Mayflower Acupuncture LLC

536 Hopmeadow St.
Simsbury, CT 06070
Phone: (860) 413-2118 Email: Forms@mayfloweracupuncture.com

Welcome to Mayflower Acupuncture.
To help us provide you with the best possible care, please fill out this form as completely as you can.
All information provided here will be held in strictest confidence.
Feel free to ask if you have any questions.

Today's Date:

First Name	Last Name		Middle Initial
Age	Date of Birth	Gender	Marital Status
Address	City	State	Zip
Email	Phone Number: Mobile: Work: Home:		
Preferred Way of Communication:			
Occupation	Employer		
Emergency Contact Name	Emergency Contact Number:	Emergency Contact Relationship:	
Physician	Phone Number	May we contact this person?	
Have you received acupuncture or herbal therapy before?			
How did you hear about Mayflower Acupuncture?			

PRIMARY REASON(S) FOR SEEKING TREATMENT:

1.
2.
3.
4.

Is there an open case for the issue/s we are treating?	
Do you have a lawyer representing you?	
When did this/these problem(s) begin?	What were the causes?
What makes your symptom(s) better?	Worse?
Please rate your current pain or discomfort on a scale of 1 to 10:	
Have you received a diagnosis from your PCP?	If so, what?
What other treatments have you tried?	

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MEDICAL HISTORY (Include Dates)

Medications you are currently taking & dosage

Supplements/Herbs you are currently taking

Allergies (food, drugs, chemicals, etc.) & reactions

Major illnesses or significant traumas
Surgeries

Check All That Apply:

Anemia	Hepatitis	Lyme Disease	Tuberculosis
Asthma	Heart Disease	Pneumonia	Other ______________
Cancer	High Blood Pressure	Seizures	________________
Diabetes	HIV/AIDS	Stroke	

FAMILY MEDICAL HISTORY (Check All That Apply)

Alcoholism/Addiction	Cancer	Heart Disease	Psychological Disorder
Arthritis	Diabetes	High /Low Blood Pressure	Stroke

PERSONAL

Height	Weight	Weight Maximum	When?
Exercise (Please describe)			
Stress (occupational, emotional, etc.			
Do you smoke?	Previously smoke?	How much?	For how long?
Do you drink alcohol?	How many drinks per week?		
Do you drink caffeinated beverages?	What kind?	How many per day?	
Please list any other drug use			
Country visited outside US for the past 6 months			

PERSONAL SIGNS AND SYMPTOMS (Please check any that apply to you)

General

Bleed or Bruise Easily
Chills
Cravings
Fatigue
Localized Weakness
Night Sweats
Poor Appetite
Poor Balance
Poor Sleep
Strong Thirst
Sudden Energy Drop
Sweat Easily
Weight Gain
Weight Loss

Musculoskeletal

Back Pain
Cold Hands/Feet
Foot / Ankle Pain
Hand / Wrist Pain
Hernia
Hip Pain
Joint Pain / Stiffness
Knee Pain
Muscle Atrophy
Muscle Pain
Muscle Twitches
Muscle Weakness
Neck Pain / Tightness
Numbness
Paralysis
Sciatica
Shoulder Pain
Spinal Curvature
Swollen Hands/Feet
Tingling
Tremor
Vertebral Disorder

Head & Throat

Blurry Vision
Cataracts
Concussions
Difficulty Swallowing
Dizziness
Dry Eyes
Earaches
Eye Pain / Strain
Facial Pain
Frequent Sore Throats
Headaches
Head Injury
Hearing Loss
Jaw Clicks / TMJ
Migraines
Mouth / Lip Sores
Night Blindness
Nose Bleeds
Ringing in Ears
Sinus Problems
Spots in Vision
Tearing
Teeth Grinding
Tooth Pain

Skin & Hair

Acne	Dry Skin	Itching	Recent Moles
Change of Hair Texture	Eczema	Psoriasis	Ulcerations
Change of Skin Texture	Hair Loss	Purpura	
Dandruff	Hives		

