ACU-MED
INTEGRATIVE MEDICINE
1428 E. Racine Ave. Waukesha, WI 53186

Date: _____/_____/_____

Patient Information

Patient Name_____ DOB:____/____/_____ Age:____ Height:____'____" Weight:_____lbs

SS #/SIN_____-_____-_____ ☐ Male ☐ Female Home phone_____ Cell Phone _____

Address:_____City:_____ State:_____ Zip:_____

E-Mail (please print)_____

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's (or parent/guardian's) employer _____ work phone _____

Business Address _____ City _____ state _____ Zip _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____Relationship_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence. □Yes □No

If Responsible Party is other than the patient

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____SS#_____DOB:____/____/_____

Is the person currently a patient at our office? □ Yes □ No

Chief Complaint: _____ **Onset Date:** _____/_____/_____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

History of Present illness:

Location: _____ **Quality:** _____
(Where is the pain/problem?) (Example: pain as dull, aching, cramphistory ing, sharp, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this Pain/ problem? when did it start?)

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

modifying factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Associated signs/symptoms _____
(what other associated problems have you been having?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no" leave blank if you are uncertain.)

Measles……	NO YES	Anemia……..NO	YES	Back Trouble……NO	YES	Hepatitis……NO	YES
Mumps…….	NO YES	Bladder infection…….NO	YES	High Blood Pressure……NO	YES	Ulcer……NO	YES
Chicken Pox……	NO YES	Epilepsy……NO	YES	Low Blood pressure…….NO	YES	Kidney Disease……NO	YES
Whooping Cough…	NO YES	Migraine Headaches. NO	YES	Hemorrhoids……..NO	YES	Thyroid Disease……NO	YES
Scarlet Fever…….	NO YES	Tuberculosis……..NO	YES	Date of Last chest X-Ray_____		Bleeding Tendency…….NO	YES
Diphtheria……	NO YES	Diabetes……..NO	YES	Asthma……..NO	YES	Any Other Disease…….NO	YES
Small pox……	NO YES	Cancer……..NO	YES	Hives of Eczema……..NO	YES	(Please List):	
Pneumonia……	NO YES	Polio……..NO	YES	AIDS & HIV……NO	YES		
Rheumatic Fever…	NO YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	_____	
Arthritis……	NO YES	Hernia……NO	YES	Bronchitis……..NO	YES		
Venereal Disease…	NO YES	Blood or Plasma Transfusion……..NO	YES	Mitral Valve Prolapses….NO	YES	_____	
				Stroke……NO	YES		

Previous Hospitalizations/surgeries/serious illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family Medical History:

	Age	Disease	If Diseased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Smoking : ☐ smoker ☐ former Smoker ☐ Never Smoked ☐ Current every day smoker ☐ Current some day smoker
☐ light smoker ☐ heavy smoker

Allergies: Do you have any allergies: ☐ No ☐ Yes, please list :_____

Medication: (include nonprescription)

Medication	Dosage	Medication	Dosage

Functional Impairment and Treatment Goals:

How would your life change if you were pain-free and/or had increased activity tolerance? _____

If you were pain-free and/or you were physically able, what are some activities that you would like to participate in again:_____

What are 2 goals that you hope to accomplish by seeking treatment (i.e., clean the house without pain, play with your kids/grandkids for longer without pain, participate in sports again, have greater activity tolerance, bathe, dress, fix dinner without help, etc.):

1._____

2._____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Constitutional. (Health in General) ❑ No Problems, Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems, Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

Cardiovascular (Heart & Blood Vessels) ❑ No Problems, Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Respiratory (Lungs & Breathing) ❑ No Problems, Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

Gastrointestinal (Stomach & Intestines) ❑ No Problems, Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

Genitourinary (Kidney & Bladder) ❑ No Problems, Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

Musculoskeletal (Muscles, Bones, Joints) ❑ No Problems, Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integumentary (Skin, Hair & Breast) ❑ No Problems, Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems, Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems, Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrine (Glands) ❑ No Problems, Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems, Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems, Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:___

To The Best of My Knowledge, The questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my Responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

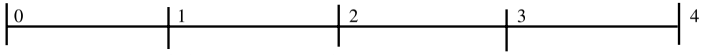
Provider Review : Signature of Provider:_____

Functional Rating Index

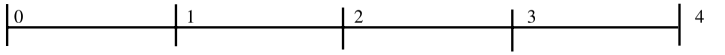
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

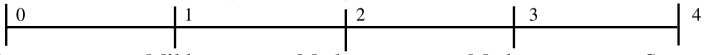
1. Pain Intensity



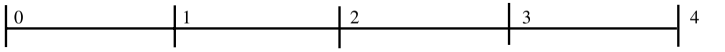
2. Sleeping



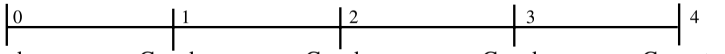
3. Personal Care (washing, dressing, etc.)



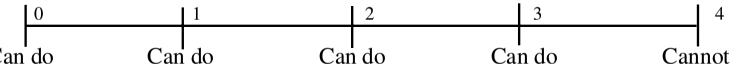
4. Travel (driving, etc.)



