ACUPROLO INSTITUTE
RESTORATIVE HEALTH & NONSURGICAL PAIN CENTER

22750 Hawthorne Blvd Suite 218, Torrance, CA 90505
2211 Corinth Ave Suite 202, Los Angeles, CA 90064
Phone: (310) 878-2874 • www.acuprolo.com

PATIENT CONFIDENTIAL INFORMATION

First name:_____Middle:_____Last name:_____DOB:_____

Home address: _____City:_____State:_____ Zip:_____

Mailing address: □ Same as home or _____City:_____State:_____Zip:_____

Home Phone: _____Work:_____Cell: _____

Email:_____

What is the best way to contact you? □ By email □ Home phone □ Work phone □ Cell phone

Can messages containing personal health-related information be left on your:

Email? □ Yes ■ No Home phone? □Yes ■ No Work phone? □ Yes ■ No Cell phone? □ Yes ■ No

Marital Status: ■ Single □ Married □ Divorced □ Widowed

Is it OK to disclose to your spouse your personal health-related information? □ Yes ■ No

Is there anyone else whom you authorize for us to share your personal health related information with? ■ No □ Yes, the following people: Name_____Relationship to you:_____

Name_____Relationship to you:_____

Occupation: _____Employer:_____

Physicians or other practitioners that are coordinating your care:

Primary Care Provider: _____Specialty: _____Phone: (_____)_____

Other Provider name: _____Specialty:_____Phone: (_____)_____

Other Provider name: _____Specialty:_____Phone: (_____)_____

Other Provider name: _____Specialty:_____Phone: (_____)_____

Emergency Contact person:_____ Relationship to you: _____Phone_____

Alternate Contact person::_____ Relationship to you: _____Phone_____

I certify that the information on this Patient Information Form is true and correct to the best of my knowledge. I agree to notify the office of any changes in my personal contact information. I also certify that I am aware I can review the Patient Bill of Rights and Privacy Practices on line at www.acuprolo.com and upon my request I can receive a hard copy.

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("HIPAA"),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, conduct normal healthcare operations such as quality assessments and physicians certifications.

I understand that I may request in writing to restrict how my private information is used. I also understand Acuprolo Institute is not required to agree to my requested restrictions.

_____ _____

Patient Signature Date

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INITIAL HEALTH QUESTIONNAIRE (page 1 of 2)

NAME: _____**Date of birth**:_____ **Height**:_____ **Weight**:_____

REFERRED BY: □ Friend (name)_____□ Internet □ Flyer □ Other: _____

CHIEF CONCERNS: Please briefly list the major reason(s) you are consulting our physicians:

1._____
2._____
3._____

GOALS: What are your health related goals?

1._____
2._____
3._____

HISTORY OF PRESENT ILLNESS:

1. When did you first notice the problem? _____
2. What do you believe caused the problem? _____
3. Was there an incidence of trauma or accident in the past? _____

_____

4. How frequently do you experience pain? (daily, weekly, monthly, etc…)_____
5. Which terms best describe the pain? □ Pressure □Burning □ Pins & needles □ Cramping □ Sharp □ Achy □ Nagging □ Dull □ Shooting 6. What helps you with the pain (relieving factors)? _____

_____

7. What factors aggravate or make the pain worse? _____

_____

8. Do you have any loss of strength or sensation? If so, please describe: _____

_____

9. Please list all the doctors you have seen for this problem, including any specialists:_____

_____

10. Please list all the diagnostic tests you have had for this problem (Xrays, CT scans, MRIs, other) and the dates they were taken: _____

_____

11. Have you had physical therapy for this problem? If so, please list where, when and physical modalities used

_____

12. Do you play any sports or are you involved in physical activities? If so, which ones:_____

_____

13. List the activities with which your problem has interfered (including daily activities, social and recreational activities:

_____

14. Have you retained services of an attorney for this problem? □ No □ Yes, Name:_____
15. Are you involved in a worker's compensation case for this problem? □ No □ Yes

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INITIAL HEALTH QUESTIONNAIRE (page 2 of 2)

PAST SURGICAL HISTORY: Please list any surgeries you have had in your lifetime, and include the year.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ □ I've never had any surgeries PAST

PAST MEDICAL HISTORY: □ None, I am generally healthy

□ Arthritis □ Diabetes □ High blood pressure □ High cholesterol □ Thyroid disease □ stroke
□ Cancer □ Heart □ Stomach problems □ COPD/ emphysema □ Asthma □ Depression
□ other: _____

MEDICATIONS: P lease list all the medications you are currently taking. Include doses, and frequency.

