

# NEW PATIENT INTAKE FORM

Katie Kapusnik L.Ac.

Name:

Date:

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Suffix \_\_\_\_\_ Sex: M/F

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ E-mail: \_\_\_\_\_

Appointment reminders by: \_\_\_ e-mail \_\_\_ text Would you like to receive monthly Qi Mail newsletters? Y/N

Marital Status: (Circle) Single Married Partnered Widowed Separated Divorced

Employment: (Circle) Employed Unemployed Disabled Retired Student

Patient's Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Responsible Party (if dependent): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## **In Case of Emergency, Contact:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

## **How Did You Hear About Our Clinic?**

(Please circle) Internet (specify) \_\_\_\_\_ Family/Friends Newspaper Walk-in

Event \_\_\_\_\_ Other \_\_\_\_\_

## **Financial Policy**

*I am committed to providing you with the best service possible. The following is a statement of the financial policy. Please read and sign this form prior to your first visit.*

**Full payment is due at time of service unless prior arrangements have been made.** Payment can be made by Visa, MasterCard, check, or cash. A \$20 handling fee will be charged for any returned checks. It is your responsibility to present your insurance ID card at the first visit. I am not to be held responsible for any incorrect charges due to any incorrect information given to me at the time of the first visit. I participate in a number of affinity or discount programs with major insurance companies. It is your responsibility to call your insurance company to find out your acupuncture benefits and if you are eligible for any of the affinity programs. I am currently a provider with Cigna health insurance, but will be opting out of the network in the fall of 2009. Until that time I will bill your insurance, after that time you will have to pay the out-of-network provider rate at the time of service or find another acupuncturist who is still an in-network provider. If your insurance company covers acupuncture and I am not a provider, I will gladly give you a super-bill for your treatments and provide any information you need so you can submit them yourself.

Charges for the first visit will range from \$108.75-\$145 and follow-up visits range from \$67.50-\$90. Most conditions require an average of 6-12 treatments. Some people will respond well within 4-6 treatments and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.

**Cancellation/Missed appointments:** Appointments missed or canceled with less than 24 hours notice incur a no-show/missed appointment fee of \$50 due before the next treatment. If you are more than 15 minutes late for your appointment, I may not be able to see you without significant wait to other patients. If this occurs you may be asked to reschedule your appointment and you may be charged for a missed appointment. The above is true, understood and agreed to.

\_\_\_\_\_  
(Patient/Responsible party signature)

\_\_\_\_\_  
(Date)

# NEW PATIENT INTAKE FORM

Katie Kapusnik L.Ac.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What Medications/Vitamins/Supplements do you take regularly?

Medicine	Dosage	Reason	How Long	Prescribed By

Are you taking a blood thinner? \_\_\_ Yes \_\_\_ No

Lithium? \_\_\_ Yes \_\_\_ No

Do you have a pace maker? \_\_\_ Yes \_\_\_ No

List any allergies or food sensitivities that you have: \_\_\_\_\_

List any accidents, surgeries, or hospitalizations (include dates): \_\_\_\_\_

Are there any issues of physical/sexual/emotional abuse that you would like to discuss? \_\_\_ Yes \_\_\_ No

What are the main health problems for which you are seeking treatment?

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What activities cause this pain and/or make it worse?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is your level of commitment to solving this problem? (circle)

(None) 0 1 2 3 4 5 6 7 8 9 10 (100% Commitment)

What other forms of treatment have you sought?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your health goals?

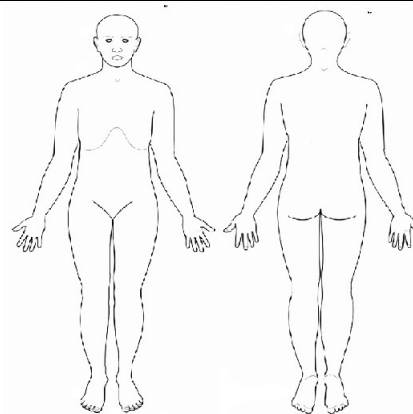
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any chronic, ongoing pain? Yes \_\_\_ No \_\_\_



**On the diagram above, please indicate the areas in which you experience discomfort. If the discomfort radiates, please draw arrows to indicate which direction.**

List any other health problems that you have:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# NEW PATIENT INTAKE FORM

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Name:

Date:

## SYMPTOM SURVEY

The following is a list of symptoms that you may or may not ever experience.

