



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:

- | | |
|---------------------------------------------|-----------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bleeding Disorders | |

<p>HEALTH HISTORY CONT. Check any you have had within <i>the last year</i>.</p> <p>MUSCLE/JOINT/BONES</p> <p><input type="checkbox"/> Tremors or Cramps</p> <p><input type="checkbox"/> Swollen joints</p> <p>Pain, tension, weakness, numbness in:</p> <p><input type="checkbox"/> Arms or Shoulders</p> <p><input type="checkbox"/> Legs or Hips</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Other _____</p> <p>EYES/EAR/NOSE/THROAT/RESP.</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Asthma/wheezing</p> <p><input type="checkbox"/> Blurred or failing vision</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Gum trouble</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p>SKIN</p> <p><input type="checkbox"/> Boils</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Itching/rash</p> <p><input type="checkbox"/> Sensitive skin</p> <p><input type="checkbox"/> Sore won't heal</p> <p><input type="checkbox"/> Sweats</p> <p>GENITO/URINARY</p> <p><input type="checkbox"/> Blood/pus in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Inability to control urine</p> <p><input type="checkbox"/> Kidney infection/stones</p> <p><input type="checkbox"/> Lowered libido</p>	<p>MENTAL/EMOTIONAL</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty in focusing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Easily startled</p> <p><input type="checkbox"/> Excessive worry</p> <p><input type="checkbox"/> Excessive anger</p> <p><input type="checkbox"/> Excessive fear</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Feel your heart beating</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High or low blood pressure</p> <p><input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Previous heart attack</p> <p><input type="checkbox"/> Rapid/irregular heart beat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Belching, gas or bloating</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Gall bladder trouble</p> <p><input type="checkbox"/> Hemorrhoids (piles)</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> GERD</p> <p>IF APPLICABLE:</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Clots in menses</p> <p><input type="checkbox"/> Excessive menstrual flow</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> Menopausal symptoms</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Previous miscarriage</p> <p><input type="checkbox"/> Scanty menstrual flow</p> <p><input type="checkbox"/> Could you be pregnant?</p>
<p>The information on this form is correct to the best of my knowledge.</p> <p>Signature _____ Date _____</p>	



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.



Financial Policy

BAC is a low-cost, high volume Community Acupuncture Clinic. Our fees are \$20-\$40 per treatment. You decide what you can pay at each visit. We will never ask for income verification and trust that you know best what you can afford to pay for your treatment. We make every attempt to make acupuncture available to as many people as possible at the most affordable rates. This is our mission. Payment is expected at the time of your visit. We accept checks, cash, Visa & MasterCard. We ask that you be prepared to pay for your treatment each time you come in. At any time you may change the amount that you pay on the sliding scale up or down. If you need a receipt to submit to your insurance, please let us know. We'd also be happy to give you a cash receipt as well. Just ask. We reserve an appointment time for you and ask that you call us if you cannot keep your appointment. In consideration of other folks who may be on a waiting list for appointments, we ask that you give us at least 12 hours notice in advance of an appointment that you'll not be able to keep.

All appointments that are canceled with less than 12 hours notice, or are missed altogether without letting our front desk know, will be charged a \$20.00 fee payable at the next visit.

We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, of course. Thanks for understanding and in doing so, helping us to keep our fees as low as possible.

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 _____