



North Park Acupuncture, Inc.  
 Gayle Kildebeck, L.Ac  
 3080 North Park Way  
 San Diego, Ca 92104  
 Tel: 619-294-6616 Fax:619-294-6618

# NEW PATIENT QUESTIONNAIRE

Date of first visit \_\_\_\_\_

Name \_\_\_\_\_ Home Number \_\_\_\_\_

Address \_\_\_\_\_ Cell Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Hand dominance?  R  L

Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you ever had Acupuncture?  Y  N For What? \_\_\_\_\_

Chiropractic?  Y  N For What? \_\_\_\_\_ Massage?  Y  N For What? \_\_\_\_\_

Referred by \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have health insurance?  Y  N If yes, what company? \_\_\_\_\_

Please list your primary health concerns \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PHYSICIAN'S USE ONLY

1 \_\_\_\_\_ 3 \_\_\_\_\_ 5 \_\_\_\_\_ T \_\_\_\_\_

2 \_\_\_\_\_ 4 \_\_\_\_\_ 6 \_\_\_\_\_ P \_\_\_\_\_

REVIEW OF HEALTH HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please list any surgeries, accidents, or injuries	Date	Physicians notes
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

List of allergies or sensitivities \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there a family history of any of the following (Please check and indicate which family member)											
	Y	N	Who		Y	N	Who		Y	N	Who
Heart disease				Migraines				Osteoporosis			
High blood press.				Diabetes				Alzheimer's			
Low blood press.				Hepatitis				Parkinson's			
High cholesterol				Cancer				Thyroid Prob.			
Emotional prob.				Asthma				Arthritis			
Obesity				Anemia				AIDS/HIV			
Others:											
Have you had any of the above illnesses?											

Please indicate any use of the following							
	Y	N	Frequency and amount		Y	N	Frequency and amount
Tobacco				Soda Regular			
Coffee Regular				Soda Diet			
Coffee Decaf				Sweets and desserts			
Tea Caffeinated				Recreational Substances			
Tea decaf				Water			
Alcohol				Meditation			

Vitamins, supplements, and herbs (dose and frequency) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescription drugs (dose and frequency) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PAIN ASSESSMENT

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Chief Complaint(s) 1 \_\_\_\_\_ 2 \_\_\_\_\_

Is your present problem due to an injury  On the Job  Auto Accident  Personal Injury  Other \_\_\_\_\_

Did your pain begin  Gradually  Suddenly

Is your pain  Constant  Intermittent

Is your pain worse when you  Sit  Bend  Walk  Lift  Push  Pull  Other \_\_\_\_\_

Which of the following areas do you have the most pain, discomfort or restriction of motion

- Neck  Shoulders  Arms  Hands  Upper Back
- Mid Back  Low Back  Pelvis  Hips  Legs
- Knees  Feet  Other \_\_\_\_\_