Prescription Routine meds:	NON prescription pills, vitamins	Pain meds:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____
6. _____	6. _____	6. _____

ALLERGIES: □ I have no known drug allergies □ I have the following food allergies: _____
Please list any medication allergies you have had and the reaction:_____

FAMILY HISTORY: Please check the box if the following conditions run in our family and list the people who have had them (parents, grandparents, siblings, etc…)

□ Arthritis, who?_____ □ Diabetes, who?_____
□ High blood pressure, who?_____ □ Stroke, who?_____
□ Heart attack, who?_____ □ Cancer, who?_____
□ other, who?_____

SOCIAL HISTORY:

1. Do you smoke? If yes, please include number of years.□ NO □ Tobacco _____ □ Cigars _____ □ Marijuana _____
2. Do you drink alcohol? □ No □Yes, occasionally □ Yes, Frequently, type of alcohol & amount:_____
3. Do you use any illicit drugs? □ No □ Yes. What kind_____
4. Do you have a known history of any exposure to toxic substances? No □ Yes. _____
5. Who do you live with? _____
6. What is your occupation? _____

Thank you for completing this questionnaire. If there is anything else you think we should know at this time, please feel free to use the space below. _____

_____

_____

Patient Signature: _____ Date:_____

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BILLING AND REIMBURSEMENT ACKNOWLEDGMENT

I, _____, acknowledge that:

- I understand and agree that, regardless of my insurance status, I am responsible for all charges incurred for professional services rendered at the time of treatment (cash or check only).
- I am aware there will be a $25 fee charged for checks with insufficient funds and that appointment cancellations need to be made prior to 24hours or I will be charged for the visit.
- I understand that if I arrive late for an appointment I will be seen only for the remainder of the time originally allotted for that visit and I am still responsible for the full cost of the visit.
- I am aware the payment fee schedule is as follows:
    - Initial comprehensive evaluation (up to 50mins) $150
    - Follow up evaluation with treatment (up to 50mins) ranges from $175 to $300 depending on the diagnosis and treatment modality (acupuncture, osteopathic manipulation, prolotherapy and other injection therapy)
- I understand AcuProlo Institute does not accept payment from insurance carriers. However, upon my request, I will receive a superbill for the visit. It will be my sole responsibility to attempt to obtain reimbursement for services rendered.
- I understand that insurance reimbursement for injection therapies (prolotherapy, trigger-point injections, intramuscular injections, scar injections, joint injections, tendon injections, ligament injections, or neural injections) varies, and that some injection therapies may be considered investigational or experimental by some carriers and will not be paid for by the insurance companies. I further acknowledge that Medicare does not cover many injection therapies.
- I understand that insurance reimbursement for Traditional Chinese Medicine modalities (acupressure, acupuncture, electroacupuncture, moxibustion, and cupping) and Osteopathic Manual Therapies varies, and that some carriers will not pay for these treatments. I further acknowledge that Medicare does not cover some of these treatments.
- I understand that Acuprolo Institute is not responsible for any costs associated with treatment complications such as but not exclusive to hospitalizations, emergency room visits, costs incurred from other providers, laboratory and diagnostic imaging fees.
- I am aware the physicians in this office are not partners. They are independent practitioners and simply share office space, equipment and some staff in their separate practices. They are not responsible for each other's practice or patients, but may at times, cover for each other. Payments will be made to the primary doctor who provided care for that visit.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Parent or legal guardian name (if patient is a minor)	Parent or legal guardian signature (if patient is a minor)	Date