North Park Acupuncture, Inc.
Gayle Kildebeck, L.Ac
3080 North Park Way
San Diego, Ca 92104
Tel: 619-294-6616 Fax:619-294-6618

NEW PATIENT QUESTIONNAIRE

Date of first visit _____

Name _____ Home Number _____

Address _____ Cell Number _____

City _____ State _____ Zip _____ Email _____

Occupation _____ Marital Status _____ Number of Children _____

Date of Birth _____ Age _____ Height _____ Weight _____ Hand dominance? ☐ R ☐ L

Emergency contact _____ Relationship _____ Phone Number_____

Have you ever had Acupuncture? ☐ Y ☐ N For What? _____

Chiropractic? ☐ Y ☐ N For What? _____ Massage? ☐ Y ☐ N For What? _____

Referred by _____ Relationship _____

Do you have health insurance? ☐ Y ☐ N If yes, what company? _____

Please list your primary health concerns _____

_____

_____

PHYSICIAN'S USE ONLY

1 _____ 3 _____ 5 _____ T _____

2 _____ 4 _____ 6 _____ P _____

REVIEW OF HEALTH HISTORY

Patient Name _____ Date _____

Please list any surgeries, accidents, or injuries	Date	Physicians notes
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

List of allergies or sensitivities _____

_____

_____

Is there a family history of any of the following (Please check and indicate which family member)										
	Y	N	Who		Y	N	Who		Y	N	Who
Heart disease	☐	☐		Migraines	☐	☐		Osteoporosis	☐	☐	
High blood press.	☐	☐		Diabetes	☐	☐		Alzheimer's	☐	☐	
Low blood press.	☐	☐		Hepatitis	☐	☐		Parkinson's	☐	☐	
High cholesterol	☐	☐		Cancer	☐	☐		Thyroid Prob.	☐	☐	
Emotional prob.	☐	☐		Asthma	☐	☐		Arthritis	☐	☐	
Obesity	☐	☐		Anemia	☐	☐		AIDS/HIV	☐	☐	
Others:											
Have you had any of the above illnesses?											

Please indicate any use of the following							
	Y	N	Frequency and amount		Y	N	Frequency and amount
Tobacco	☐	☐		Soda Regular	☐	☐	
Coffee Regular	☐	☐		Soda Diet	☐	☐	
Coffee Decaf	☐	☐		Sweets and desserts	☐	☐	
Tea Caffeinated	☐	☐		Recreational Substances	☐	☐	
Tea decaf	☐	☐		Water	☐	☐	
Alcohol	☐	☐		Meditation	☐	☐	

Vitamins, supplements, and herbs (dose and frequency) _____

_____

_____

Prescription drugs (dose and frequency) _____

_____

_____

PAIN ASSESSMENT

Patient Name _____ Date _____

Chief Complaint(s) 1 _____ 2 _____

Is your present problem due to an injury ☐ On the Job ☐ Auto Accident ☐ Personal Injury ☐ Other _____

Did your pain begin ☐ Gradually ☐ Suddenly

Is your pain ☐ Constant ☐ Intermittent

Is your pain worse when you ☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other _____

Which of the following areas do you have the most pain, discomfort or restriction of motion

☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Upper Back

☐ Mid Back ☐ Low Back ☐ Pelvis ☐ Hips ☐ Legs

☐ Knees ☐ Feet ☐ Other _____

Using the following chart, how would you rate your pain in percentages when you

Occasionally = 33%
Frequently = 34-66%
Constantly = 67-100%

Sit _____% of the time

Stand _____% of the time

Walk _____% of the time

Rate the severity of your pain by checking one box on the following scale

10 = Extreme Pain
1= least pain

Extreme

10
9
8
7
6
5
4
3
2
1
0

None

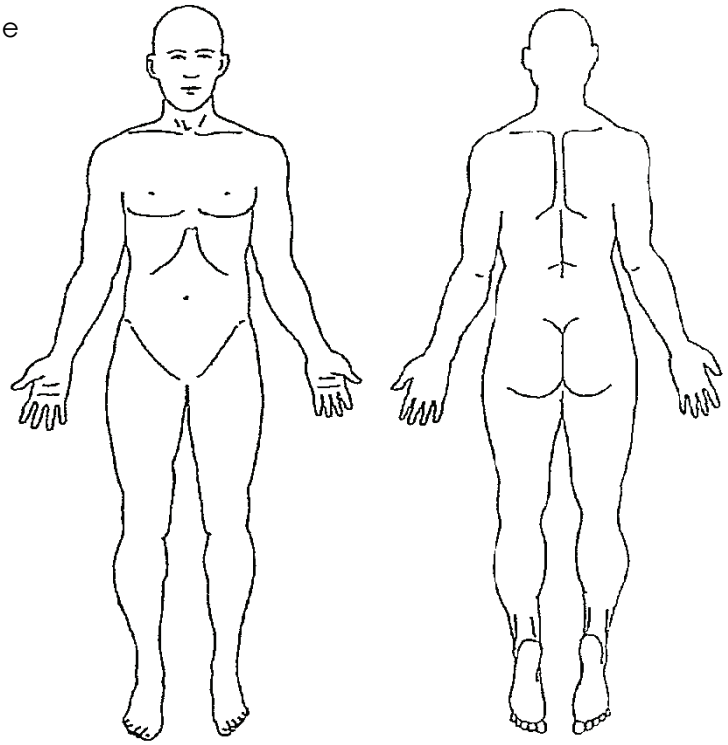
Circle the areas of pain on the figure to the right. Then indicate the type of pain using the codes below:

+++ Burning

- - - Sharp

000 Stabbing

III Constant



Does your pain interfere with your ☐ Work ☐ Sleep ☐ Daily Routines

Do you feel your present condition is ☐ Temporary ☐ Permanent ☐ Not Sure

List as additional comments you wish to make regarding your condition _____

_____

_____

Patient Signature _____

North Park Acupuncture, Inc.
Gayle Kildebeck, L.Ac
3080 North Park Way
San Diego, Ca 92104
Tel: 619-294-6616 Fax:619-294-6618

LATE CANCEL POLICY

When you schedule your acupuncture appointments you are making a commitment to your health and your well-being. Making an appointment is a time and money commitment that we make to each other. Cancelling your appointment without sufficient notice creates a loss situation for all of us. You aren't getting the health support that you need, other patients are prevented from scheduling that treatment time, and the clinic loses the financial support that sustains it.

In effort to support you in keeping your appointments we will:

- Call you at least 24 hours prior to confirm your appointments.
- Offer you a reminder card with the date and time of your appointment.
- Email an appointment confirmation to you.
- Keep a waiting list for people who want appointments on that day so it will be easier to fill a missed appointment.
- Provide a 24-hour voicemail system that will time stamp your cancellation message.

Please sign your agreement to the following statement:
I agree and commit to keep my scheduled appointments to the best of my ability. I will call 24 hours prior to my appointment if I cannot keep my scheduled appointment or by noon on Saturday for Monday appointments. If I fail to do this, I understand that I will be charged twenty- five dollars ($25.00) for a missed appointment. I understand that insurance does not cover missed appointment fees and therefore the $25.00 fee is my sole responsibility.

_____ _____ _____
Signature Print Name Date

North Park Acupuncture, Inc.
Gayle Kildebeck, L.Ac
3080 North Park Way
San Diego, Ca 92104
Tel: 619-294-6616 Fax:619-294-6618

BILLING ACKNOWLEDGEMENT OF THERAPY NOT COVERED BY INSURANCE

It is the policy of North Park Acupuncture to provide the highest standard of care to our patients. In doing so, we recommend additional procedures and services which augment patient care. These procedures however may not be covered by a patient's HMO, PPO, insurance company, or health plan under the terms of their benefit plan.

One procedure we offer and recommend is Cupping and Soft Tissue Manipulation. Cupping and massage releases rigid soft tissue, drains excess fluids and toxins, loosens adhesions, lifts connective tissue, and brings blood flow to stagnant skin and muscles. It is an excellent modality for releasing chronically held muscle tissue and holding patterns that are the main causes of physical pain. It gets to places that acupuncture alone just cannot reach. If you choose to receive this additional level of care please complete and sign this form.

I acknowledge that a certain portion of my care will not be covered by my HMO, PPO, insurance company, or health plan under the terms of my benefit plan. I understand and agree and elect to be responsible to self-pay for the following procedure:

Code: 97139 / 97140 Cupping and Soft Tissue Manipulation Fee: $15.00

I agree that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my acupuncture provider to pay for this procedure myself.

Patient Name (Please Print) _____

Patient Signature _____

Date _____