VITALITY ACUPUNCTURE + INTEGRATIVE MEDICINE
716 EAST 71st STREET SAVANNAH, GA 31405

Information for New Patients

Welcome to Vitality Acupuncture + Integrative Medicine. We want your experience here to be nurturing and relaxing so please let us know if there is anything we can do to make your visit more comfortable.

Payments: We accept cash, checks, debit, and most major credit cards. Payment is to be made at the time of the visit. Checks may be made out to Vitality. All returned checks will incur a $50.00 service fee.

Acupuncture Fees (Self Pay):

Initial Visit	$130.00
Follow ups	$68.00

Insurance: We are happy to check on your policy and see if you have coverage for any of our services. If you are covered, we will bill the insurance company for you. Any services that are not covered will be charged at the time of your visit.

CANCELLATION POLICY

If you cannot keep an appointment please contact us at least 24 hours in advance to cancel or reschedule your appointment. We adhere to a strict cancellation policy and you will be charged for your scheduled appointment time if cancellation or rescheduling is less than 24 hours. Thank you for your time and understanding.

I_____(print name), have read and understand the above policy and acknowledge that I will be charged the full cost of the appointment if I cancel or reschedule with less than a 24 hour notice. I give permission for Vitality Acupuncture + Integrative Medicine to keep a credit card on file and understand that this credit card will be charged for missed and late cancellation appointments.

Signature_____Date _____

Preferred Appointment Reminder Method: ☐ **Phone** ☐ **Email** ☐**Text**

Phone # or Email _____

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 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 your 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 electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medication
- If you have a 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 your name in full ___

_____ Date _____

PATIENT CONSENT FOR PRIVACY PRACTICES

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____	_____
Signature of Patient or Patient Representative	Date
_____	_____
Printed Name of Patient or Patient Representative	Relationship of Patient Representative

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