



Acupuncture POINTS



your way to health

Licensed Acupuncturist ~ Yosef Pollack ~ IL #198-000085

Patient Health Appraisal

~ Strictly confidential ~

Please, legibly fill in this form to the best of your ability...add any additional information you deem necessary

Name _____ Age _____ Date of birth ____/____/____ Relationship status _____
 Address _____ Birthplace _____ Number of Children _____
 City _____ State ____ Zip _____ Referred to us by _____
 Phone: (home) _____ (work) _____ (mobile) _____
 e-mail: _____ Occupation _____ # work hrs/wk _____
 Emergency Contact: _____ Relationship _____ Phone _____
 Physicians name: _____ Phone: _____
 May I contact your physician to discuss your condition? ___Yes ___ No Your Health Ins Co? _____

Height: __ ft. __ in. Weight: _____ pounds Blood pressure: __high __low __normal (office use WTP__)

Why have you come for acupuncture treatment?

New/Acute problems:

Old/Chronic problems:

Treatments to date:

Current medications (taken within last 2 months):

Current "natural" remedies/supplements:

What do you do for exercise?

Present living situation:

Major Stresses in life:

Where do you hold tension?

~ Personal Health History ~

Hospitalizations:

Surgeries:

Injuries//traumas:

Broken bones:

Scars/stitches:

Medicinal allergies:

Environmental allergies:

Food allergies:

Catch cold or virus easily?

Frequent sore throat?

Childhood Illness

___ Chicken Pox

___ Measles

___ Mumps

___ German Measles

___ Scarlet Fever

Immunizations

___ DPT

___ Tetanus Booster

___ Measles/Mumps/Rubella

___ Hepatitis B

___ Influenza

Exposures

___ Hepatitis

___ Tuberculosis

___ Herpes

___ HIV exposure

___tested positive ___tested negative

Implants/Prostheses

___ Breast implant (s)

___ Pace Maker

___ other (describe)

General Body Check ~ Do you have problems with any of these:

