BOISE ACUPUNCTURE CO-OP

Registration & New Patient Form

Name: _____ Date: _____

Address: _____City: _____State: _____

Zip:_____ Date of Birth: _____ Gender (optional):_____

Occupation:_____ Best Phone:_____

Email Address:_____

Have You Had Acupuncture Previously? □ Yes □ No

How Did You Hear About Us?_____

MAIN COMPLAINT

1._____

When did this start? _____

What makes it better? _____

What makes it worse? _____

Treatment you've had? _____

SECONDARY COMPLAINT

2._____

When did this start? _____

What makes it better? _____

What makes it worse? _____

Treatment you've had? _____

HEALTH HISTORY

Medications/Supplements: _____

Do you have any trouble sleeping? _____

Do you have enough energy throughout the day? _____

Do you have any digestive trouble? _____

Do you move your bowels daily? _____ With ease?(circle one) Yes No

If you could get one thing from today's treatment… _____

_____

Check all you have had in the past:

□	AIDS	□	Cancer
□	Allergies	□	Diabetes
□	Arthritis	□	Anemia
□	Bleeding Disorders		

HEALTH HISTORY CONT.
Check any you have had within *the last year*.

MUSCLE/JOINT/BONES
□ Tremors or Cramps
□ Swollen joints
Pain, tension, weakness, numbness in:
□ Arms or Shoulders
□ Legs or Hips
□ Feet
□ Neck
□ Hands
□ Back
□ Other_____

EYES/EAR/NOSE/THROAT/RESP.
□ Headaches
□ Asthma/wheezing
□ Blurred or failing vision
□ Difficulty breathing
□ Earache
□ Frequent colds
□ Hay fever
□ Hoarseness
□ Gum trouble
□ Nose bleeds
□ Loss of hearing
□ Persistent cough
□ Ringing in ears
□ Sinus problems

SKIN
□ Boils
□ Bruise easily
□ Dry skin
□ Itching/rash
□ Sensitive skin
□ Sore won't heal
□ Sweats

GENITO/URINARY
□ Blood/pus in urine
□ Frequent urination
□ Inability to control urine
□ Kidney infection/stones
□ Lowered libido

MENTAL/EMOTIONAL
□ Depression
□ Difficulty in focusing
□ Dizziness
□ Easily startled
□ Excessive worry
□ Excessive anger
□ Excessive fear
□ Anxiety
□ Feel your heart beating

CARDIOVASCULAR
□ Chest pain
□ High or low blood pressure
□ Pain over heart
□ Poor circulation
□ Previous heart attack
□ Rapid/irregular heart beat
□ Swelling of ankles

GASTROINTESTINAL
□ Belching, gas or bloating
□ Constipation
□ Diarrhea
□ Difficulty swallowing
□ Excessive hunger
□ Gall bladder trouble
□ Hemorrhoids (piles)
□ Indigestion
□ Nausea
□ Pain over stomach
□ Poor appetite
□ GERD

IF APPLICABLE:
□ Erection difficulties
□ Penis discharge
□ Prostate trouble
□ Bleeding between periods
□ Clots in menses
□ Excessive menstrual flow
□ Extreme menstrual pain
□ Irregular cycle
□ Menopausal symptoms
□ PMS
□ Previous miscarriage
□ Scanty menstrual flow
□ Could you be pregnant? _____

The information on this form is correct to the best of my knowledge.
Signature _____ Date _____

BOISE
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Patient Responsibilities

As a patient at the Boise Acupuncture Cooperative Inc., I understand that I will: (please initial)

____ Completely silence my cell phone and any other devices that may disturb my fellow patients.

Our treatment room is a group setting and we try to be courteous and compassionate of others sharing this healing space. You are more than welcome to bring headphones for your own listening pleasure.

_____ Sit in a chair that does *not* look like it has been sat in and is tidy. When I am finished with my treatment I will leave my chair and sheet as is.

After a patient's needles are removed and they leave the treatment room, the acupuncturist will make sure the chair is tidy and ready for the next patient. Don't be nice and straighten your own chair. Really, we mean it. ☺

_____ Prepare for my treatment by pulling sleeves up to my elbows and pants up to my knees, removing socks and shoes, reclining back, and relaxing.

Please leave shoes on until you reach your chair. We appreciate your preparedness and patience in helping us to serve our patients as efficiently as we can. Feel free to get comfortable for your treatment.

_____ Tell my acupuncturist when I am done with my treatment OR when I *need* to be done with my treatment.

The acupuncturist will remove your needles when you indicate you are done by making eye contact with them. If you need to be somewhere at a specific time, it is your responsibility to inform your acupuncturist before they are done needling you. If you wake up and the acupuncturist is not in the room, please wait patiently, or impatiently if you would like, as long as you do not remove your own needles unless there is an emergency. Acupuncturists check in regularly.

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Financial & Cancellation Policy

BAC is a low-cost, high volume community acupuncture clinic. Our fees are $20-$50 per treatment, with an additional $15 for the first visit. You decide what you can pay at each visit. Payment is expected before or at the time of your visit. We accept checks, cash, Visa & MasterCard. If you need a receipt to submit to your insurance, please let us know.

Appointments canceled with less than 12 hours notice, or are missed altogether, are responsible for the minimum fee on our sliding scale ($20 for returning visits and $35 for first time visits). We do also recognize that emergencies happen, and would be happy to consider these on an individual basis. We aim to provide affordable acupuncture services in a community setting, serving everyone in the community regardless of their income. If you are unable to pay the cancellation fee, please let us know.

I agree to the above policy:

Print Name _____

Signature _____ Date _____

Informed Consent

Acupuncture involves the insertion of special needles into particular points on the body. The purpose of this treatment is to prevent or reduce pain and to help your body function better. There are some risks to treatment, including bruising of the skin and/or slight bleeding, weakness, fainting and aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection when all needles are sterile. **BAC uses only one-time use, sterile disposable needles. We do not reuse needles, even at different areas of the body for the same person.** We do not provide primary care, or Western (allopathic) medical care. Please see your medical doctor for those services and for routine check-ups. If you are pregnant, have a bleeding disorder, pacemaker, high blood pressure, local infection or have been prescribed anticoagulant medications like Coumadin, by signing below you state that you have informed your acupuncturist of such conditions.

With this knowledge, I voluntarily consent to the above procedures.

Print Name _____

Signature _____ Date _____