Patient Intake Form

Please help me to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Even though some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. Thank you.

Contact Information Today's Date:___/___/_____

Name:_____ Sex: F M DOB:__/__/___ Age:_____

Street:_____ Email Address:_____

City:_____ State:_____ Zip:_____ Phone Number:_____

# of Children:_____ Ages of Children: _____ Alternate Phone Number:_____

Marital Status: Single Married Domestic Partner Divorced Widowed Separated

Occupation: _____ Employer: _____

Emergency Contact:_____ Phone:_____

How did you find out about us?_____ Referred By:_____

Have you had acupuncture before? Y N Allow email/mail/phone contact by us? Y N

Primary Care Physician:_____ Phone:_____

Primary Insurance Company:_____ ID #:_____ Group #:_____

Name of Insured:_____ Relationship to Patient: Self Spouse Parent

Customer Service Phone Number:_____

Secondary Insurance:_____ ID #:_____ Group #:_____

Name of Insured:_____ Relationship to Patient: Self Spouse Parent

Customer Service Phone Number:_____

Medications and Supplements

List all prescription medications, vitamins, supplements, over-the-counter drugs, herbal supplements, etc. that you are currently taking. Include the dose, frequency, & reason for use:

_____

_____

_____

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today**.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

When did the checked problem begin?_____

Are you being treated for this condition by anyone else? Please provide name._____

Have you been given a diagnosis for this problem? If so, please describe._____

What kind of treatments have you tried?_____

What makes this problem worse?_____ Better?_____

Is there anybody in your family with the same problem?_____

Please describe how these conditions affect or impair your daily activities? (E.g., quality of life, work, family life, self-esteem) _____

Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C		P	C		P	C		P	C		P	C	
AIDS/HIV			Alcoholism			Anemia			Arthritis			Asthma		
Auto Immune			Bleeding Disease			Bronchitis			Cancer			Candida (Yeast)		
Chronic Fatigue			Colitis			Diabetes			Eating Disorder					
Gallstones			Glaucoma			Gout			Headaches					
Heart Disease			Hemorrhage			Hepatitis			Hernia			Herniated disc		
High Cholesterol			Hypertension			Hypotension			Jaundice			Kidney Disease		
Liver Disease			Mental Illness			Migraine			Mono			MS		
Osteoporosis			Organ Transplant			Pacemaker			Parkinson's					
Pneumonia			Rheumatic Fever			Seizures			STD's			Stroke		
Substance Abuse			Suicide Attempt			Thyroid Disorder			Tuberculosis					
Ulcer			Vein Condition			Whooping Cough			Other:_____					

Allergies (food, medications, other):_____

Traumatic Injury (car accident, falls, sports injuries etc.):_____

Immunizations:_____

Hospitalizations/Surgeries (procedures & dates):_____

Do you have a history of frequent antibiotic use? Please Describe._____

Family Medical History

AIDS/HIV	Alcoholism/Substance Abuse	Allergies	Asthma	Cancer	Diabetes	
Heart Disease	Hypertension	Mental Illness	Miscarriage	Osteoporosis		
Respiratory Diseases	Seizures	Stroke	Other_____			

Current Health & Lifestyle

Do you smoke? Y N If yes, how many per day?_____ How many years?_____

Do you exercise? Y N If yes, how many times per week?_____ Please describe _____

Do you make time for relaxation, meditation, or prayer? Y N

Do you travel frequently? Y N Have you traveled overseas to developing countries? Y N

Do you sit in traffic/commute as a daily routine? Y N

Height:_____ Weight: _____ One year ago_____ Maximum weight (include date) _____

How many hours do you sleep in general?_____ What time do you usually go to bed?_____

Easy to fall asleep? Y N Easy to stay asleep? Y N Sleep apnea? Y N

Wake tired? Y N Nightmares? Y N

Diet

Number per day: Water_____ Alcohol_____ Coffee_____ Soft drinks_____ Tea_____

Please describe your average daily diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Foods you tend to crave:_____

Profile

Please circle any of the following symptoms that **currently** pertain to you.

