Student Health & Wellness
Acupuncture Intake

Potential billing costs: Please review our Costs of Services sheet that outlines when SHW bills your insurance and when you may incur out-of-pocket costs. Most primary care services done at Student Health are billed to insurance, and have no out-of-pocket cost to you **however, acupuncture is an exception.** Billing options for acupuncture include a **$35 flat-fee self-pay option *OR* billing to insurance**, which would be subject to insurance benefit coverage costs. SHW can check insurance coverage for acupuncture services, but it can take a few weeks to process. Appointments can not be billed as self-pay retroactively. Please ask our front desk team, your provider, or refer to our costs of services sheets if you have any questions or concerns about billing.

Name you go by: _____ Date of birth:_____

MEDICAL HISTORY

Do you have diabetes?_____
Have you ever fainted?_____
Have you been fitted with a pacemaker or any other electrical implants? _____
Do you have a bleeding disorder? _____
Are you pregnant or actively trying for a pregnancy? _____
Do you suffer from metal or silicone allergies?_____
Do you know of any reason why you should not receive acupuncture?_____
Have you ever had acupuncture treatment(s) before today?_____

1. In general, would you say your health is: □Excellent □Very □Good □Fair □Poor
2. How would you rate your physical health: □Excellent □Very □Good □Fair □Poor
3. How would you rate your mental health: □Excellent □Very □Good □Fair □Poor
4. In the past 7 days, how often have you been bothered by emotional problems, such as feeling anxious, depressed or irritable: □Never □Rarely □Sometimes □Often □Always
5. How would you rate your fatigue on average: □None □Mild □Moderate □Severe □Very Severe

Why are you seeking care today?

Briefly describe symptoms and duration:

_____
_____
_____
_____
_____
_____

Please Circle Other Symptoms or Concerns:

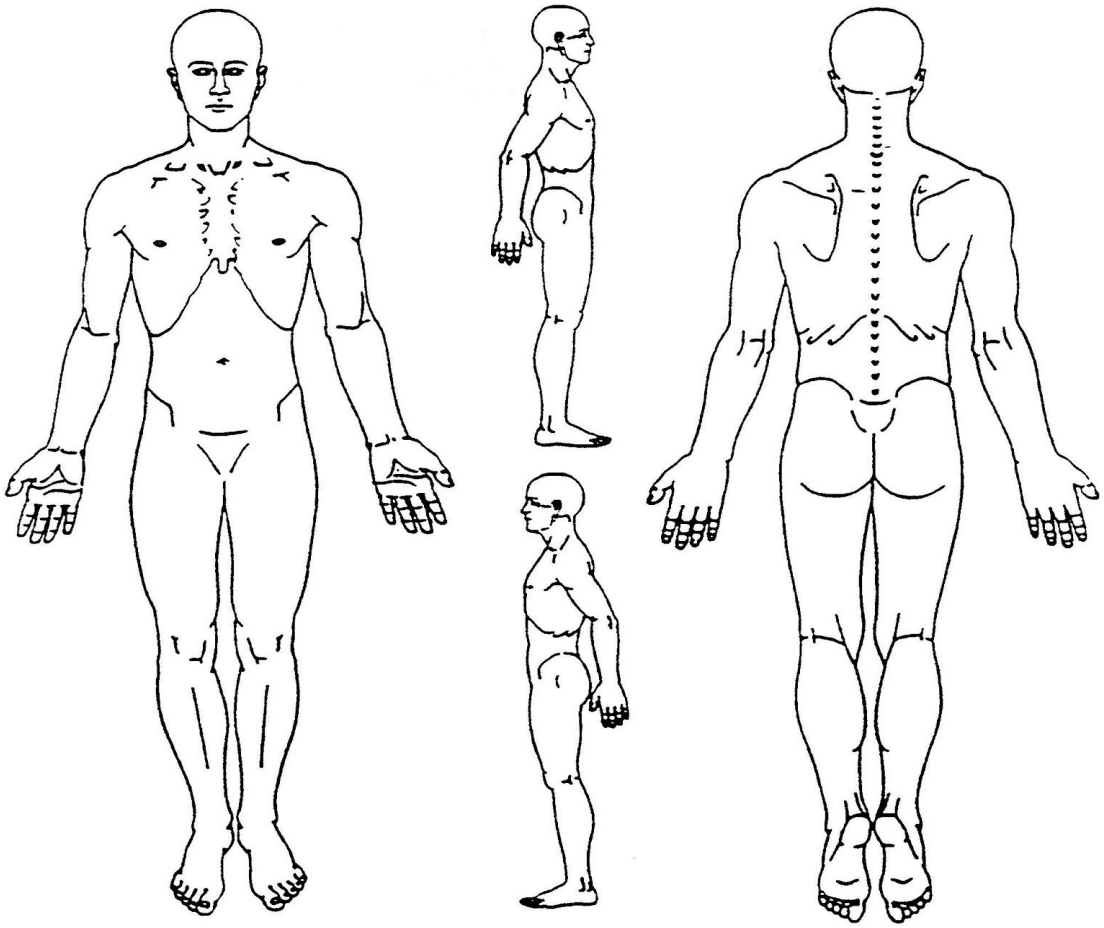
□Pain in muscles or joints □Headache □Unexplained fatigue □Insomnia □Skin problems □Excess worry or anxiety □Sadness or depression □Addictions or related problems □Asthma □Cancer □Allergies □Frequent colds, cough, sore throat □Vision or hearing problems □Heart problems □Women's health problems □Men's health problems □Digestive or stomach problems

□Other (please describe):_____
_____
_____

PAIN DIAGRAM

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbeness ---- Pins & Needles oooo Burning xxxx Aching **** Stabbing ////



My pain is a _____ on a scale from 1-10.

Any additional information you would like to add:_____
_____
_____