



VITALITY ACUPUNCTURE + INTEGRATIVE MEDICINE

716 EAST 71st STREET SAVANNAH, GA 31405

(912) 308 - 1103

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.

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

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

SKIN AND HAIR

- | | | | |
|--|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Purpura | <input type="checkbox"/> Other hair or skin problem _____ | |

HEAD, EYES, EARS, NOSE, AND THROAT

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

CARDIOVASCULAR

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

RESPIRATORY

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

GASTROINTESTINAL

- Nausea
- Gas
- Bad Breath
- Constipation
- Pain or cramps
- Vomiting
- Belching
- Rectal pain
- Bloody stools
- Laxative use: _____ /week; type _____
- Diarrhea
- Black stools
- Hemorrhoids
- Sensitive abdomen
- Bowel Movement:
 - _____ Frequency
 - _____ Color
 - _____ Odor
 - _____ Texture/form

GENITO-URINARY

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

PREGNANCY AND GYNECOLOGY

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

MUSCULOSKELETAL

- Neck pain
- Other joint or bone problems?
- Muscle pains
- Back pain(where) _____
- Joint pains(where) _____

NEUROPSYCHOLOGICAL

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

COMMENTS

