MVA form

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This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name_____Date _____

Gender _____ Age_____ Birthdate_____

Address_____

City_____State _____Zip_____

Home Phone_____Work Phone_____

Wireless Phone_____

Email_____

If under 18, person responsible for your account_____

Emergency Contact: Name_____
Emergency Contact Phone:_____

Occupation _____
Hobbies _____
Living situation _____
How did you hear about me?_____

Have you had acupuncture therapy before? How was it?_____
_____

Insurance company and claim number _____
Named insured _____

_____

Please CIRCLE if any of the following pertain to you (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

Hepatitis B/C HIV/AIDS High Blood Pressure Seizures Blood-Thinning Medication Pacemaker Current Pregnancy

Please indicate the use and frequency of the following:

Coffee _____Soda _____ Tea _____ Water _____

Alcohol_____

Recreational drugs _____

Tobacco (include history)_____

Exercise _____

Name and phone number of primary care physician: _____

_____

Please list any prescription or over-the-counter medications you are presently taking:

Medication & Dosage (incl. Supplements) Reason / How long

_____

_____

_____

_____

_____

_____

Health History

Please list your health concerns in order of priority:

1. _____

2. _____

3. _____

In what state did your accident occur? _____ Date of accident_____

Where were you sitting? _____ Were you belted? _____

What happened?

What other forms of treatment have you sought?

What helps your condition?

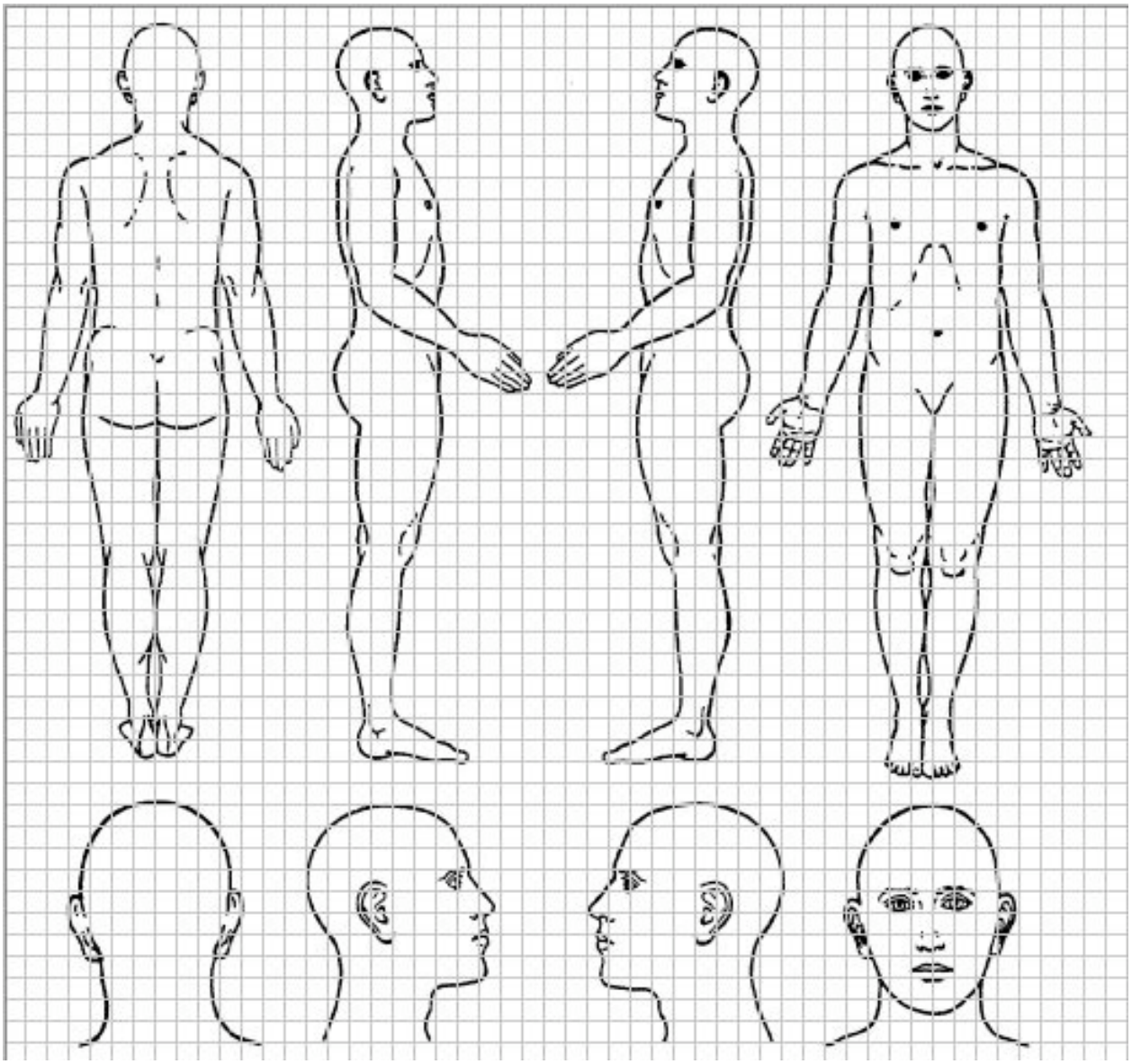
What aggravates your condition?