Using the following chart, how would you rate your pain in percentages when you

Occasionally = 33%  
 Frequently = 34-66%  
 Constantly = 67-100%

Sit \_\_\_\_\_% of the time

Stand \_\_\_\_\_% of the time

Walk \_\_\_\_\_% of the time

Rate the severity of your pain by checking one box on the following scale

10 = Extreme Pain  
 1 = least pain

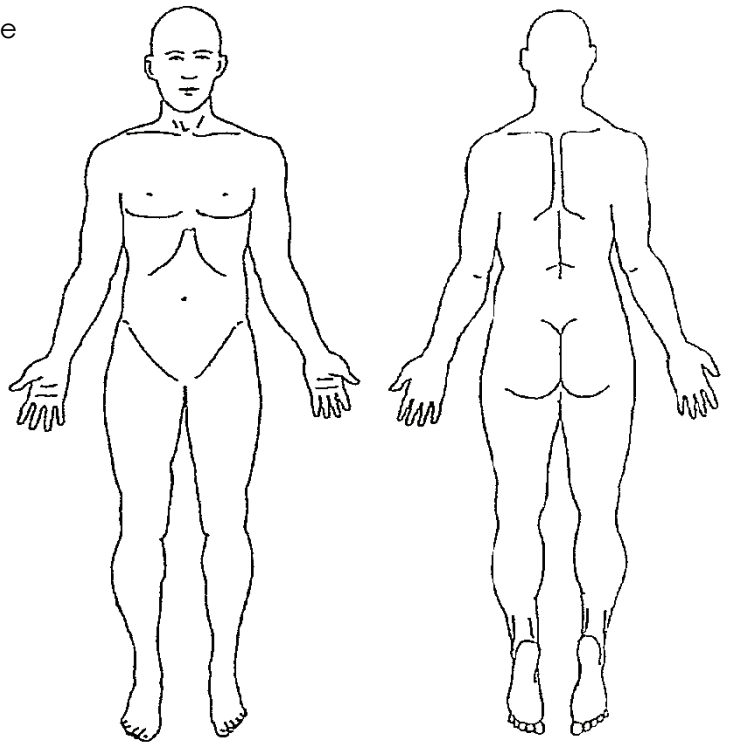
Extreme

10
9
8
7
6
5
4
3
2
1
0

None

Circle the areas of pain on the figure to the right. Then indicate the type of pain using the codes below:

- +++ Burning
- Sharp
- 000 Stabbing
- III Constant



Does your pain interfere with your  Work  Sleep  Daily Routines

Do you feel your present condition is  Temporary  Permanent  Not Sure

List as additional comments you wish to make regarding your condition \_\_\_\_\_

Patient Signature \_\_\_\_\_



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# LATE CANCEL POLICY

When you schedule your acupuncture appointments you are making a commitment to your health and your well-being. Making an appointment is a time and money commitment that we make to each other. Cancelling your appointment without sufficient notice creates a loss situation for all of us. You aren't getting the health support that you need, other patients are prevented from scheduling that treatment time, and the clinic loses the financial support that sustains it.

In effort to support you in keeping your appointments we will:

- Call you at least 24 hours prior to confirm your appointments.
- Offer you a reminder card with the date and time of your appointment.
- Email an appointment confirmation to you.
- Keep a waiting list for people who want appointments on that day so it will be easier to fill a missed appointment.
- Provide a 24-hour voicemail system that will time stamp your cancellation message.

Please sign your agreement to the following statement:

I agree and commit to keep my scheduled appointments to the best of my ability. I will call 24 hours prior to my appointment if I cannot keep my scheduled appointment or by noon on Saturday for Monday appointments. If I fail to do this, I understand that I will be charged twenty- five dollars (\$25.00) for a missed appointment. I understand that insurance does not cover missed appointment fees and therefore the \$25.00 fee is my sole responsibility.

\_\_\_\_\_

Signature

\_\_\_\_\_

Print Name

\_\_\_\_\_

Date



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BILLING ACKNOWLEDGEMENT OF THERAPY  
 NOT COVERED BY INSURANCE

It is the policy of North Park Acupuncture to provide the highest standard of care to our patients. In doing so, we recommend additional procedures and services which augment patient care. These procedures however may not be covered by a patient's HMO, PPO, insurance company, or health plan under the terms of their benefit plan.

One procedure we offer and recommend is Cupping and Soft Tissue Manipulation. Cupping and massage releases rigid soft tissue, drains excess fluids and toxins, loosens adhesions, lifts connective tissue, and brings blood flow to stagnant skin and muscles. It is an excellent modality for releasing chronically held muscle tissue and holding patterns that are the main causes of physical pain. It gets to places that acupuncture alone just cannot reach. If you choose to receive this additional level of care please complete and sign this form.

I acknowledge that a certain portion of my care will not be covered by my HMO, PPO, insurance company, or health plan under the terms of my benefit plan. I understand and agree and elect to be responsible to self-pay for the following procedure:

Code: 97139 / 97140 Cupping and Soft Tissue Manipulation Fee: \$15.00

I agree that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my acupuncture provider to pay for this procedure myself.

Patient Name (Please Print) \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_