Please indicate as follows: PLUS SIGN =    +    = FREQUENTLY EXPERIENCE

NO MARK =    = NEVER EXPERIENCE X MARK = X = SOMETIMES EXPERIENCE

<input type="checkbox"/> lack of appetite	<input type="checkbox"/> digestive problems	<input type="checkbox"/> loose stools or diarrhea
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> belching, burping	<input type="checkbox"/> vomiting
<input type="checkbox"/> tendency be obsessive in work, relationships, etc.	<input type="checkbox"/> feeling of retention of food in the stomach	<input type="checkbox"/> heartburn/reflux

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<input type="checkbox"/> insomnia, difficulty sleeping	<input type="checkbox"/> nightmares	<input type="checkbox"/> angina pains
<input type="checkbox"/> laughing for no reason	<input type="checkbox"/> heart palpitations	<input type="checkbox"/> abdominal pains
<input type="checkbox"/> cold hands and feet	<input type="checkbox"/> chest pain	<input type="checkbox"/> sciatic pain
<input type="checkbox"/> mentally restless	<input type="checkbox"/> pain or coldness in genitals	<input type="checkbox"/> headaches

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<input type="checkbox"/> cough	<input type="checkbox"/> feelings of claustrophobia	<input type="checkbox"/> colitis or diverticulitis
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> sinus congestion	<input type="checkbox"/> constipation
<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> bronchitis	<input type="checkbox"/> hemorrhoids
<input type="checkbox"/> nasal problems	<input type="checkbox"/> recent use of antibiotics	<input type="checkbox"/> skin problems

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<input type="checkbox"/> jaundice	<input type="checkbox"/> light colored stools	<input type="checkbox"/> difficulty making decisions
<input type="checkbox"/> difficulty digesting oily foods	<input type="checkbox"/> soft or brittle nails	<input type="checkbox"/> easily angered or agitated
<input type="checkbox"/> gall stones	<input type="checkbox"/> eye twitching	<input type="checkbox"/> tendency to faint
	<input type="checkbox"/> spasm or twitching of muscles	<input type="checkbox"/> eye problems or floaters
	<input type="checkbox"/> fibrocystic breasts	

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<input type="checkbox"/> low back pain	<input type="checkbox"/> ear ringing	<input type="checkbox"/> hair loss
<input type="checkbox"/> knee problems	<input type="checkbox"/> kidney stones	<input type="checkbox"/> urinary problems
<input type="checkbox"/> hearing impairment	<input type="checkbox"/> asthma	<input type="checkbox"/> urinary infection
<input type="checkbox"/> blood in stool	<input type="checkbox"/> tendency to catch colds	<input type="checkbox"/> edema
<input type="checkbox"/> black tarry stools	<input type="checkbox"/> intolerance to weather changes	<input type="checkbox"/> decreased sex drive
<input type="checkbox"/> easily bruised	<input type="checkbox"/> allergies	<input type="checkbox"/> dizziness
<input type="checkbox"/> difficulty to stop bleeding	<input type="checkbox"/> hay fever	<input type="checkbox"/> head injuries

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# NEW PATIENT INTAKE FORM

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## FOR WOMEN

Age of first period \_\_\_\_\_ Age at menopause \_\_\_\_\_ Number of days between periods \_\_\_\_\_

Number of days of flow \_\_\_\_\_ Color of flow \_\_\_\_\_ Clots? Y \_\_\_ N \_\_\_ Color? \_\_\_\_\_

Average number of pads you use per day:

1st day \_\_\_\_\_ 2nd day \_\_\_\_\_ 3rd day \_\_\_\_\_ 4th day \_\_\_\_\_ 5th day \_\_\_\_\_

Have you been diagnosed with: Fibroids \_\_\_\_\_ Endometriosis \_\_\_\_\_ PCOS \_\_\_\_\_ Cysts \_\_\_\_\_

