Elements Healing Arts Center

1916 S. Glenburnie Rd. #9 | New Bern, NC 18562 | 252-631-5281

Patient Health Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire as completely as possible. All your information will be kept confidential. Feel free to use additional pages if necessary.

Name _____

Date of Birth _____ **Age** _____

Main Phone _____ **Other Phone** _____

Email _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact Name _____ **Phone** _____

Primary Care Physician/Clinic _____

Main concern(s): _____

_____

_____

Allergies: (medications/foods/etc.): _____

Medical Implants/Devices/Pacemakers: _____

Women: Are you pregnant? Y ___ N ___ Unsure ___ Are you trying to get pregnant? Y ___ N ___

Medicines taken within the last two months (including vitamins, OTC, herbs, etc., and their dosages):

_____

_____

_____

Current Health Status

Please check any of the symptoms below that apply to your *current or recent* health status.

General	**Head, Eye, Ear**		**Cardiovascular**
☐ Low energy	☐ Headaches	☐ Trouble concentrating	☐ Chest pain
☐ Spontaneous sweating	☐ Migraines	☐ Mentally restless	☐ High blood pressure
☐ Feel too hot	☐ Jaw pain/TMJ	☐ Worry a lot	☐ Low blood pressure
☐ Feel too cold	☐ Impaired hearing	☐ Feel sad often	☐ High cholesterol
☐ Excessively thirsty	☐ Hearing loss	☐ Cry uncontrollably	☐ Palpitations
☐ Chills/fever	☐ Ear aches	☐ Terrors	☐ Heart racing
☐ Avoid heat or cold	☐ Ringing in ears	☐ Fearful often	☐ Poor circulation
☐ Cold hands/feet	☐ Dizziness	☐ History of abuse	☐ Irregular heartbeat
☐ Sweaty palms/feet	☐ Spots in vision	☐ Considered/attempt suicide	☐ Fainting spells
☐ Hot flashes	☐ Poor night vision	**Digestive**	☐ Blood clots
☐ Night sweats	☐ Double/blurred vision	☐ Nausea	☐ Swelling of ankles
☐ Lack of sweating	☐ Eye pain/strain	☐ Vomiting	☐ Varicose veins
☐ Weight loss	☐ Contacts or glasses	☐ Low appetite	☐ Bleeding disorders
☐ Weight gain	☐ Tearing of eye	☐ Excessive hunger	**Urinary tract**
Skin and nails	☐ Dry or burning eye	☐ Hypoglycemia	☐ Frequent urination
☐ Rashes	☐ Itchy eye	☐ Fatigue after meals	☐ Frequent night urination
☐ Itching	☐ Red or inflamed eye	☐ Indigestion	☐ Poor bladder control
☐ Color change of skin	**Nose, Throat, Mouth**	☐ Bloating after meals	☐ Burning/pain on urinating
☐ Bruise easily	☐ Sinus problems	☐ Gas	☐ Very pale urine
☐ Slow wound healing	☐ Nasal obstruction	☐ Stomach ulcer	☐ Dark urine
☐ Acne	☐ Runny nose	☐ Reflux or heartburn	☐ Cloudy urine
☐ Boils	☐ Sneezing	☐ Diarrhea/loose stool	☐ Scanty urine
☐ Hives	☐ Nose bleeds	☐ Constipation	☐ Profuse urine
☐ Hair falling out	☐ Loss of smell	☐ Stomach ache	☐ Frequent UTI's
☐ Weak or brittle nails	☐ Teeth problems	☐ Abdominal pain	☐ Blood in urine
☐ Pitted nails	☐ Mouth ulcers	☐ Hemorrhoids	☐ Kidney or bladder stones
☐ Grooves in nails	☐ Sores/ulcers on tongue	☐ Gallstones	**Musculoskeletal**
Respiratory System	☐ Bad breath	☐ Jaundice	☐ Pain/weakness/numbness
☐ Cough	☐ Bleeding gums	☐ Blood in stool	☐ Joints
☐ Production of phlegm	☐ Dry mouth	☐ Eating disorder	☐ Arms
☐ Wheezing	☐ Oral thrush	☐ Less than 1 BM per day	☐ Hands
☐ Shortness of breath	☐ Recurrent sore throat	**Lifestyle**	☐ Hips
☐ Coughing up blood	☐ Hoarseness	☐ Vegetarian/Vegan	☐ Legs
☐ Frequent colds/flus	☐ Difficulty swallowing	☐ Healthy diet	☐ Feet
☐ Recurrent sinus infections	**Emotional/Psych/Mental**	☐ Eat a lot of junk food	☐ Neck
☐ Chronic allergies:	☐ Trouble falling asleep	☐ Eat a lot of fried foods	☐ Shoulders
☐ Mold	☐ Trouble staying asleep	☐ Eat a lot of meat	☐ Upper back
☐ Cedar	☐ Vivid/disturbing dreams	☐ Smoke cigarettes	☐ Lower back
☐ Pet fur	☐ Anxiety	☐ Drink alcohol	☐ Pain all over
☐ Dust	☐ Depression	☐ Drink coffee	☐ Muscle spasms/cramps
☐ Pollen	☐ Mood swings	☐ Use drugs	☐ Joint stiffness
☐ Oak	☐ Irritability	☐ Eat a lot of sweets	☐ Broken bones
☐ Hay fever	☐ Often feeling angry	☐ Exercise regularly	
☐ Enviro sensitivity	☐ Poor memory		

