

Misty Nault L.Ac.

INFORMATION FORM

Today's Date: _____

Name: _____ Sex: M _____ F _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email : _____

Birth date: ____/____/____ Age: _____ Marital Status: _____

EMERGENCY CONTACT:

Name: _____ Telephone: (____) _____

PRIMARY CARE PHYSICIAN:

Name: _____ Telephone: (____) _____

Medical Questionnaire

Have you had acupuncture before? Yes _____ No _____

How did you hear about us? _____

Reason(s) for today's visit: _____

How long have you had this condition? _____

Does it bother you: Sleep Work Other (Please explain) _____

What seemed to make it better/worse? _____

What other therapies are you currently using? _____

Current Medications: _____

Current Vitamins/Supplements: _____

Allergies: _____

Height: _____ Weight _____

Family Medical History

- Allergies Arteriosclerosis Cancer Diabetes Seizures
- Asthma Heart Disease Stroke Alcoholism High Blood Pressure

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are significant part of your medical history.)

- AIDs/HIV Epilepsy Pacemaker Thyroid Disorders Other (Specify)
- Alcoholism Heart Disease Seizure Major Trauma _____
- Allergies Hepatitis Stroke _____
- Asthma Herpes Surgery (List) _____
- Cancer High Blood Pressure Tuberculosis
- Diabetes Multiple Sclerosis Whooping Cough

YOUR LIFESTYLE

- Alcohol Marijuana Stress Tobacco Drugs
- Occupational Hazards **(Specify)** _____
- Regular Exercise **(Specify)** _____

GENERAL SYMPTOMS

- Poor appetite Poor / Heavy sleep Lack of strength Shortness of breath Bleed or bruise easily
- Excessive appetite Dream disturbed sleep Body heaviness Fever Peculiar taste (describe)
- Prefer cold / hot drinks Vertigo or dizziness Cold hands or feet Chills
- Sweat easily Weight gain or loss Fatigue Poor circulation Night sweats
- Muscle cramps

HEAD/EYES/EARS/NOSE/THROAT

- Glasses Night blindness Facial pain Excessive phlegm Ringing in ears
- Eye pain/strain Glaucoma Color or phlegm Poor hearing Red eyes
- Cataracts Dry mouth Sore throat Earaches Itchy eyes
- Teeth problems Excessive saliva Lumps in throat Headaches Spots in vision
- Grinding teeth Sinus problems Enlarged thyroid Concussions Poor / Blurry vision
- TMJ Gum problems Nose bleeds Sores on lips or tongue

RESPIRATORY

- Tightness in chest Bronchitis Pneumonia Shortness of breath Asthma/wheezing
- Cough
Productive? _____
Color of phlegm: _____
Wet or dry? _____

CARDIOVASCULAR

- High blood pressure Low blood pressure Chest pain Tachycardia Palpitations
- Blood clots Fainting Difficult breathing Irregular heartbeat

GASTROINTESTINAL

- Nausea Diarrhea Intestinal pain/cramp Bowel movements:
- Vomiting Constipation Itchy / Burning anus
- Acid regurgitation Laxative use Rectal pain Frequency _____ per day /week
- Gas Black stools Hemorrhoid Hiccup Bloody stools
- Anal fissures Bloating Mucous in stools Bad breath

MUSCULOSKELETAL

- Neck/shoulder pain Upper back pain Joint pain Muscle pain Low back pain
- Rib pain Limited range of motion _____
 Other (Please describe) _____
 Limited use _____

SKIN/HAIR

- Rashes Eczema Dandruff Change in hair Hives
- Psoriasis Itching Fungal infection Ulcerations Acne
- Hair loss Change in skin texture Other (Please describe) _____

NEUROPSYCHOLOGICAL

- Seizures Poor memory Irritability Considered suicide Numbness
- Depression Easily stressed Attempted suicide Tics Anxiety
- Abuse survivor Seeing therapist Other (Please describe) _____