Sexual Transmitted Infections: Gonorrhea \_\_\_ Syphilis \_\_\_ HIV \_\_\_ HPV \_\_\_ Chlamydia \_\_\_ Herpes \_\_\_

Other symptoms related to menses (please indicate before, during, or after menses):

Pain:

Cramping \_\_\_\_\_

Aching \_\_\_\_\_

Intermittent \_\_\_\_\_

Stabbing \_\_\_\_\_

Dull \_\_\_\_\_

Bearing down sensation \_\_\_\_\_

Burning \_\_\_\_\_

Consistent \_\_\_\_\_

Discharge \_\_\_\_\_

Ravenous appetite \_\_\_\_\_

Decreased libido \_\_\_\_\_

Vaginal Dryness \_\_\_\_\_

Hot flashes \_\_\_\_\_

Mood swings \_\_\_\_\_

Nausea \_\_\_\_\_

Night sweats \_\_\_\_\_

Swollen Breasts \_\_\_\_\_

Bloating \_\_\_\_\_

Poor appetite \_\_\_\_\_

Headache \_\_\_\_\_

Diarrhea \_\_\_\_\_

Insomnia \_\_\_\_\_

Constipation \_\_\_\_\_

Increased libido \_\_\_\_\_

Pregnancy History:

# of pregnancies \_\_\_\_\_

# of abortions \_\_\_\_\_

# of live births \_\_\_\_\_

# of miscarriages \_\_\_\_\_

Do you have any children? (list their dates of birth) \_\_\_\_\_

Do you want to become pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Maybe, in the future \_\_\_\_\_

Dates and results of last: Gynecological exam \_\_\_\_\_ Pap smear \_\_\_\_\_

Mammogram \_\_\_\_\_ Bone Density \_\_\_\_\_

Scan \_\_\_\_\_

## FOR MEN

Date of last prostate check up \_\_\_\_\_ PSA results \_\_\_\_\_

Manual prostate exam and lab results \_\_\_\_\_

Frequency of Urination: Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_

Color of Urine: Clear \_\_\_\_\_ Cloudy \_\_\_\_\_ Odor: \_\_\_\_\_

Please check all that apply:

Prostate problems \_\_\_\_\_

Impotence \_\_\_\_\_

Testicular pain \_\_\_\_\_

Delayed stream \_\_\_\_\_

Retention of urine \_\_\_\_\_

Increased libido \_\_\_\_\_

Dribbling \_\_\_\_\_

Groin pain \_\_\_\_\_

Decreased libido \_\_\_\_\_

Rectal dysfunction \_\_\_\_\_

Back pain \_\_\_\_\_

Incontinence \_\_\_\_\_

Premature ejaculation \_\_\_\_\_

Sexual Transmitted Infections: Gonorrhea \_\_\_ Syphilis \_\_\_ HIV \_\_\_ HPV \_\_\_ Chlamydia \_\_\_ Herpes \_\_\_

Do you have any children? (list their dates of birth) \_\_\_\_\_



# NEW PATIENT INTAKE FORM

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

### I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

### I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

\_\_\_\_\_  
\_\_\_\_\_

### Patient:

X \_\_\_\_\_  
Patient Signature or Legal Representative      Date      Witness Signature

Office Use Only:

\_\_\_\_\_  
Signature                              Title              Date

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Consent to Treatment Form**

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist, Katie Kapusnik L.Ac.. I understand that acupuncturists practicing in the state of Virginia are not primary care providers and that regular primary care by a licensed physician is an important choice that is recommended by Katie Kapusnik L.Ac..

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body’s physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body’s physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Katie Kapusnik L.Ac. as soon as possible.*

**Acupressure/Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body’s physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

Name:

Date:

**Recommendation for Examination by a Physician**

Katie Kapusnik L.Ac. recommends to you \_\_\_\_\_  
(patient)

that you be examined by a physician regarding the condition for which you are seeking  
acupuncture treatment.

I understand this recommendation.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

**Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).**

\_\_\_\_\_  
Acupuncturist

\_\_\_\_\_  
Date

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