PAIN (WHERE) <input type="checkbox"/> sharp/stabbing: <input type="checkbox"/> dull/aches: <input type="checkbox"/> localized: <input type="checkbox"/> crampish: <input type="checkbox"/> moving/tingling:	CIRCULATION: <input type="checkbox"/> numbness <input type="checkbox"/> cold areas <input type="checkbox"/> Reynaud's disease <input type="checkbox"/> hot areas <input type="checkbox"/> bruise easily	HEADACHES (DESCRIBE) <input type="checkbox"/> Migraine <input type="checkbox"/> Cluster headaches w/Allergies <input type="checkbox"/> Headaches with nausea <input type="checkbox"/> Frontal <input type="checkbox"/> Temples <input type="checkbox"/> Occipital/base of skull		
MENTAL/NEUROLOGIC <input type="checkbox"/> slow thinking <input type="checkbox"/> fast thinking <input type="checkbox"/> forgetful <input type="checkbox"/> lack concentration <input type="checkbox"/> vertigo <input type="checkbox"/> seizures	EMOTIONAL PROBLEMS <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> panic attacks <input type="checkbox"/> phobias <input type="checkbox"/> mania stress <input type="checkbox"/> irritable/angry	EYES <input type="checkbox"/> vision problems <input type="checkbox"/> blurry vision <input type="checkbox"/> photosensitivity <input type="checkbox"/> infections <input type="checkbox"/> dryness <input type="checkbox"/> redness <input type="checkbox"/> pain behind eyes	EARS <input type="checkbox"/> hearing loss <input type="checkbox"/> tinnitus <input type="checkbox"/> frequent infections <input type="checkbox"/> clogged <input type="checkbox"/> popping	NOSE <input type="checkbox"/> sinus infections <input type="checkbox"/> sinusitis <input type="checkbox"/> postnasal drip <input type="checkbox"/> deviated septum <input type="checkbox"/> loss of smell <input type="checkbox"/> bleeding <input type="checkbox"/> allergy/sniffles
SKIN <input type="checkbox"/> acne <input type="checkbox"/> itching <input type="checkbox"/> eczema	HAIR <input type="checkbox"/> dryness <input type="checkbox"/> alopecia <input type="checkbox"/> premature graying	NAILS (FINGERS/TOES) <input type="checkbox"/> dry <input type="checkbox"/> brittle <input type="checkbox"/> cracks/splits	TONGUE <input type="checkbox"/> discolored <input type="checkbox"/> infected <input type="checkbox"/> ingrown	<input type="checkbox"/> hives <input type="checkbox"/> rashes <input type="checkbox"/> hair loss <input type="checkbox"/> peeling areas <input type="checkbox"/> sores/blisters <input type="checkbox"/> sensitivity
MOUTH <input type="checkbox"/> lips chapped <input type="checkbox"/> cold sores <input type="checkbox"/> bleeding gums <input type="checkbox"/> periodontitis <input type="checkbox"/> lots of cavities <input type="checkbox"/> silver fillings <input type="checkbox"/> teeth loose <input type="checkbox"/> teeth hurt/ache <input type="checkbox"/> without cavities <input type="checkbox"/> Temporo-Mandibular Joint (TMJ) problems	THROAT <input type="checkbox"/> dry <input type="checkbox"/> itchy <input type="checkbox"/> sore <input type="checkbox"/> hot <input type="checkbox"/> excess mucus <input type="checkbox"/> swollen glands <input type="checkbox"/> tight <input type="checkbox"/> thyroid VOICE <input type="checkbox"/> hoarseness <input type="checkbox"/> stuttering	BLOOD TESTS WITH IRREGULAR RESULTS: <input type="checkbox"/> high cholesterol <input type="checkbox"/> hyperthyroid (high) <input type="checkbox"/> hypothyroid (low) <input type="checkbox"/> diabetes <input type="checkbox"/> high blood sugar <input type="checkbox"/> hypoglycemic <input type="checkbox"/> low blood sugar <input type="checkbox"/> anemia <input type="checkbox"/> Candida/yeast	AUTONOMIC NERVOUS SYSTEM <input type="checkbox"/> low blood pressure <input type="checkbox"/> high blood pressure <input type="checkbox"/> cold hands/feet <input type="checkbox"/> night sweats <input type="checkbox"/> sweat easily <input type="checkbox"/> particular areas: <input type="checkbox"/> never sweat <input type="checkbox"/> often hot <input type="checkbox"/> often cold <input type="checkbox"/> slow pulse (less than 60) <input type="checkbox"/> fast pulse (more than 100)	
HEART & LUNGS <input type="checkbox"/> asthma <input type="checkbox"/> shallow breathing <input type="checkbox"/> short of breath: <input type="checkbox"/> on exertion <input type="checkbox"/> at rest <input type="checkbox"/> when lying down <input type="checkbox"/> pressure on chest <input type="checkbox"/> cough <input type="checkbox"/> chronic bronchitis <input type="checkbox"/> phlegm/mucus <input type="checkbox"/> frequent colds <input type="checkbox"/> mitral valve prolapse <input type="checkbox"/> palpitations DIGESTION <input type="checkbox"/> have no appetite <input type="checkbox"/> good appetite <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> easily get carsick <input type="checkbox"/> easily get air sick <input type="checkbox"/> easily get seasick	DIGESTION CONT'D. <input type="checkbox"/> belching <input type="checkbox"/> rumbling sounds <input type="checkbox"/> heartburn <input type="checkbox"/> ulcer <input type="checkbox"/> lack of stomach acid <input type="checkbox"/> can't digest fats <input type="checkbox"/> hiccups <input type="checkbox"/> hiatal hernia <input type="checkbox"/> stomach problems <input type="checkbox"/> liver problems <input type="checkbox"/> spleen problems <input type="checkbox"/> gall bladder problems <input type="checkbox"/> pancreas problems <input type="checkbox"/> large intestine problems <input type="checkbox"/> sm. intestines problems <input type="checkbox"/> colitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> appendix <input type="checkbox"/> ileocecal valve <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> undigested food in stool	DIGESTION CONT'D. <input type="checkbox"/> blood in stool <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> hemorrhoids <input type="checkbox"/> itching <input type="checkbox"/> burning <input type="checkbox"/> bleeding <input type="checkbox"/> flatulence <input type="checkbox"/> hernia URINATION <input type="checkbox"/> kidneys <input type="checkbox"/> adrenal <input type="checkbox"/> bladder <input type="checkbox"/> frequent urge to urinate <input type="checkbox"/> scanty urination <input type="checkbox"/> urinary tract infections <input type="checkbox"/> frequent <input type="checkbox"/> pain or discomfort <input type="checkbox"/> color of urine: <input type="checkbox"/> golden yellow <input type="checkbox"/> pale <input type="checkbox"/> deep yellow/orange <input type="checkbox"/> stones <input type="checkbox"/> strong odor	MUSCULO-SKELETAL <input type="checkbox"/> rheumatism <input type="checkbox"/> arthritis <input type="checkbox"/> connective tissue <input type="checkbox"/> ligament disease <input type="checkbox"/> lupus erythematosus <input type="checkbox"/> upper back/spine <input type="checkbox"/> mid back/spine <input type="checkbox"/> lumbar spine <input type="checkbox"/> whiplash <input type="checkbox"/> neck <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/> wrists <input type="checkbox"/> hands <input type="checkbox"/> fingers <input type="checkbox"/> rib cage <input type="checkbox"/> pelvis sacrum <input type="checkbox"/> coccyx <input type="checkbox"/> hips <input type="checkbox"/> knees <input type="checkbox"/> shins <input type="checkbox"/> feet <input type="checkbox"/> ankles <input type="checkbox"/> toes	