GENITO-URINARY

- Pain on urination Blood in urine Venereal disease Increased libido Impotence
- Frequent urination Unable to hold urine Bedwetting Decreased libido Premature ejaculation
- Urgent urination Incomplete urination Wake to urinate Kidney stone Nocturnal emission

GYNECOLOGY

- o Age menses began _____
- o Length of cycle _____
- o Date last period began _____
- o Clots _____
- o Age at Menopause _____
- o #Pregnancies _____
- o Duration of flow _____
- o Vaginal discharge(color?) _____
- o Irregular periods _____
- o Breast Lumps _____
- o Date of last PAP _____
- o # births _____
- o Vaginal sores _____
- o Painful periods _____
- o PMS _____
- o Vaginal odor _____
- o Premature births _____

GUARANTOR: Party Responsible for Payment if not self

Name: (please print) _____ Birth date: ___/___/_____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Relationship to Insured: _____

INSURANCE INFORMATION

Name of Policy Holder: _____ Birth date: ___/___/_____ SSN#: _____

Insurance Name: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my insurance benefits be directly paid to Misty Nault L.Ac., for the treatment of _____.

I understand that I am financially responsible to the charges not covered by this assignment. I also authorize the doctor, attorney, or insurance company to release any information required for this claim.

Signature: _____
Person Authorized to Consent

Date: _____

Last Updated 2/28/10

Office Policies and Authorization for Treatment

I, _____, understand that acupuncture is an energetic form of therapy based on the regulation of energy, and is not intended to replace conventional medical treatment. I assume full responsibility for consulting with appropriate physician since I understand that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Misty Nault L.Ac., to perform the following specific procedures:

Acupuncture procedures involving insertion of special needles through the skin into the underlying tissue at specific points on the surface of the body, as well as other techniques as specifically described in the Washington State Law for Licensed Acupuncturists, such as moxibustion, cupping, electroacupuncture, acupressure, and herbal consultation.

I recognized the potential benefits and risks of the above procedures included reactions as described below:

Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention, or elimination of the presenting problem.

Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruised, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given me by Misty Nault L.Ac., regarding cure or improvement of my condition.

I hereby release Misty Nault L.Ac., from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

FEE:

I understand that fee for treatment is payable at the time of service unless I am receiving treatment via a medical plan which recognizes Misty Nault L.Ac., as a Preferred provider. In such an event, payment shall be provided as per the terms of the plan. If it is found I am not eligible for coverage of treatment by my medical plan, I assume full responsibility for paying Misty Nault L.Ac., any money owed for treatment.

MISSED APPOINTMENT:

I will give 24 hours notice if I need to cancel an appointment. I understand without that advance notice, the time reserved for me is my responsibility and will be charged to me as a missed appointment. Missed appointments are charged at the same rates as regular appointment. Insurance companies do not pay for missed appointments so I understand that any appointments missed are my financial responsibility. Exceptional circumstances will be considered regarding this policy.

Signature of Patient

Date

PROFESSIONAL FEE SCHEDULE

Misty Nault L.Ac.
9415 Roosevelt Way NE
Seattle, Wa 98115
Ph: 206 452-5965

New Patient Consultation/Examination Consulting based on patient's symptom, Tongue and pulse diagnosis	\$45.00 - \$150.00
Established Patient Consultation/Examination	\$25.00 - \$85.00
Acupuncture Treatment \$50.00 - \$100.00	
Electro Acupuncture Treatment	\$60.00 - \$90.00
Infra-red (TDP) Heat Treatment	\$35.00
Return Check Charge	\$30.00
Missed Appointment Charge	\$55.00

** If I am not covered by insurance, I am responsible for any balance not paid within 90 days. Any quote of insurance benefits made to me by Misty Nault L.Ac. is only done as a courtesy and is not a guarantee of payment. I am still responsible for coordination of my insurance.

Thank you for your cooperation

Revised 02/27/10

Initial & Date _____