General

Energy level: High Moderate Low
Thirst desire: Hot Cold Room temperature No thirst or Excessive
Coldness: Hands Feet Back Whole body
Heat: Hands Feet Abdomen Whole body
Stiffness: Back Joints Limbs Neck
Intolerance: Heat Cold Wind Fan or A/C
Edema: Face Hands Legs Feet

Chills Fever Sweaty hands Sweaty feet
Profuse sweating No sweating Hot flashes Night sweating
Bleed easily Knee soreness Lower back pain

Skin/Hair

Acne Bruise easily Change in skin texture Dandruff
Dry or Flaky Skin Eczema Fungal/yeast infection Hair loss
Herpes Hives Itching/Burning Psoriasis
Rashes Sores Ulcerations/Boils

Head

Dizziness Facial pain Facial paralysis Headaches
Migraines Head injury Heaviness in head Sinus problems

Eyes

Blurry vision Cataracts Dry eyes Eye pain
Floaters/spots Glasses/contacts Glaucoma Itchy eyes
Night blindness Red/irritated eyes Twitching Watery eyes

Ears

Discharge Earaches/Infections Hearing loss Itchy ears
Ringing in ears: Y N High pitch Low pitch

Nose

Dry nose Heightened sense of smell Loss of smell Nose bleeds Sneezing
Nasal discharge: Y N Color: Clear White Yellow Green
Is nasal discharge: Thick Thin

Mouth/Throat/Neck

Bad breath Difficulty swallowing Drooling Dry lips/mouth/throat
Excess saliva Frequent throat clearing Grind teeth Gum bleeding/disease
Hoarseness Loss of voice Feeling of lump in throat Mouth sores
Snoring Sore throat Tonsillitis

Cardiovascular

Chest heaviness/tightness Chest pain Coma Fainting High BP Low BP
Insomnia Irregular heart beat Mania/delirium Palpitations Poor memory
Restless sleep Speech impediment Swelling in hands/feet

Respiratory

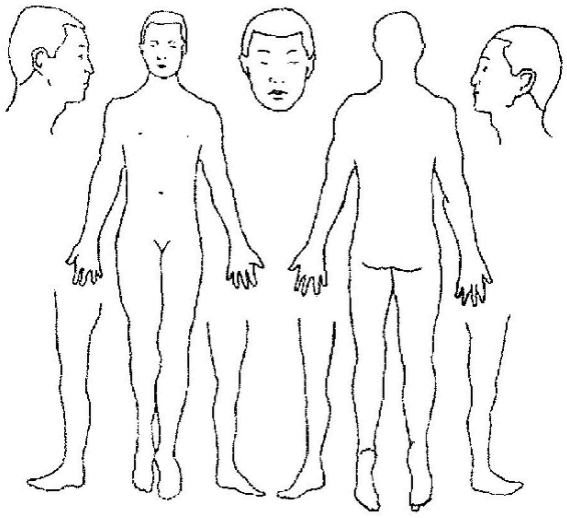
Chest congestion Persistent cough Coughing blood
Phlegm color: Clear White Yellow Green
Consistency: Thin Thick
Difficulty Breathing: Inhaling Exhaling When lying down When sitting up
Frequent colds/flu Frequent sighing Pneumonia Shortness of breath
Wheezing

Gastrointestinal

Abrupt weight gain Abrupt weight loss Acid reflux Bad breath
Belching Bloating/fullness Blood in stools Constipation
Diarrhea Less than 1 BM per day Loose stools Mucus in stools
Small, hard, dry stools Easily fatigued Fatigue after eating Food allergies
Gas Gurgling in intestines Heartburn Heavy limbs/head
Hemorrhoids Hiccups Indigestion Like/dislike pressure
Mental fogginess Nausea Nervous stomach Poor appetite
Ravenous appetite Rectal bleeding Stomach pain Stomach ulcer
Strong cravings Taste in mouth Vomiting

<u>Musculoskeletel</u>

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:	
X	Sharp / Stabbing
P	Pins and Needles
D	Dull / Aching
N	Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Location: Face Jaw Neck Shoulders Chest Epigastric area
Rib cage Abdomen Pelvic Genitals Knees Upper back Mid back
Lower back Sacrum Fingers Feet Upper limbs Lower limbs Whole body

Pain feels like it's in: Bone Joint Muscle

Aggravated by: Cold Damp Heat Movement Rest Pressure

Alleviated by: Cold Damp Heat Movement Rest Pressure

Check all that apply: Fixed pain Moving pain Radiating pain Burning Clicking
Soreness Spasms Stiffness Swelling Weakness