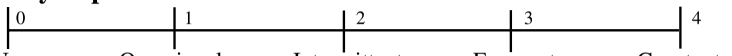
5. Work



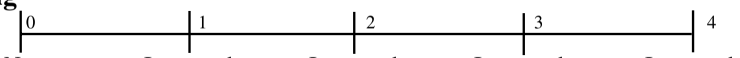
6. Recreation



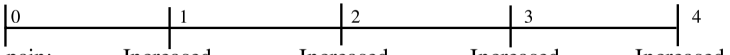
7. Frequency of pain



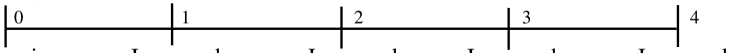
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

NOTICE OF PRIVACY PRACTICES (HIPPA)

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we will respect the privacy of your health information. You also acknowledge that you have received or reviewed a copy of our Notice of Privacy Practices. We reserve the right to change our privacy practices as described in that notice and we will advise you in writing of any change.

You have a right to refuse or revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before receiving your revocation request. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restriction on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restriction, the restriction is binding on us. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

By signing this Notice of Privacy Practices, you have authorized Acu-Med Integrative Medicine to disclose your health information in the manner described below:

You are giving us authorization to send the WCA information. We may need to disclose your name, address, phone number, billing information, and your clinical records to the Wisconsin Chiropractic Association (WCA). This disclosure will be made if we need the WCA's assistance to receive reimbursement for your services or, we need the WCA's assistance because the party responsible for reimbursing your services has improperly processed your claim. You may inspect or copy the information we may send to the WCA at any time. You are also authorizing the WCA to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, state or federal agencies that may be asked to intercede on your behalf.

You are giving us authorization to contact you and leave messages on your answering machine or with individuals at your home or place of employment. We may need to use your name, address, phone number, and/or clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are unavailable, a message will be left on your answering machine or with the person answering the phone.

We may need to disclose your health care information in the following circumstances. 1) To another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. 2) Billing records to another party if they are potentially responsible for the payment of your services. 3) Within our practice for quality control or other operational purposes.

You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to the address listed below. If you would like further information about our privacy policies and practices please contact: Acu-Med 1428 E. Racine Ave Waukesha, WI 53186

This notice is effective as of April 1, 2003. This notice will expire seven years after the date upon which you last received services from us. By signing below, I acknowledge that I have reviewed or received a copy of this notice and agree to its terms.

****Please request a complete copy of our Privacy Practices if you would like one for your records**.**

INFORMED CONSENT TO TREAT

I hereby consent that I have given the provider/doctor permission and authority to care for me in accordance with the proper training and licensing of his/her scope of practice.

I am giving my permission to the performance of acupuncture, chiropractic manipulation and/or manual therapy techniques, x-rays (where warranted), physical therapeutic modalities, physical rehabilitation, massage, cupping, electrical stimulation, ultrasound, chinese herbal medicine, and nutritional counseling.

I have been informed of potential risks of the following treatments:

Acupuncture: I have been informed that acupuncture is generally a 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, dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. 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. 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.

Chiropractic: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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.

Patient Signature:_____ Print Name: _____ Date: _____

Financial policy

_____ (Initial) I understand that all responsibility for payment of services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office endorse co-issued remittance for conveyances of credit to my account. In the event payment are not received by the agreed upon dates. I understand that a 1.5% finance charge (18%APR) will be added to my account. I agree to pay all attorneys and collection fees if this account is turned over for collection.

_____ (Initial)I understand it is my responsibility to read my insurance policy to assure that I am aware of any limitations of the benefits provided. It is my responsibility to pre-certify, authorize treatment, or receive necessary referrals for my services. I also understand it is my responsibility to notify the clinic of any changes in your insurance coverage.

_____ (Initial)I understand **if my insurance company sends me checks for any amount, I will notify this clinic immediately. If my insurance company sends me insurance payments and checks, my bills will automatically be my responsibility if I have not notified this clinic within 30 days of receipt.**

_____ (Initial) In order to give our patients the best possible care, we request that you review our policy regarding missed and/or cancelled appointments. Please remember that we have reserved your allotted appointment time especially for you. Therefore we request a **24-hour cancellation notice in order to reschedule your appointment. A fee will be charged if you fail to comply with the posted policy.**

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESTENATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of the health insurance of medical benefits I have) I am ultimately responsible to pay Acu-Med Integrative Medicine LLC, Wade Rex Lac or Dr. Joseph Beier,DC, Danielle Partain, DC, Natalie Peters,APNP, as well as employees, employers, representatives, and agents thereof, (herein collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been and will be** rendered or provided; as well as designating and appointment Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same.

I hereby assign directly to Healthcare Provider any and all rights to payment, benefits, and all other legal rights under or pursuant to, any health plan (including, but not limited to any ERISA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests treatments, or medications that have been previously provided by healthcare provider. A photocopy or scan of this document is to be considered as valid and enforceable as the original.

Signed this _____ day of _____, 20_____

X_____ X _____

(Patient Signature) (Print Name)