



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:

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

Reason for your visit today?

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 \$70.00 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 \$70.00 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 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 to 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, is certified by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), and is 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 assess, 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 your physician about the problem for which you have come here to be treated-

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

Date

Practitioner Signature

Date