How severe is it? Does it interfere with your daily life?

Is it worse or better at a particular time of day?_____

What pain, if any, did you experience before the accident?

Please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain?

__dull/achy ____sharp/stabbing ____burning ____tingling ____numbness ____electrical

On a scale of 0-10, 0 being no pain, and 10 being the worst pain imaginable, how do you feel right now?

_____

What's the worst your pain has been over the past week? _____

Since the accident, note any **changes** in these areas:

Psychological:

Depression Anger Anxiety Stress Irritability Other emotional upset _____

Neurological:

Headache Migraine Head injury Loss of Consciousness Stroke Fainting/Dizziness
Blackout Seizures Paralysis Local weakness Numbness Tingling
Tremors Difficulty thinking/ confusion Difficulty with memory

Vision:

Trouble focusing Eye Pain Redness Tearing Double Vision

Ears:

Hearing problems Tinnitus Vertigo Balance Earaches

Gastrointestional:

Low appetite Excess hunger Nausea Vomiting Constipation
Diarrhea Food allergies
IBS Excess belching / gas Bowel incontinence Rectal bleeding Indigestion
Heartburn / Reflux Hemorrhoids Recent change in BM _____

Urinary:

Frequency_____Color _____
Bloody Frequent urination At night Painful Urgency Hesitancy Incontinence

Musculoskeletal:

Pain Stiffness Swelling Redness Weakness Limited range of motion
Neck Shoulders Arms Hands Upper back Middle back Lower back Ribs Hips
Legs Knees Ankles Feet

Anything else?

INFORMED CONSENT

I understand that although all efforts will be made to ensure that my treatment is as painless and side-effect-free as possible, sometimes life is not perfect.

I understand that although the acupuncture needles are sterile, and my skin will be cleaned, there is a small risk of infection.

I understand that there is a risk of bleeding, bruising, or pain with needling.

I understand there are a few serious risks associated with acupuncture, such as pneumothorax (punctured lung) or nerve irritation.

I understand that therapeutic bodywork (medical massage) may result in soreness or bruising.

I understand that there are no guarantees with regard to treatment outcome, and that symptoms may become worse after treatment.

I understand that I am free to withdraw this consent and stop treatments at any time.

With this knowledge, I voluntarily consent to acupuncture, moxibustion, cupping, and therapeutic bodywork, and agree to release Sharon Rose from any liability that may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care.

CANCELLATION POLICY

I understand that if I cannot keep an appointment I need to call as soon as possible. I understand that cancellation within 24 hours of the appointment creates a hardship for both Rose City Acupuncture and for patients who may have wanted that time slot, and that I may be charged a $35 cancellation fee for that appointment.

Date _____

Patient name (printed) _____

Patient signature _____

Parent / Legal Guardian's name (if applicable) _____

Parent / Legal Guardian's signature _____