SkyAcupuncture
Functional Health Clinic

Intake Form

Welcome to Sky Acupuncture PLLC (SkyAcupuncture), we consider this information privileged physician/patient communication and holds it in confidence, following HIPPA Rules. Please print, fill out and bring this to clinic or email before visiting.

(Personal Information) Date: _____

Full Name				Occupation	
Date of Birth		Body	Height: Weight:	Sex	M___ F___
Address	(City) (State) (Zip)				
Phone		Email			
Emergency Contact	(Name) (Relationship) (Phone)				
Marital Status	Married, Single, Divorced, Separated, Widowed			# of Children	
Have you received acupuncture before? Yes_____ No_____ , If yes, When?					
How did you hear about us? Internet, Family, Friend, Local News, Direct Contact, Referred by ( )					
Family Physician: _____, or Chiropractor_____					
Diagnosis by Physician or Doctor? If you have:					

Notifying the Acupuncturist Whether He/She Has Been Evaluated by a Physician, and Other Information

(Pursuant to the requirements of '183.6(e) of this title (relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I(Patient) have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature:_____ Date: _____

Note:

Exemptions according to Rule 183.6 (e) Scope of Practice

3) ...an acupuncturist holding a current and valid license my without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.

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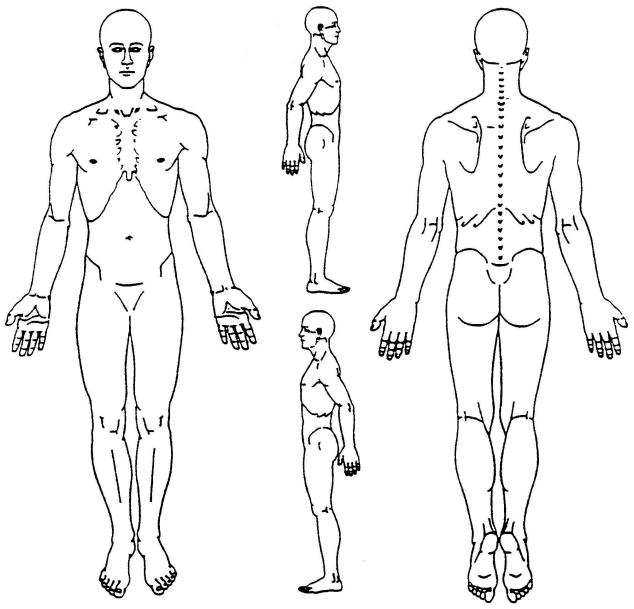
(Patient Medical History)

What is your major complaint (symptom)?	
When did it start?	How long has it persisted?
What kind of treatment have you tried? When: Who: What?	

(Pain or Symptoms Evaluation):



- Draw Circle location of Pain or Symptoms

- Mark your pain or symptoms level

0 (no pain) (Severe) 10

0	1	2	3	4	5	6	7	8	9	10

- Type of Pain or feeling on body

Burning, Stabbing, Dull, Numbness, Tingling, Itching,

- Others

(Medical History): Check your condition with P=Past, C=Current, F=Family

Diagnosis	P/C/F	Diagnosis	P/C/F	Diagnosis	P/C/F
High Blood Pressure		Migraines		Arthritis	
High Blood Sugar		Epilepsy/Seizures		Stroke/Alzheimer	
High Cholesterol		HIV (AIDS) or STD		Asthma or Eczema	
Emotional Disorder		Heart Disease		Digestive Disorder	
Alcoholism		Liver Disease		Autoimmune Disorder	
TMJ or Bell's Palsy		Kidney Disease		Nervous Disorder	
Sleep Disorder		Lung Disease		Others	

(Intaking Medicine or Supplements, Allergy Issues, Pace makers, Accident Trauma, Others)

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Consent Form

I (Name: _____) do hereby voluntarily consent to be treated with eastern medicine (acupuncture, cupping, moxibustion, Herbal therapy) by Junghee Kim (Joy) L.Ac./ Donghan Seo (David) L.Ac. at Sky Acupuncture PLLC.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), the prescription of herbal and nutritional counselling.

I understand that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. 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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts they known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I come here to receive treatment as above description, and understand that Acupuncture, herbs, and related treatments, as in any medical therapy, may make no guarantee to the results.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

Signature:_____ Date: _____

PAYMENT

We request payment at the time of services rendered. I understand that SkyAcupuncture reserves the right to charge me **$20** for cancellations made less than 12 hours before the appointment time. No Shows pay 50% of full cost of missed appointments. There is a $25 fee for all returned checks. Tardy policy is more than 15 min late without notice, and the penalty will be charged by $10. Payment is due at time of service.

Prepaid Treatment Plan (PTP) will be required for future visits that need to be paid on your first PTP's session. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Please note, PTP are valid for 4 months (for 10 treatments) from the date purchased. No refunds will be made if your plan is expired. Our office only accepts cash, check and all major credit cards.

Signature:_____ Date: _____

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Credit Card Authorization Form

Please Complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder Zip Code (from credit card billing address): _____
CVV (at back side): _____

I, _____, authorize Sky Acupuncture PLLC

to charge my credit card above for agreed upon service. I understand that my information will be saved to file for future transactions on my account.

Customer Signature: _____ Date: _____