**FOUR GATES ACUPUNCTURE, LLC**

805 S. Black Horse Pike, Blackwood NJ 08012

Phone: 856.228.1330 Fax: 856.228.4322

Date / / Telephone of a Friend or Relative

 You Would Want Contacted Incase

 of an Emergency \_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Social Security Number - - .

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth / / -

Home Telephone \_(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M\_\_\_\_\_ F\_\_\_\_\_\_\_

Cell Phone \_\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: M S W D

Work Telephone \_\_(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_ Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.)Have you ever had acupuncture before? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

Have you eaten today? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_ At what time was your last meal? \_\_\_\_\_

2.) Problem that brought you here today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) Has there been anything that has ever been able to change your problem in anyway?

Yes\_\_\_\_\_ No\_\_\_\_\_ Please describe-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.) When did this problem first appear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.) Is it constant or does it come and go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) If applicable, does the problem ever move? (for example, pain or spasms that occur in different joints or muscles at different times) Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_

7.) If applicable, is the pain sharp or dull? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8.) What makes your pain better? Please circle: heat or cold, movement or rest, pressure, massage. Describe any other ways in which your pain is made better.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9.) Is your illness affected by seasonal changes? Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10.) Other problems you would like addressed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11.) Are you currently on any medication? Please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12.) Do you take any vitamins/supplements? Please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13.) Have you had any surgeries? Yes \_\_\_ No \_\_\_ If yes, what kind of surgery, and when did you have it done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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14.) History of Significant Illnesses: (Please include all past accidents, childhood illnesses, and the dates that they occurred)

SELF

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER FATHER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GRANDMA/GRANDPA GRANDMA/GRANDPA

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15.) Do you smoke? Yes \_\_\_ No\_\_\_ If yes, the number of cigarettes you smoke per day \_\_\_\_\_ or the number of packs \_\_\_\_\_

16.) Do you drink alcohol? Yes\_\_\_ No\_\_\_ How many glasses per day\_\_\_\_ per week \_\_\_\_ per month \_\_\_\_

17.) Describe your sleep habits (for example, number of hours per night that you sleep, do you have trouble falling to sleep, or do you awake very early and are then unable to go back to sleep)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18.) Circle your bowel habits: Regular Constipation Diarrhea

19.) If you suffer from constipation, do you feel better or worse immediately after moving your bowels? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days pass before you move your bowels? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20.) If you suffer from diarrhea, does it occur early in the morning when you first wake up?

Yes \_\_\_\_ No\_\_\_\_ Does your rectum burn as the stool exits? Yes\_\_\_ No\_\_\_ How many episodes of diarrhea do you have per day? \_\_\_\_\_\_

21.) Do you regularly experience abdominal pain? Yes\_\_\_\_ No\_\_\_\_

If yes, what makes it better? Please circle: Heat/Cold Eating/Not Eating Massage Rest/Movement Other\_\_\_\_\_\_\_\_

22.) Do you have any emotional difficulties? Please circle:

Anxiety Panic Attacks Depression Mania Mood Swings SAD

23.) How would you rate your ability to concentrate/maintain focused thinking, and have clarity of thought? Please circle:

Poor Moderate/Good Excessive

24.) Is your urine clear: scanty/abundant **OR** dark: scanty/abundant? Please circle.

How many times a day do you urinate? \_\_\_\_\_\_\_

25.) How would you rate your appetite? Please circle:

Poor Moderate/Good Excessive

26.) Do you crave sweets? Yes\_\_\_ No\_\_\_ List any other foods that your crave.\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27.) Do you get headaches often? Yes\_\_\_ No\_\_\_ If yes, is the headache always in the same location? Yes\_\_\_ No\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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28.) Do you ever experience dizziness? Yes\_\_\_ No\_\_\_

29.) Are you often thirsty? Yes\_\_\_\_ No\_\_\_\_

30.) Do you prefer cold or warm drinks? Please circle.

