

Stumptown Acupuncture LLC

New Patient Intake Form

GENERAL INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____
 home cell work home cell work

Email: _____ Add to Stumptown e-newsletter? Yes No

Gender: Male Female Relationship Status: Single Married Partnered Separated Divorced Widowed

Current Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Hours per week: _____ Do you enjoy your work? Yes No

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about Stumptown Acupuncture? _____

Have you had acupuncture before? Yes No What is your primary reason for this visit? _____

Date symptoms started: _____ Triggering event? Yes No If so, please describe: _____

My symptoms are: Severe Moderate Mild My symptoms are: Improving Worsening Unchanged

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Do your symptoms affect your daily activities? Yes No If so, please describe: _____

Have you received a medical diagnosis? Yes No If so, please list: _____

What are you hoping to achieve with treatment? _____

FAMILY HEALTH HISTORY

Do you have a family history of any of the following diseases or conditions? Check all that apply:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Obesity | _____ |

SOCIAL & LIFESTYLE HISTORY

- Do you exercise? Yes No How often? _____
- Hours of sleep per night? _____ Do you sleep well? Yes No Wake rested? Yes No Do you dream? Yes No
- Do you use tobacco? Yes No How often? _____ How much? _____
- Do you use alcohol? Yes No How often? _____ How much? _____
- Do you use caffeine? Yes No How often? _____ How much? _____

PERSONAL HEALTH HISTORY

Do you have a history of any of the following diseases or conditions? Check all that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colitis/IBS | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Reynaud's Disease | _____ |

Have you had any major injuries, surgeries or hospitalizations? Yes No If so, please list along with dates: _____

Are you allergic or hypersensitive to any foods or medications? Yes No If so, please list along with reaction: _____

List prescription medications, over the counter medications, vitamins or supplements that you are taking: _____

SYMPTOM PROFILE

Are you currently experiencing any of the following symptoms? Check all that apply:

General:

- Tend to Feel Hot
- Tend to Feel Cold
- Insomnia
- Heavy Sleep
- Dream-Disturbed Sleep
- Fatigue
- Body Feels Heavy
- Frequent Fever
- Frequent Chills
- Sweat Easily
- Night Sweats
- Muscle Cramps
- Recent Weight Loss
- Recent Weight Gain
- Bleed Easily
- Bruise Easily
- Excessive Thirst
- Excessive Hunger

Head:

- Headaches
- Migraines
- Concussions
- Dizziness/Vertigo

Eyes:

- Tearing
- Dryness
- Red/Itchy
- Eye Pain
- Impaired Vision
- Double Vision
- Floaters/Spots
- Night Blindness
- Color Blindness

Ears:

- Earaches
- Ringing in Ears
- Impaired Hearing

Nose:

- Nose Bleeds
- Nasal Drainage
- Sinus Congestion
- Loss of Smell
- Sensitive to Smell

Mouth:

- Bleeding Gums
- Dry Mouth
- Oral Sores
- Teeth Grinding
- Jaw Problems (TMJ)

Throat:

- Frequent Sore Throats
- Swollen Glands
- Trouble Swallowing
- Hoarseness
- Phlegm

Skin & Hair:

- Dryness
- Itching
- Hives
- Rash
- Acne
- Eczema
- Psoriasis
- Slow Wound Healing
- Dandruff
- Hair Loss

Respiratory:

- Frequent Colds
- Chronic Cough
- Coughing Blood
- Tight Chest
- Shortness of Breath
- Pain when Breathing
- Difficulty Breathing

Cardiovascular:

- Chest Pain
- Heart Murmur
- Fainting
- Blood Clots
- Varicose Veins
- Ankle Swelling

Musculoskeletal & Neural:

- Neck/Shoulder Pain
- Upper Back Pain
- Lower Back Pain
- Hip Pain
- Knee Pain
- Ankle Pain
- Elbow Pain
- Wrist Pain
- Sciatica
- Muscle Weakness
- Numbness/Tingling
- Loss of Balance
- Paralysis

Gastrointestinal:

- Nausea
- Vomiting
- Bad Breath
- Acid Reflux
- Hiatal Hernia
- Intestinal Pain/Cramping
- Gas
- Bloating
- Loose Stools
- Black Stools
- Blood in Stools
- Mucus in Stools
- Diarrhea
- Constipation
- Hemorrhoids

Genito-Urinary:

- Frequent Urination
- Incomplete Urination
- Painful Urination
- Urgent Urination
- Blood in Urine
- Frequent Infections
- Kidney Stones

Mental Health:

- Anxiety
- Depression
- Irritability
- Mood Swings
- Nervousness

Male Reproductive:

- Prostate Problems
- Testicular Pain/Swelling
- Penile Discharge
- Sexual Difficulties

Female Reproductive:

- Breast Pain/Tenderness
- Nipple Discharge
- Vaginal Discharge
- Fibroids/Ovarian Cysts
- Painful Menses
- Clotting During Menses
- Bleeding Between Periods
- PMS Symptoms
- Menopausal Symptoms
- Sexual Difficulties

Pregnant? Yes No
 Date of last period: _____
 Length of cycle: _____
 # days bleeding: _____
 Age of first period: _____
 # Pregnancies: _____
 # Live Births: _____
 Menopause? Yes No
 Age at onset: _____

Information on this form is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____

Stumptown Acupuncture LLC

CONSENT TO TREAT

I, the undersigned, understand that methods of treatment may include, but are not limited to, acupuncture, electrical stimulation, moxibustion, cupping, gua sha, Chinese massage, qigong, herbal therapy and nutritional counseling.

