Welcome to AcuArtz Integrative Therapy.

Acupuncture Clinic of Rebecca Tabatzky, L.Ac.

CONFIDENTIAL HEALTH QUESTIONNAIRE

Name:_____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed
Last *First* *MI*

Address:_____City:_____State:_____Zip:_____

Email:_____Contact Phone: (_____)_____❒ Home ❒ Work ❒ Mobile

DOB:____/____/_____ Age:_____Height:_____Weight:_____Occupation:_____

Emergency Contact:_____Phone:_____

❒ Insurance Coverage: Plan_____Subscriber ID:_____Group ID:_____

List the reason(s) for which you are seeking treatment:

_____

_____

_____

Has a physician given you a diagnosis? ❒ No ❒ Yes, please describe:_____

Physician's Name:_____Phone:_____

❒ Labs? Please describe:_____

Do you have any ❒ prosthetic devices ❒ pacemaker ❒ metal staples/pins? Are you taking ❒ Coumadin/Warfarin ❒ Lithium?

Please select any significant illnesses you or a blood relative have had:

Illness	*You*	*Relative*		*You*	*Relative*	*Year Diagnosed*
Cancer	❒	❒	Hepatitis	❒	❒	
High Blood Pressure	❒	❒	Rheumatic Fever	❒	❒	
Diabetes	❒	❒	Heart Disease	❒	❒	
Seizures/Epilepsy	❒	❒	Emotional Disorder	❒	❒	
Tuberculosis	❒	❒	Infectious Diseases	❒	❒	

Please list any:

Medicine/Supplement *Dosage* List surgeries, hospitalizations or accidents: *Year*

_____

_____

_____

_____

Please indicate if you have any of these symptoms with the following:

+ I have this symptom OFTEN

✓ I have this symptom SOMETIMES

Leave **BLANK** if you NEVER experience the symptom

__Palpitations
__Shortness of breath when breathing
__Spontaneous sweating
__Fatigue
__Listlessness
__Discomfort in or stuffy chest
__Cold limbs
__Cold hands and feet
__Weak/Shallow breathing
__Heavy sweating
__Fainting
__Blue lips
__Dizziness
__Insomnia
__Dream disturbed sleep
__Poor long term memory
__Anxiety
__Easily startled
__Pale lips
__Mental restlessness
__Uneasiness/Fidgeting
__Low fever or feeling of heat in the afternoon
__Night sweats
__Excessive thirst
__Mouth sores
__Tongue sores
__Feeling agitated
__Impulsiveness
__Dark yellow urine
__Bitter taste in the mouth
__Sweet taste in the mouth
__Mental confusion
__Depression
__Rattling sound in throat
__Inability to speak
__Pain radiating down left arm or shoulder
__Pain under sides of ribcage
__Frequent sighing
__Frequent hiccups
__Moodiness

__Nausea
__Vomiting
__Stomach pains
__Poor appetite
__Acid regurgitation
__Belching
__Noisy stomach
__Feeling of lump in throat
__Difficulty swallowing
__Vomiting blood
__Abdominal pain
__Abdominal masses
__Irritability
__Angry outbursts
__Ear ringing/Tinnitus
__Neck/shoulder pain
__Constipation
__Loose stool
__Diarrhea
__Blood in stool
__Alternating loose & constipation
__Hemorrhoids
__Coughing up blood
__Fever
__Convulsions
__Neck Stiffness
__Bell's Palsy
__Sudden unconsciousness
__Paralysis
__Numbness or tingling of limbs
__Jaundice
__Blurred vision
__"Floaters" in the eyes
__Muscle weakness
__Muscle spasm
__Muscle cramps
__Soft/Brittle nails
__Dry mouth/throat
__Frequent shouting in anger
__Flatulence
__Cough
__Difficulty inhaling
__Difficulty exhaling

__Watery sputum
__Weak voice
__Dislike to speak
__Dislike of cold
__Daytime sweating
__Easy to catch colds
__Feeling of heat in the afternoon
__Hoarse voice
__Dry skin
__Stuffy nose
__Runny nose
__Sneezing
__Aversion to cold
__Body aches (flu feeling)
__Sore throat
__Dislike of lying down
__Asthma
__Chilliness
__Edema/Swelling
__Feeling of heaviness of the head
__Fatigue after eating
__Weak arms or legs
__Decreased sense of taste
__Feeling of heaviness of the body
__Burning sensation of the anus
__Difficulty concentrating
__Vertigo
__Poor short term memory
__Aching in the bones
__Dry mouth at night
__Low back Pain
__Knee pain
__Frequent urination
__Frequent urination @ night
__Difficult urination
__Painful urination
__Incontinence
__Headache
Location_____

__Low sex drive
__Excessive sexual desire
__Phlegm in throat
__Desire to lie down
__Burning sensation in stomach
__Constant hunger
__Swelling/Pain in gums
__Bleeding gums
__Bad breath
__Difficulty digesting fats
__Lack of courage
__Lack of initiative
__Timidity
__Sexually transmitted disease:
❒ Herpes ❒ HPV
❒ HIV/AIDS ❒ Chlamydia
❒ Gonorrhea ❒ Syphilis
Date:_____

WOMEN:

__PMS
__Breast distention
__Vaginal itching
__Vaginal discharge
__Lack of period
__Infertility
__Painful periods
__Heavy periods
__Clotting
__Irregular periods
__Spotting between periods
Days between periods:____
# of children:_____

MEN:

__Pain or swelling of scrotum
__Irregularity of urine flow &/or frequency
__Impotence
__Premature ejaculation
__Erectile dysfunction

OFFICE POLICIES

FEES: The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE: Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

Initial_____

ADDITIONAL THERAPEUTIC SERVICES: Other therapeutic services, such as herbal formulas, Cupping, Moxa, or Tui Na, may be recommended in order to maximize treatment outcomes. These services are often not reimbursable by insurance plans. If you are using an insurance plan that does not reimburse for these services and would like to receive them, there is an additional $20.00 fee payable at the time of service.

Initial_____

RELEASE OF INFORMATION: Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS: As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $25.00 fee for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations.

Initial_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving/about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand that I will be responsible for all "non covered" services and /or coinsurance/co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Rebecca Tabatzky, L.Ac.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment by Rebecca Tabatzky, L.Ac., payment and healthcare operations received, incurred or carried out at this practice. I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Signed_____Date_____