common Colds
__ Difficulty Breathing
__ Emphysema
__ Persistent Cough
__ Pleurisy
__ Tuberculosis
__ Shortness of breath</td>
</tr>
<tr>
<td>Musculo-Skeletal
__ Neck/Shoulder Pain
__ Muscle Spasm/cramps
__ Arm Pain
__ Upper Back Pain
__ Mid Back Pain
__ Lower Back Pain
__ Leg Pain
__ Osteoporosis
__ Arthritis
__ Joint Pain</td>
<td>Head, Eye, Ear, Nose & Throat
__ Impaired Vision
__ Eye Pain/Strain
__ Glaucoma
__ Glasses/Contacts
__ Tearing/Dryness
__ Impaired Hearing
__ Ear Ringing
__ Earaches
__ Ear Infections
__ Headaches
__ Sinus Problems
__ Nose Bleeds
__ Teeth Grinding
__ Frequent Sore throat
__ TMJ / Jaw problems
__ Hay Fever</td>
<td>Gastrointestinal
__ Stomach Ulcers
__ Changes in Appetite
__ Nausea/vomiting
__ Epigastric Abdominal Pain
__ Passing Gas
__ Heart Burn
__ Belching
__ Gall Bladder Disease
__ Gall Bladder Stones
__ Hemorrhoids
__ Constipation
__ Diarrhea
__ Irritable Bowel Syndrome
__ Leaky Gut Syndrome</td>
<td>Endocrine
__ Hypothyroid
__ Hypoglycemia
__ Hyperthyroid
__ Diabetes Type I
__ Diabetes Type II
__ Night Sweats
__ Unusual Sweating
__ Feeling Hot or Cold</td>
</tr>
<tr>
<td>Neurological
__ Vertigo
__ Paralysis
__ Numbness/Tingling
__ Loss of Balance
__ Seizures / Epilepsy</td>
<td>Genito-Urinary Tract
__ Kidney Disease
__ Kidney Stones
__ Painful Urination
__ Dribbling Urination
__ Frequent Urination
__ Frequent UTI
__ Blood in Urine
__ Incontinence</td>
<td></td>
<td></td>
</tr>
</table>

Reason for your visit today?

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____

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How long have you had this condition: ____

Has this condition been diagnosed by a MD? ◯ Yes ◯ No Diagnosis? ________________________

Have you been treated by anyone else for this condition? ◯ Yes ◯ No

Have these treatments helped? Specify: ____

Have you seen an acupuncturist in the past? ◯ Yes ◯ No

Name of Acupuncturist? ____

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Financial Policy

Time of Service - Cash Rate

Patients are required to pay for their acupuncture treatment the same day treatment is received at this clinic. By paying same day, you will be eligible for a ***Time of Service*** rate of $65.00 per treatment. By law, our clinic is also required to administer an initial exam. The cash rate for this one time initial exam service is $100.00. Time of Service cash rates do not apply toward your annual out-of-pocket spending limits or yearly deductible. Cash, checks, all major credit cards or HSA/Flex spending cards are all forms of cash payments. If patient account is 90 days delinquent, account will be turned over to a credit agency.

Please note: Time of Service rate fees will not be submitted to any insurance.

☐ I choose to pay the *Time of Service Rate* of $65.00 for my acupuncture treatment.

Cancellation policy:

As a courtesy, please remember to call us as soon as you know that you will be unable to make your schedule appointment and we'd be happy to rebook it for you.

If you miss an appointment or fail to give us a call you cannot make it to your appointment you will be billed for 50% of your service total. I understand and a agree to these terms and understand my account will be billed under the conditions stated.

____
Patient Signature Date

____
Printed Name

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture according the Minnesota State Law, on me (or the patient below, for whom I am legally responsible), by Katie Pierson, L. Ac. I understand that Katie Pierson, L. Ac completed a formal program of study from an accredited university, are certified by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), and are licensed with the State of Minnesota by the Minnesota Board of Medical Practice.

I understand that the forms of therapy stated below, which have the benefits to treat specific types of problems will be following the Oriental Medical Theory to access, diagnose a patient, and to develop a plan to treat a patient.

I understand that forms of therapy may include, but not limited to:

- Acupuncture
- Cupping
- Moxibustion
- Dermal Friction
- Electro Stimulation
- Tuina
- Herbal therapies
- Nutritional counseling based on Traditional Chinese Medicine principles

Risks of the above forms of therapy include:

- Acupuncture needles inserted into the skin can cause **pain or discomfort, bruising, infection, risks of feeling weak, fainting or nausea, and broken needles**. Risk of fainting, weakness and nausea are increased with an empty stomach, alcohol, and drugs.
- Electro-acupuncture can cause some conditions to worsen. It should be used with caution in cases where patient has a heart condition. It should not be used across the midline of the body or with a pacemaker.
- Moxibustion can cause burns when used in areas with compromised sensation and/or circulation or when improperly used.
- Acupressure, cupping, Tuina massage and dermal friction may cause bruising and/or soreness.
- Herbs have different properties and may have adverse reactions/side effects if improperly used.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist or clinical staff to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interests. I understand the results are not guaranteed.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I do / do not have a pacemaker.
I do / do not have a bleeding disorder.
I have been / have not been examined by a physician or other licensed health care provider for what I am being treated for today.
-You are advised to see you physician about the problem for which you have come here to be treated-

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Patient Signature (or patient representative; indicate relationship if signing for patient) **Date**

Practitioner Signature **Date**