The Point Acupuncture – Initial Intake Form

Personal Information

Name:________________________ Age:_________ Birth Date:_________________

Address:___________________________ City:_________________ State:________ Zip:________

Cell phone:_________________________ Do you accept text messages: Yes/No

Email:_______________________________ Occupation:_________________________________

Referral Source:_____________________________ Primary Care Provider:________________________

Emergency Contact:__________________________ Phone:____________________________

Main Concerns

Please identify your main health concerns:

1. ____

When did this start? ____

How did this start? ____

What makes it better? ____

What makes it worse? ____

What other treatments have you tried? ____

On a scale of 1-10 how much does this affect your daily life? 1 2 3 4 5 6 7 8 9 10

2. ____

When did this start? ____

How did this start? ____

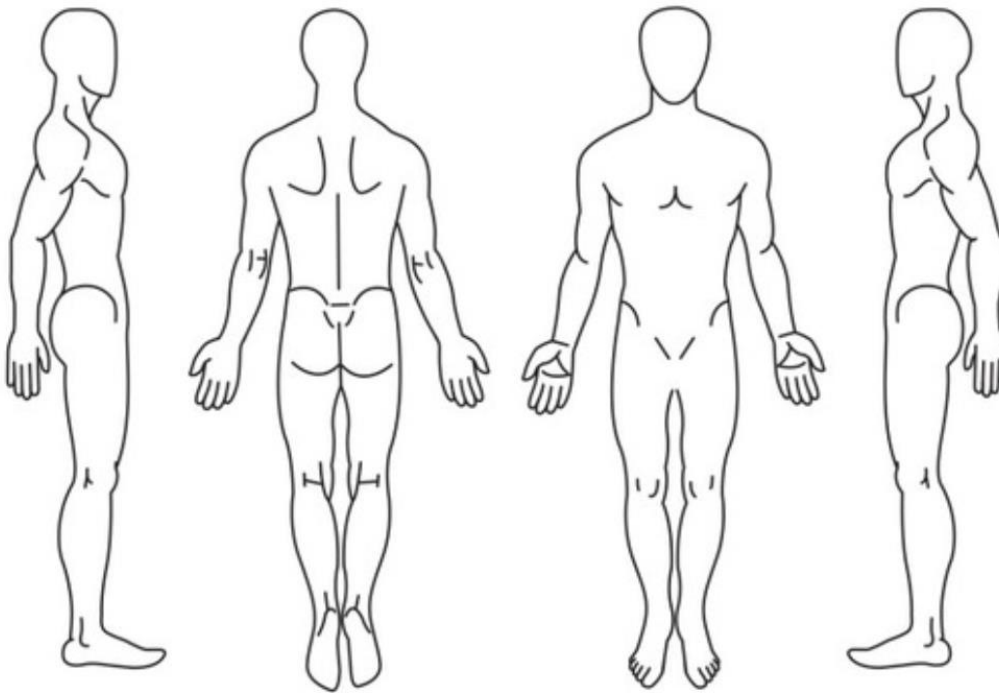
What makes it better? ____

What makes it worse? ____

What other treatments have you tried? ____

On a scale of 1-10 how much does this affect your daily life? 1 2 3 4 5 6 7 8 9 10

Please indicate all areas of pain:



Please circle the qualities of the pain(s):

Dull Sharp Aching Burning Fixed Moving Intermittent Constant Other

Personal Medical History *(Please include your childhood history)*

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor vehicle accidents, fractures, etc.)	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

Have you ever been diagnosed with any of the following conditions?

- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Kidney Stones
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Cancer
- ❑ Blood disorder
- ❑ High/Low BP
- ❑ Diabetes
- ❑ Obesity
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Arthritis
- ❑ Mental Illness
- ❑ Measles
- ❑ Mumps
- ❑ STD
- ❑ HIV/AIDS
- ❑ Systemic Infection
- ❑ Gout

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Large Appetite
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Hot Flashes
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Cold Hands/Feet
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Restlessness
- ❑ Frequent Dreams
- ❑ Weight Gain
- ❑ Weight Loss

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Pain
- ❑ Dry Eyes
- ❑ Itchy Eyes
- ❑ Blurry Vision
- ❑ Night Blindness
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Sinus Problems
- ❑ Nose bleeds
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Bleeding gums
- ❑ Migraines
- ❑ Headaches
- ❑ Concussions
- ❑ Poor Hearing
- ❑ TMJ Pain
- ❑ Recurrent sore throat
- ❑ Floaters
- ❑ Sinus congestion

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Cardiovascular

- ❑ High Blood Pressure
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Chronic Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Heartburn/Reflux
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Fatigue after meals
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Gas
- ❑ Belching
- ❑ Bloating

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Waking to Urinate

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Worry
- ❑ Mental Fogginess
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings
- ❑ Overthinking

Musculo-Skeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain with Weather Changes
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Pain with Activity
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Pain After Waking

Gynecology

______ Age of Menses
______ Duration of Menses
______ Date of Last Menses
______ # of Pregnancies
______ # of Births

- ❑ Irregular Periods
- ❑ Painful Periods
- ❑ Breast Lumps
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems

What are your health goals? ____
How often do you exercise? ______________________ How do you exercise? ______________________
How many ounces of water do you drink daily? ____
Do you have a pacemaker? Yes No
Are you pregnant? Yes No

Jordan Burk
544 Main St. Ste. 2
Shelbyville, KY 40065
Phone: 502-437-4613

The Point Acupuncture
MANDATORY DISCLOSURE STATEMENT

Education and Experience

Jordan Burk earned his Master of Acupuncture and Oriental Medicine degree from Southwest Acupuncture College in Boulder, CO in August 2016. This four-year program consists of 3,500 hours of education including 1,000 hours of clinical practice. He was certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2016. This includes certification in Clean Needle Technique and Chinese Herbology.

Jordan's training includes adjunctive therapies such as moxibustion, tui-na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations.
He is a registered acupuncturist in Kentucky. None of these licenses, certificates, or registrations has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Kentucky Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Initial Consultation and Treatment $125
Follow-up Treatment $90

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at anytime.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Executive Director of the Public Protection Cabinet in the Office of Occupations and Professions
- The practice of acupuncture is regulated by the Executive Director of the Public Protection Cabinet. If you have comments, questions, or complaints, contact the Office of Occupations and Professions, P.O. Box 1360 Frankfort, KY 40602. Telephone 502-564-3296

I have read and understand this document.

______________________________ ______________________________

Patient or Guardian's Signature Date

The Point Acupuncture
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

The Practice may use and/or disclose your PHI (Personal Health Information) for the purposes of:

Treatment: In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

Payment: In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

Health Care Operations: In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

Law Enforcement: Your PHI may be disclosed when required by law.

Other Uses and Disclosures: Excluding the above, your PHI will be disclosed only with your consent or authorization. If you refuse us authorization it will not affect the treatment we provide to you. You may revoke your authorization to us at any time. Your revocation must be in writing.

Your rights:
You have certain rights under the federal privacy standards. These rights include:

- The right to request restrictions on certain uses and disclosures of PHI.
- The right to receive confidential communications of PHI, as permitted by law.
- The right to inspect and copy PHI.
- The right to amend PHI, as permitted by law.
- The right to receive an accounting of disclosures of PHI.
- The right of an individual to obtain a paper copy of the notice, upon request.
- The right to complain to the covered entity and to the Secretary of Health and Human Services if an individual believes his or her privacy rights have been violated.

The Point Acupuncture REQUIREMENTS AND DUTIES
The Practice

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

If you have a question, comment, or complaint about our privacy practices please send a letter outlining your concerns to:
Privacy Officer/Administrator
The Point Acupuncture, LLC
544 Main St. Ste. 2
Shelbyville, Ky. 40065

Effective date: This notice is effective on or after July 10th, 2017.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have read and/or received a copy of the Notice of Privacy Practices for The Point Acupuncture

Name of Patient Date

Signature of Patient (Or Patient Representative) Relationship to Patient

The Point Acupuncture
ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINTED NAME:____

PATIENT SIGNATURE:___________________________________Date________________
(Or Patient Representative)