Welcome to Acupuncture POINTS “your way to health”

HEALTH INSURANCE ~

We are often asked, “Do you accept insurance?” The simple answer is “no”.

However, it may still be possible for you to be reimbursed by your insurance carrier for treatment. Fortunately, more and more insurance companies are now covering acupuncture treatment, but we still have a long way to go.

We have found that insurance companies are much more responsive to patients rather than providers. We will do whatever we can to help you receive reimbursement.

Here is a brief explanation of the process. Call your insurance company today (there should be an 800 number on the back of your card). Determine if they cover acupuncture administered by a Licensed Acupuncturist (not an MD, DC or DO). They should be able to tell you how many visits are authorized, if you need pre-authorization or a physician’s referral, etc. See INSURANCE on our website.

We will provide you a receipt with the dates and specific CPT codes (Current Procedural Terminology) for acupuncture treatment. You will submit this receipt to your insurance company for reimbursement. If they require any additional information or documentation, we will be happy to provide it.

FLEX SPENDING ~

Many Flex Spending Accounts support the use of “alternative” medicine provided by licensed acupuncturists. We will provide all necessary receipts for you to submit.

CANCELLATION POLICY ~

While we do understand that sometimes it cannot be avoided, we reserve the right to a \$50 charge for acupuncture appointments cancelled or broken without 24 hours-notice and the full fee for cancelled massage appointments without 24 hours notice.

I have read and fully comply with this Cancellation Policy ~ my initials: _____

REFERRALS ~

The highest compliment our patients can pay us is the referral of their friends or family. Thank you for your trust. To show our appreciation, we offer a reduced fee for your next acupuncture session for each activated referral.

PLEASE EXCUSE ANY DELAYS ~

The nature of our business is to give our patients the utmost in care and service. We will give you the same care and attention as soon as possible.

SUPPLEMENTS ~

While we often recommend supplements and herbs to our patients, you are under no obligation to purchase from us. We offer convenience, competitive prices and advice; however, you may find better prices elsewhere.

We encourage you to make the best decisions for yourself.