Respiratory

Allergies	Chest Pain	Difficulty Breathing	Persistent Cough
Asthma	Coughing Blood	Emphysema	Pleurisy
Bronchitis	Coughing Up Phlegm	Frequent Common Colds	Wheezing

Cardiovascular

Blood Clots	Heart Murmurs	Low Blood Pressure	Rapid Heartbeat
Chest pain	High Blood Pressure	Palpitations	Varicose Veins
Fainting	Irregular Heartbeat	Phlebitis	

Gastrointestinal

Abdominal Pain / Cramps	Crohn's Disease	Hemorrhoids	Rectal Pain
Acid Reflux	Constipation	IBS	Ulcers
Bad Breath	Diarrhea	Indigestion	Undigested Food in Stools
Belching	Gallbladder Problems	Mucus in Stool	Vomiting
Black Stools	Gas/ Bloating	Nausea	
Blood in Stools	Heartburn	Parasites	

Neuro-Psychological

ADD / ADHD	Concussion	Loss of Balance	Stress
Anxiety	Depression	Memory Loss	Vertigo
Bad Temper / Irritability	Dizziness	Mood Swings	
Bipolar	Lack of Coordination	Seizures	

Genito-Urinary

Blood in Urine	Frequent Urination at Night	Inability to Hold Urine	Pause of Urine Flow
Burning Urination	Genital Itching	Kidney Stones	Urinary Tract Infection
Dribbling	Genital Pain	Painful Urination	Urinary Urgency
Frequent Urination			

FEMALE

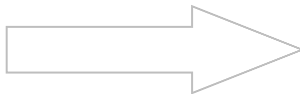
- Breast Lumps
- Breast Tenderness
- Clotting During Menstruation
- Difficult / Painful Intercourse
- Endometriosis
- Frequent Vaginal Infections
- Infertility
- Irregular Menstruation
- Menopausal Symptoms
- Nipple Discharge
- Ovarian Cysts
- Painful Menstruation
- Pelvic Infection
- PMS
- Polycystic Ovarian Syndrome
- Sexually Transmitted Disease
- Spotting
- Uterine Fibroids
- Vaginal Discharge
- Vaginal Dryness

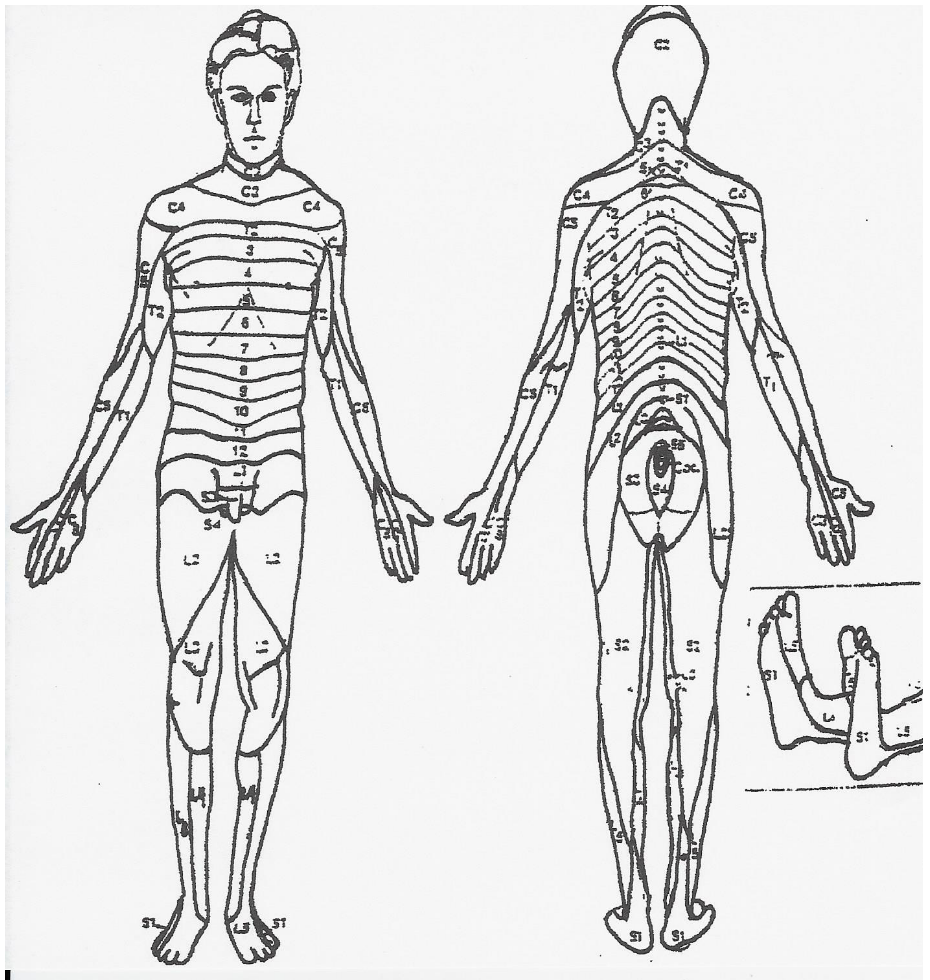
Is there any possibility that you may be pregnant?		
Date of last menses	Length of menstrual cycle	Duration of period
Number of Pregnancies	Number of births	

