



Renewed Health Acupuncture and Herbal Medicine
893 N. IH-35, Suite 140
Round Rock, TX 78664
(512) 341-9900

Patient Intake

Thank you for choosing Renewed Health as your wellness provider. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have any questions, please ask. Thank you. **Date** ___/___/___

Patient Name: (first) _____ (last) _____ (middle init.) _____
(preferred to be called) _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Male Female

Date of Birth: _____

Marital Status: S M D W

Emergency Contact

Name: _____

Phone: _____

Relationship: _____

Phone: (home) _____

(work) _____

(cell) _____

E-mail: _____

Family Physician: _____

Do you have health insurance? Yes No If yes, does your insurance cover Acupuncture? Yes No

How did you find out about us? _____

Current Health:

What health concerns brought you here today: (list in order of importance)

1) Condition: _____ Past Treatment: _____

2) Condition: _____ Past Treatment: _____

Any other health concerns that you may want to address in the future: (list in order of importance)

1) Condition: _____ Past Treatment: _____

2) Condition: _____ Past Treatment: _____

Is there any chance you might be pregnant? Y N Hepatitis: Y N If Yes, type: (A/B/C/D) HIV/AIDS: Y N

Pacemaker? Y N Chronic infectious diseases? Y N Height: _____ Weight: _____

Significant Illness (please include month/year when the diagnosis was established)

Cancer _____ Thyroid disease _____ Diabetes _____ Seizures _____

Arthritis _____ Tuberculosis _____ Anemia _____ Sexually transmitted diseases _____

Fibromialgia _____ Heart disease _____ Emotional imbalance _____ Breathing problems _____

Past Medical History: (Please check if you have or have had any of the following diseases or conditions in the last 3 months)

General None

- Poor appetite Change in appetite Weight loss Weight Gain Cravings Peculiar tastes Bleed/bruise easily
 - Poor balance Sweat easily Fatigue Tremors Localized Weakness Strong thirst
 - Poor sleep Night sweats Fevers Chills Desire cold food Desire hot food
 - Chronic infections Slow wound healing Sudden energy drop (What time of day) _____
- Stress level: High Medium Low Is it manageable? Y N Cause: _____

Head, Ear, Eyes, Nose, Throat None

- Poor vision Night blindness Eye floaters Eye tearing/dryness Headaches Migraines Sinus/Allergies
- Poor Hearing Ear ringing Earaches TMJ/jaw problems Frequent sore throat Facial pain
- Nose bleeds Dizziness Teeth/gum problems Other: _____

Cardiovascular None

- High blood pressure Irregular heartbeat Heart disease Chest pain Stoke Heart attack Palpitations
- Low blood pressure Swelling of ankles Varicose veins Other: _____

Respiratory None

- Asthma Shortness of breath Chest pain Cough Coughing blood Phlegm – what color? _____
- Wheezing Difficulty breathing Bronchitis Pneumonia Frequent common colds

Gastrointestinal None

- Ulcers Nausea Indigestion Abdominal pain/cramps Liver disease Parasites Bad breath
 - Belching Vomiting Hemorrhoids Gall bladder problems Rectal pain Gas Chronic laxative use
- Stool:** Black stools Blood in stools Undigested food Diarrhea Constipation

Bowel Movements: # per day/week _____ Color _____ Extreme Odor _____ Texture/form _____

Genital/Urinary None

- Pain on urination Urgent to urinate How many times do you urinate/day? _____ (scanty or profuse)
- Blood in urine Trouble holding urine Dribbling Kidney stones Pain of genital Itching of genital
- Frequent urinary tract infections Vaginal/genital discharge

Neurological/Emotional None

- Lack of coordination Concussion Depression Anxiety Easily angered Bi-polar Vertigo/dizziness
- Numbness/tingling Paralysis Frequent headaches Difficulty Concentrating

Male Reproductive None

- Prostrate problems Testicular pain/swelling Impotence Fertility problems Ejaculation problems
- Sexual difficulties: Explain _____

Female Reproductive/Breasts None

Frequent vaginal infections Endometriosis Fibroids Ovarian cysts Hot flashes Fertility problems

Breast lumps Breast tenderness Menopausal symptoms

On birth control For how long? _____ What type? _____

Sexual difficulties/pain during sex

Menses: How many days is cycle? _____ How many days does menses last? _____ Cramping/pain? _____

Describe typical flow? _____ Any clots (describe)? _____

Any bleeding between normal periods? Y N Moodiness related to menses? Y N PMS? Y N

First date of last period: _____ Age of first menses: _____

Pregnancies _____ # Births _____ # Miscarriages _____ # Abortions _____ # Premature births _____

Cesareans _____ # Difficult births _____

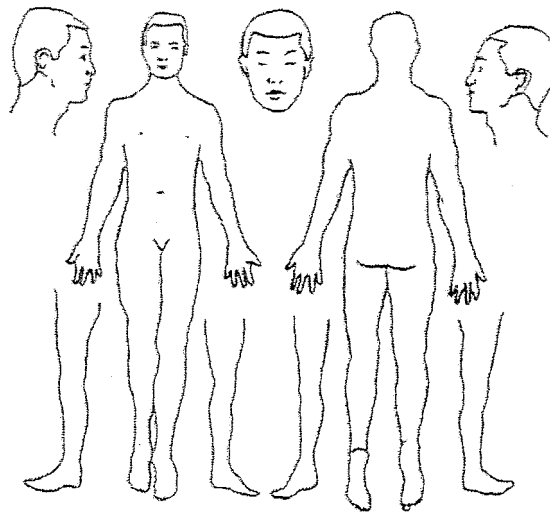
Musculoskeletal None

Neck/shoulder pain Sciatica pain Joint pain Upper back pain Middle back pain Lower back pain