Neurophysiological

Anger Anxiety Bad-tempered Bipolar Concussion Confusion
Convulsions Depression Easily stressed Fear Feeling stuck
Frequent worrying Frustration Grief Hyper Hopelessness
Irritability Joyful Lack of coordination Loss of balance Mania
Mood swings Nervousness Obsessive/Compulsive Over-thinking
Panic attacks Paralysis Phobias Poor memory Sadness Shaking Tics

Genito-Urinary

Urine Color: Clear Cloudy Pale yellow Dark yellow Reddish
Difficulty initiating urination Dribbling Frequent urination Incontinence
Pain or burning Strong odor Unable to hold urine Urgency to urinate
History of bladder infections History of Kidney stones Wakes to urinate more than 1x/night
Sexually active Increased sex drive Low sex drive Impotency Genital itching
Genital sores/pain

Men's Health

Difficulty achieving erection Difficulty maintaining an erection Discharge
Ejaculation problems Feeling of cold/numbness of genitalia Infertility
Injury to reproductive organs Low sperm count Nocturnal emission Painful erections
Premature ejaculation Prostate Problems Testicular pain/swelling

Women's Health (Please indicate when you experience symptoms. B= Before period, D=During period, A=After period, X=Not related to period)

Abdominal cramps Abnormal pap smear Acne Breast discharge
Breast lumps Breast tenderness/swelling Change in bowel movement
Endometriosis Fertility problems Fibroids Food cravings Headache/migraine
Heavy bleeding Hot flashes Irritability Lower back pain Mood swings
Night sweats Ovarian cysts Pain during intercourse Pelvic infection
Scanty/light bleeding Spotting between periods Vaginal discharge Vaginal dryness
Vaginal infections Water retention

_____ # pregnancies _____ # live births _____ # miscarriages _____ # abortions

_____ # premature births _____ #cesareans

At what age did you get your first period:_____ First day of last menstrual period:_____

Are your menstrual cycles regular? Y N Period beings every _____ days and last _____ days

Color: Light red Red Dark red Purple Brown Clots

Are you currently using birth control? Y N If yes, what type and for how long?_____

Have you experienced menopause? Y N When?_____

Is there <u>any</u> possibility you are pregnant now? Y N

Is there anything else you would like to comment on? Y N _____

By signing, I attest that all information I have provided on this form is true, accurate and complete.

_____

Patient Signature Date

Notice of Privacy Practices - Standard Authorization of Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Release of Confidential Information
This disclosure pertains to HIPAA – The Health Insurance Portability and Accountability Act of 1996. HIPAA calls for, among other things, security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present and future. Your medical records will be kept confidential and only you the patient will have access to them, except in certain circumstances, for example for billing purposes, your insurance company may request your records in order to clear a claim. When you signed with your insurance company, you already signed for the release of relevant records if necessary. Also, when you need authorization from your insurance company to see a specialist, your insurance company may request a copy of your records. In order to continue your care through a specialist, we may fax or mail or give verbal knowledge of your medical history to the specialist.

This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003, we may only release medical information to the following:

1. Healthcare providers involved in your care
2. Insurance companies to secure payment
3. Laboratories involved in your care
4. Attorneys with your permission

By HIPAA standards, we are not allowed to discuss your medical problems with your spouse, significant other, or adult children. Please indicate if you would like us to speak with your spouse/significant other, or adult child if and when the need arises.

YES, you have my permission to discuss any medical matters pertaining to my health with:

_____ _____
Name of person, please print Relationship

_____ _____
Name of person, please print Relationship

By HIPAA standards, we are not allowed to leave results of your lab tests, x-rays, diagnostics, medications, etc., related to your specific health condition on your voicemail, answering machine, fax, etc. However, if you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to allow us to leave your information on your messaging systems. Please choose one of the options below. Note: if you would like to revoke your option at any time, we will need your written notification.

Appointment reminders and any information regarding your treatment may be called to: _____ _____
Phone Number Initials

By my signature below I give my permission to use and disclose my health information.

_____ _____ _____
Print Patient Name Patient Signature Date

_____ _____
Witness Signature Date

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by the state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A Claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature (or Patient Representative)	Date	(Indicate relationship if signing for patient)
Acupuncture Physician Signature	Date	