Past History

Please check any conditions you've had in the *past*.

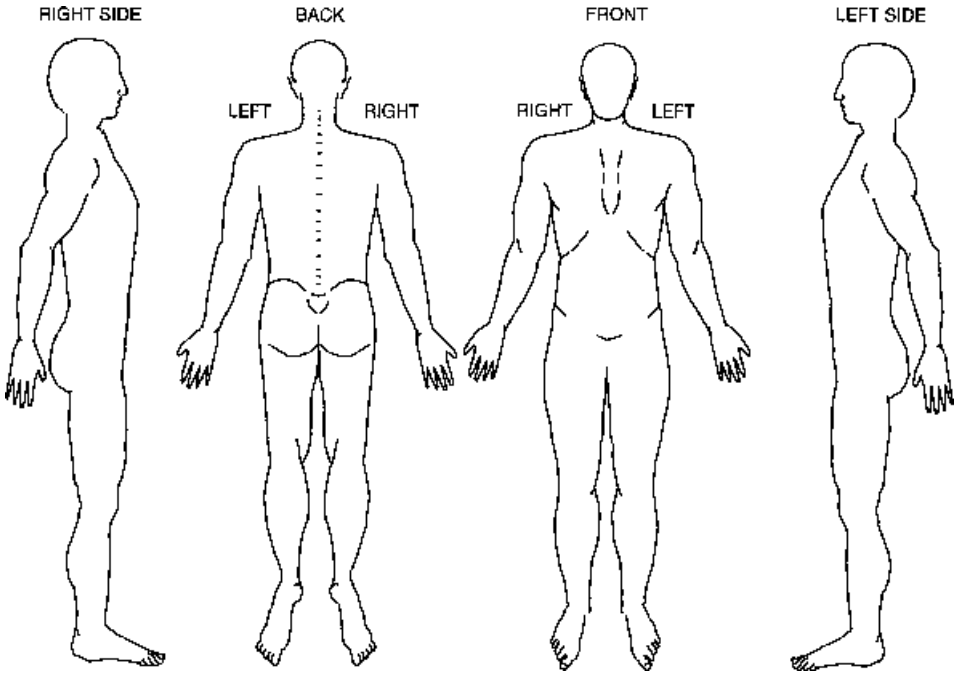
	Addictions (drugs, food, tobacco, etc.)				Hernia		Neuralgia
	AIDS				Hepatitis		Nervous disorder
	Alcoholism		Chronic bronchitis		High cholesterol		Panic attacks
	Allergies		Chronic Fatigue Syn.		Hypertension		Paralysis
	Anemia		Colitis/IBS/Crohn's		Hypotension		Pneumonia
	Anorexia		COPD		Hysterectomy		Polio or meningitis
	Anxiety		Depression		HIV positive		Prostate problems
	Appendicitis		Diabetes		Jaundice		Rheumatism
	Arteriosclerosis		Digestive Disorders		Kidney disease		Scarlet fever
	Asthma		Elevated liver enzymes		Liver disease		Small pox
	Autoimmune disorder		Emotional imbalance		Low blood pressure		Stroke
	Bladder disease		Emphysema		Malaria		Suicidal thoughts
	Blood transfusion		Epilepsy		Measles		Thyroid disorder
	Bleeding/hemorrhage		Fibromyalgia		Mental illness		Tonsillitis
	Breast lumps		Food, chemical poisoning		Migraines		Tuberculosis
	Breathing difficulties		Gallstones		Mononucleosis		Typhoid fever
	Bulemia		German measles		Multiple Sclerosis		Ulcers
	Bursitis		Glaucoma		Mumps		Vein condition
	Cancer		Goiter		Nephritis		Venereal disease
	Candida		Gout				
	Chicken pox		Heart disease				