MALE

- Erectile Dysfunction
- Fertility Problems
- Frequent Nocturnal Emissions
- Frequent Seminal Emissions
- Painful / Swollen Testicles
- Penile Discharge
- Premature Ejaculation
- Prostate Problems
- Sexually Transmitted Disease

This diagram is to indicate your site(s) of pain. This will be filled-out in the office on your visit.





Payment: *Prior to making an appointment, should you wish to find out if your policy covers acupuncture treatment, you may send us your insurance card photo (front and back) by text at (860) 970-4232.*

Insurance (We are in-network with Cigna, United HealthCare & Harvard Pilgrim)

We will verify your coverage for acupuncture. We do all the paperwork and follow-ups with your insurance carrier should you have coverage.

***If you have deductible to satisfy:** Patient liability to cover the deductible or out of pocket varies from the insurance allowable amount.

Anthem: Payment/Reimbursement will send directly to the member/patient. Any amount paid by Anthem is payable to Mayflower Acupuncture.

Out of Pocket /Cash-Pay

Out of Pocket/No coverage: Our office accepts cash, checks, American Express, VISA, MasterCard and Discover cards. Payments are due at the time of service. After your 1st 3 sessions, we offer packages to help you lower your expenses.

FEE SCHEDULE

Cash Non-Insurance Submission Prompt-Pay Discount Applied	
Initial Visit	$135.00 1 hour to 1.5 hour
Follow-up Visits	$110.00 1 hour
Packages	
Package 10 [Offered after the 1st 3 visits] Individual or Family See Package Fee Agreement	$990.00 1 visit free out of 10 / $110 Savings
Package 15 [Offered after the 1st 3 visits] Individual or Family See Package Fee Agreement	$1,440.00 2 visits free out of 15 / $220 Savings
Package 20 [Offered after the 1st 3 visits] Individual or Family See Package Fee Agreement	$1,870.00 3 visits free out of 20 / $330 Savings
Fees are subject to change without notice	

OFFICE POLICIES – PLEASE READ AND SIGN BELOW

1. In fairness to all patients, we regret that appointments cancelled less than 24 hours before appointed time are charged $50.00.
2. Herbs are refundable within 7 days of purchase.
3. Herbal prescriptions are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
4. Payment is due at time of service. Any outstanding balance remaining after 90 days is subject to a 10% charge.
5. *I acknowledge that I have read and consent to the **"Notice of Privacy Practices"** of Mayflower Acupuncture, LLC. I understand that I may receive a copy of the above "Notice of Privacy Practices" and may ask any questions about the notice prior to signing this document.*

Patient's Signature: ______________________________ Date: ________________________