I understand that acupuncture, electrical stimulation, moxibustion, cupping, gua sha, Chinese massage and pricking are all safe methods of treatment. Potential risks of acupuncture include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the practitioner uses alcohol, sterile disposable needles and maintains a safe and clean environment. Adverse side effects of electrical stimulation included electrical shock, pain or discomfort, possible aggravation of symptoms existing prior to treatment. Potential risks of moxibustion are burns, blistering, or scarring. A common side effect of cupping and gua sha includes temporary bruising or redness lasting a few days. Adverse effects from Chinese massage may include muscle soreness or achiness and possible aggravation of symptoms existing prior to treatment.

I understand that herbal therapy and nutritional supplements recommended to me are safe in the prescribed doses. Large doses of herbs and supplements taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that if I experience any discomfort or adverse reactions with these substances, I must stop taking them and call Stumptown Acupuncture as soon as possible.

Treatments may be administered in a group setting in a single room. It is possible that other individuals in the room may hear or see case and treatment information in this type of setting. No disrobing will be done in such cases.

I will advise the practitioner about any of the following: pacemaker, prosthetic valve, bleeding disorder, anticoagulant therapy, pregnancy and/or contagious disease. I may be referred to the emergency room or to a licensed physician with regard but not limited to: cardiac conditions including uncontrolled hypertension; acute, severe abdominal pain; acute undiagnosed neurological changes; unexplained weight loss or gain in a three month period; suspected fracture or dislocation; suspected systemic infections; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history.

I have been adequately informed, and questions I have asked have been satisfactorily answered. I am aware that I may withdraw this consent and stop treatment at any time. I also understand that there is always the possibility of unexpected complication and I understand that no guarantee can be made concerning the results of the treatment. I am aware that acupuncture or Chinese medicine does not substitute for appropriate advice and care from a licensed medical doctor.

In signing this form, I give my consent for treatment and acknowledge any inherent risks of the above mentioned treatment methods.

Signature: _____ Date: _____

Stumptown Acupuncture LLC

HIPAA NOTICE OF PRIVACY PRACTICES

Your protected health information may be used and disclosed by Stumptown Acupuncture for the purpose of providing health care services to you, to support the healthcare operation, and as required by law.

Treatment: to provide, coordinate, or manage your health care and any related services. This includes the coordination of your health care with a third party. For example, to another healthcare professional to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Healthcare operations: in order to support the business activities of Stumptown Acupuncture. These activities include, but are not limited to, quality assessment and review activities, licensing, and conducting or arranging for other business activities. For example, to contact you to remind you of your appointment or review your case to determine a continued course of treatment.

Use required by law: in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Organ Donation; Research; National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, disclosures must be made available to you and are required by the Secretary of the Department of Health and Human Services.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. You may ask Stumptown Acupuncture not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care. Your request must state the specific restriction and to whom the restriction will apply.

You have the right to request to receive confidential communications by alternative means or at an alternative location.

You may have the right to amend your protected health information. If denied, you have the right to file a statement of disagreement with Stumptown Acupuncture.

You have the right to receive an accounting of certain disclosures made, if any, of your protected health information.

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to Stumptown Acupuncture or to the Secretary of Health and Human Services if you believe your privacy rights have been violated.

Stumptown Acupuncture is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

I acknowledge that I have received the HIPAA Notice of Privacy Practices.

Signature: _____ Date: _____

Stumptown Acupuncture LLC

FINANCIAL POLICY

Stumptown Acupuncture makes every attempt to make acupuncture and Chinese medicine available at affordable rates:

- Group treatments are offered on a sliding scale of \$20-40 per person per visit.
- Private treatments are offered on a sliding scale of \$40-60 per visit.
- No proof of income is required and you can change the amount you pay at any time.
- There is a \$10 new patient fee for your first visit.
- All payments (cash or check) are due at the time service.

Stumptown Acupuncture understands that it is not always possible to keep scheduled appointments. Appointments that are missed, cancelled or rescheduled with less than 24 hour advance notice will be charged a \$20 fee. The payment is due at the time of the next scheduled appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Stumptown Acupuncture does not bill insurance. However, a receipt will be provided upon request. The patient is responsible for determining if their insurance company covers acupuncture and Chinese medicine. Receipts will be provided for patients who desire them either by mail, email or at the time of the next appointment.

Thank you for your understanding.

I have read, fully understand and agree to all the above mentioned financial policies and terms of service.

Signature: _____ Date: _____