31.) Do you often feel cold? Yes\_\_\_ No\_\_\_ If yes, where? Please circle: Hands/feet Limbs Entire body Other\_\_\_\_\_\_\_\_\_\_

32.) Describe the degree to which you sweat: Please circle: Very Little Average Excessive

On a moderate temperature day, do you tend to sweat more during the day or at night? \_\_\_\_\_\_\_

33.) Do you exercise? Yes \_\_\_\_ No \_\_\_\_ How often?\_\_\_\_\_\_\_ What do you do? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

34.) How would you rate your energy level? Please circle:

Poor Fair Good Excellent Other\_\_\_\_\_\_\_\_\_

35.) Describe your diet: Number of vegetables eaten daily \_\_\_\_\_\_\_\_\_ Number of meat products eaten daily \_\_\_\_\_\_\_\_\_\_ Number of caffeine containing products eaten daily \_\_\_\_\_\_\_\_\_\_ Number of whole grain products eaten daily \_\_\_\_\_\_\_\_\_

36.) Have you had any lymph nodes removed? Yes\_\_\_\_ No\_\_\_\_ If yes, please describe\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

37.) Do you have any infectious diseases? Yes\_\_\_\_ No\_\_\_\_

38.) Do you have a history of drug abuse? Yes\_\_\_\_ No\_\_\_\_

**WOMEN ONLY**

39.) Is there any chance you could be pregnant? Yes\_\_\_\_ No\_\_\_\_

40.) Are your menstrual cycles regular, irregular, early, or late? Please circle.

41.) Is your menstrual flow normal, light, or heavy? Please circle.

42.) Is the blood normal, purplish, dark, or light in color? Please circle.

43.) Does your menstrual blood contain clots? Yes\_\_\_ No\_\_\_

44.) Is your vaginal discharge clear/white and thin, or yellow and thick? Please circle.

45.) Do you have itching or soreness of the vagina? Yes\_\_\_\_ No\_\_\_\_

46.) If you generally experience mood swings, use the choices below to describe how they are around the time of your menses: Better Worse Same Not Applicable

47.) Number of children\_\_\_\_\_\_ Number of miscarriages\_\_\_\_\_\_\_ Number of abortions\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date

**FOUR GATES ACUPUNCTURE, LLC**

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Phone: 856.228.1330 Fax: 856.228.4322

**ACUPUNCTURE CONSENT FORM**

“Acupuncture” means the stimulation of a certain point or points on or near the surface of the body by insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunction of the body. Acupuncture includes the techniques of electro-acupuncture (therapeutic use of weak electric currents at acupuncture points), and mechanical stimulation (stimulation of a/an acupuncture point or points by means of apparatus or instrument).

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

The potential benefits: acupuncture may allow for the painless relief of ones symptoms without the need for drugs, and improve the balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

PLEASE NOTE: The acupuncture treatment (which includes procedures described above) that you will receive today and in the future, at this office is by a NJ licensed acupuncturist and a Diplomate of the NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine).

“With this knowledge, I voluntarily consent to the above procedures.”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

**FOUR GATES ACUPUNCTURE, LLC**

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Phone: 856.228.1330 Fax: 856.228.4322

Office of Dr. Michael A. Rubcich

**AUTHORIZATION RELEASE MEDICAL RECORDS AND XRAYS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the release of my x-rays and any other medical records or copies of such that may be pertinent to my condition.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax to:**

Michael A. Rubcich

805 S. Black Horse Pike

Blackwood, NJ 08012

856-228-4322 (fax)

856-228-1330 (phone)

Dr. Michael A. Rubcich

805 S. Black Horse Pike

Blackwood, NJ 08012

ASSIGNMENT OF BENEFITS FORM

Patients Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I irrevocably assign to Doctor Michael A. Rubcich all my rights and benefits under any

insurance contract for payments for services rendered to me by Doctor Michael A.

Rubcich. I irrevocably authorize all information regarding my benefits under any

insurance policy relating to any claim by Doctor Michael A. Rubcich to be released to

Doctor Michael A. Rubcich . I irrevocably authorize Doctor Michael A. Rubcich to file

insurance claims and law suits on my behalf for services rendered to me. I irrevocably

direct that all such payments go directly to Doctor Michael A. Rubcich. I irrevocably

authorize Doctor Michael A. Rubcich to act on my behalf and report any suspected

violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand

 its nature and effect and execute it voluntarily.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_