Return Visit Intake Form

**Please complete the top half of this form before each visit**

Community Clinic - Campus Health Services

Personal Information

Name: ___________________________   PID#: ___________________________   Date: ___________________________

Please describe the main concern you’re coming in for today:

____________________________________________________________________________________

Since your last visit, condition is:
Improving ( )  Unchanged ( )  Worsened ( )  Incicent Aggravated Condition ( )

Symptom Intensity:    Absent  0  1  2  3  4  5  6  7  8  9  10  Severe

Please note any significant changes to symptoms, such as location, aggravating or alleviating factors, quality of pain, etc.:

____________________________________________________________________________________

Please note any new symptoms or changes to current medications:

____________________________________________________________________________________

***For Practitioner Use Only***

Practitioner: ___________________________   Time needles inserted: ___________________________

Subj/Obj Notes:

____________________________________________________________________________________

Tongue: ___________________________   Pulse: ___________________________

Treatment:

____________________________________________________________________________________

Tx Plan for next visit: ___________________________   Herbs: ___________________________
Acknowledgement and Agreement for Payment / Acupuncture Services

By signing this agreement, I acknowledge
1. Acupuncture services provided at UNC Campus Health Services carry a $50.00 charge per visit and
2. These services will not be billed to any insurance carrier and
3. I will be financially responsible for the entire cost of the service; it will be billed to a student’s university account or invoiced to private patients.

I have read and understand the above and agree to pay all charges for treatment(s) or diagnostic procedure(s) to Campus Health Services.

______________________________  ______________________________
Date  Signature of Patient

______________________________  ______________________________
PID #  Printed Name of Patient

______________________________  ______________________________
Signature of Parent/Guarantor

** PARENT/GUARANTOR INFORMATION AND SIGNATURE REQUIRED FOR PATIENTS UNDER AGE 18**

Name (Print): ____________________________ Relationship to Patient: _______________________

Address: ______________________________________________________

Phone: ___________  Date of Birth: ___________

Revised 9-7-18