Muscle spasm/cramps Arm pain Leg pain Weak muscles Cold hands/feet Spinal curvature

Hernia Knee pain Hip pain

Indicate painful or distressed areas: place an "X" over severe pain or an "O" over dull pain areas



Surgeries/ Hospitalizations:

Trauma (auto accidents, sports injuries, etc): _____

Allergies (drugs, chemicals, food): _____

Any other conditions: _____

Current Medications: (including prescriptions, vitamins, OTC drugs, herbs)

Family Medical History:

Please indicate if any immediate family members have had the following diseases.

	<u>Relation</u>
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Asthma	_____

Other: _____

Lifestyle:

Typical daily food intake: Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much coffee/day? _____ Tea/day? _____ # Sodas/day? _____ Water/day? _____

Vegetarian? Y N Yes, but not so strict Do you eat a lot of spicy food? Y N

Exercise: Do you get daily exercise? Y N How often? _____ What kind? _____

Sleep: Do you fall asleep easily? Y N Wake during the night? Y N How many times? _____

If waking, what wakes you? _____

Able to fall back asleep? Y N Wake refreshed? Y N How many hours/night? _____

Education: _____

Occupation: _____ How many hours do you work per week? _____

Do you enjoy your work? Y N Why/why not? _____

Habits: Do you use tobacco? Y N What type? _____ How many times a day? _____ Since when? _____

Do you use any drugs for non-medical purposes? Y N Explain: _____

What kind of alcohol beverage do you usually drink? _____ Ave. # drinks per week: _____

I understand that the above information is complete and is correct to the best of my knowledge.

Signature: _____ Adult patient Parent/guardian Spouse

Physician Evaluation

Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture

I (patient’s name) _____, am notifying the licensed acupuncturist of **one** of the following:

1) I have been evaluated by a physician or dentist for the condition(s) being treated within the 6 months before this acupuncture treatment was performed. Yes ____ No ____

I recognize that I should be evaluated by a physician for the current condition(s) or any future condition(s) treated by the licensed acupuncturist _____ (patient initials)

2) I understand that the following conditions do not require evaluation from a physician within the last 6 months (please circle those that apply): Smoking Cessation Weight Loss Chronic Pain Cosmetic Facial Ac.

3) I have received a referral from my chiropractor within the last 30 days for acupuncture. Yes ____ No ____
After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the licensed acupuncturist is required to refer me to a physician. It is my responsibility and **choice** whether to follow this advice.

Signature of Patient _____ Date: _____

Financial Policy

Most conditions require an average of 6-12 treatments, although some will respond well within 4-6 visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint and how your body individually responds to the treatment.

Renewed Health is a Blue Cross Blue Shield provider and does accept insurance. Your insurance will be verified for in-network or out-of-network benefits. I understand that insurance verification is strictly an estimate and not a guarantee of payment according to my insurance company. I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services, that I will be directly responsible for payment to Renewed Health.

MasterCard, Visa, and Discover are accepted as well as cash and checks. Any checks with insufficient funds will be charged an additional \$30 by this clinic.

Your appointment time is reserved specifically for you. Cancellation of any appointment should be made within 24 hours prior to your scheduled time. We reserve the right to charge \$30 for cancellations less than 24 hours or for missed appointments.

Please indicate your understanding and acceptance of these policies by signing below.

Signature Printed Name Date

Fax to: 512-410-2322

TAX ID# 26-3792216

NPI# 1538308671

Insurance Benefit Verification

Date: ____/____/____

Contact Phone #: _____

Patient Name: _____ DOB: _____

Patient Address: _____ City/St/Zip: _____

Primary Policy holder: _____ DOB: _____

Insurance : _____ Ins. Phone#: _____

Policy ID#: _____ Group #: _____

General Complaint: _____

Upon verification of your acupuncture, your insurance company has informed us that you are covered as follows: effective date: _____

Deductible: _____ Co-insurance: _____ calendar year or plan year

Max number of visits or dollars per year for Acupuncture: _____

THIS MEANS:

At each visit you are responsible for \$ _____ until your deductible has been met (which is approximately _____ visits). Thereafter you will be responsible for \$ _____ for the remaining _____ visits for each year.

OR:

At each visit your are responsible for a co-payment of \$ _____ for a maximum of _____ visits per year.

I have read and understand my acupuncture benefits as explained to me. I also understand that this is strictly an estimate and not a guarantee of payment according to my insurance company. I authorize payment of medical benefits to Renewed Health for my treatments. I authorize the release of medical records or other information necessary for the processing of my claims. I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services, that I will be directly responsible for no more than \$70 per visit.

Patient's Signature: _____ Date: ____/____/____

Verified By: _____ Date: ____/____/____ Spoke to : _____ @ _____