VITALITY ACUPUNCTURE + INTEGRATIVE MEDICINE

9100 WHITEBLUFF ROAD · SUITE 601 · SAVANNAH, GEORGIA 31406
(912) 308 - 1103

Information for New Patients

Fees:	Initial Visit	$125.00
	Once per week	$65.00
	Twice per week	$50.00 each visit ($100.00 for the week)

Welcome to Vitality Acupuncture + Integrative Medicine. Your initial visit lasts about 1 hour and 30 minutes and will take more time than the follow up visits. During the initial visit, we examine your medical history and ask any additional questions to better understand your healthcare needs. Follow up visits last about an hour.

Appointments: Our office is open Monday – Friday and Saturdays upon request. **If you cannot keep an appointment please give us 24 hour notice; otherwise, you will be charged for the appointment time.** Even on days we are not seeing patients, our phone messages are checked regularly, so your notice allows us time to notify other patients who may be on the waiting list.

Payments: We accept cash, checks, debit, and most major credit cards. If you have multiple visits scheduled in a week, payment is to be made at the first visit of the week. Checks may be made out to Vitality. Returned checks will incur a $50.00 service fee.

If you have any questions or concerns please feel free to call or email us. If you get our voicemail, please leave a message and we will return your call as soon as possible.

Once again welcome to Vitality Acupuncture + Integrative Medicine, we want your experience here to be nurturing and relaxing. If there is anything else we can do please let us know.

** Complimentary medicine and therapies are meant to complement traditional or conventional medicine and do not take the place of appropriate medical advice.*

I have read and understand all of the above information:

Name (print) _____ Date _____

Signature _____

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PATIENT INFORMATION AND CONSENT FORM

(Please read this information carefully and ask your practitioner if there is anything that you do not understand.)

WHAT IS ACUPUNCTURE?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

IS ACUPUNCTURE SAFE?

Acupuncture is generally very safe. Serious side effects are rare – less than one per 10,000 treatments.

DOES ACUPUNCTURE HAVE SIDE EFFECTS?

You need to be aware that:

- Drowsiness occurs after treatment in a small number of patients and, if affected, you are advised not to drive.
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments.
- Pain during treatment occurs in about 1% of treatments.
- Symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign.
- Fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

IS THERE ANYTHING YOUR PRACTITIONER NEEDS TO KNOW?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a seizure, dizziness, or fainting episode
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medications
- If you have damaged heart valves or have any other particular risk of infection

SINGLE-USE, STERILE, DISPOSABLE NEEDLES ARE USED IN THE CLINIC.

STATEMENT OF CONSENT

I confirm that I have read and understood the above information and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature_____

Print name in full _____

Date _____

Patient Intake Form

Name:

Street	E-mail :	
City	Phone: Home	Work
State Zip	Birthdate	Age Ht. Wt.
Referred By:	Occupation:	Sex
Physician:		
Main Problem:		Onset:
Other Concurrent Therapies		Emerg. #:

Past Medical History (include date):

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other.

Surgeries:

Significant Trauma (auto accidents, falls, etc.)

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological,etc.)

Exercise:

Comments:

Average daily diet:

Morning *Afternoon* *Evening*

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Family Medical History: ___Diabetes ___Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___ Seizures ___ Asthma ___Allergies ___Alcoholism ___ Other _____

Notes _____

GENERAL

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Insomnia
- ☐ Fatigue
- ☐ Tremors
- ☐ Vertigo
- ☐ Cold hands
- ☐ Cold feet
- ☐ Cold back
- ☐ Cold abdomen
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Cravings
- ☐ Localized weakness
- ☐ Poor coordination
- ☐ Change in appetite
- ☐ Sudden energy drop at _____ (time)
- ☐ Peculiar tastes/smells_____
- ☐ Strong thirst (cold/hot drinks) _____
- ☐ Bleed or bruise easily (where) _____

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Change in hair/skin texture
- ☐ Purpura
- ☐ Other hair or skin problem_____

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glassses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Mucus
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Copius saliva
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Gum problems
- ☐ Spots in eyes
- ☐ Recurrent sore throats _____/month
- ☐ Sores on lips or tongue
- ☐ Headaches (where and when) _____
- ☐ Other head or neck problems _____

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest Pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Difficulty in breathing when lying down ☐ Tight chest
☐ Production of phlegm _____what color _____ ☐ Other lung problems

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools _____Frequency
☐ Bad Breath ☐ Rectal pain ☐ Hemorrhoids _____Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____Odor
☐ Pain or cramps ☐ Laxative use:_____ /week; type _____ _____Texture/form

GENITO-URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency
☐ Wake up to urinate How often_____/night; time:_____ ☐ Other G/U problems

PREGNANCY AND GYNECOLOGY

☐ Number pregnancies ☐ Number births ☐ Premature births ☐ Miscarriages
☐ Age at first menses ☐ Period (days) ☐ Duration ☐ Irregular periods
☐ Flow (describe) ☐ Clots Last PAP_____ Last menses _____
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps Menopause _____
☐ Birth control type and duration _____ ☐ Changes in body/psyche prior to menstruation

MUSCULOSKELETAL

☐ Neck pain ☐ Mucscle pains ☐ Back pain(where) ☐ Joint pains(where)
☐ Other joint or bone problems?

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Treated for emotional problems ☐ Considered/attempted suicide
☐ Other neurological or psychological problems?

COMMENTS