Surgeries:	(Include dates/types/reasons)
Significant Traumas:	(Accidents, disasters, death of loved one, etc.)

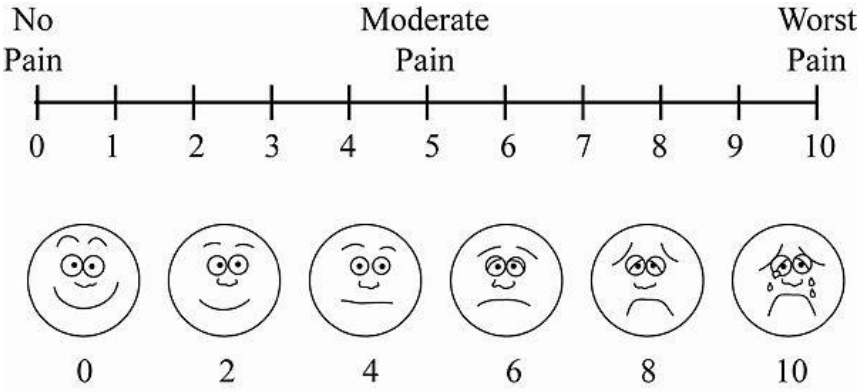
Pain and Sensory Patients

If you are coming in for physical pain and sensation issues, please fill out this portion of the paperwork. If not, you can skip this.

Where is the pain for which we will be treating you located? Please circle or mark the areas. You are welcome to briefly describe what it feels in the margins if you like. Words that people use about pain are deep ache, tight, pinching, sharp, burning, constant, or pinpricks. For odd sensations other than pain, you might note numbness, tingling, electrical sensations, pins and needles, etc.

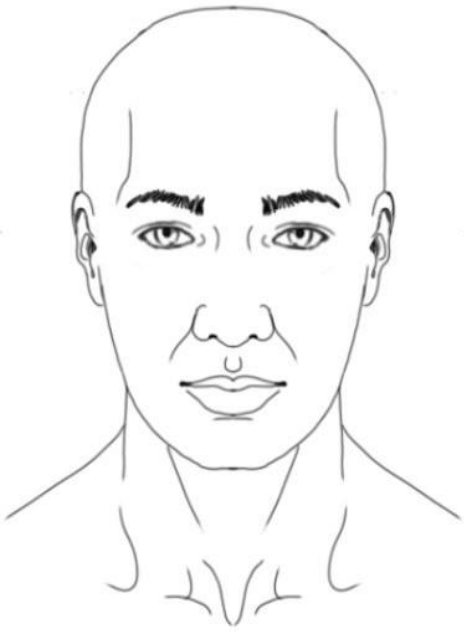


Rate your pain level on a scale of 1-10.

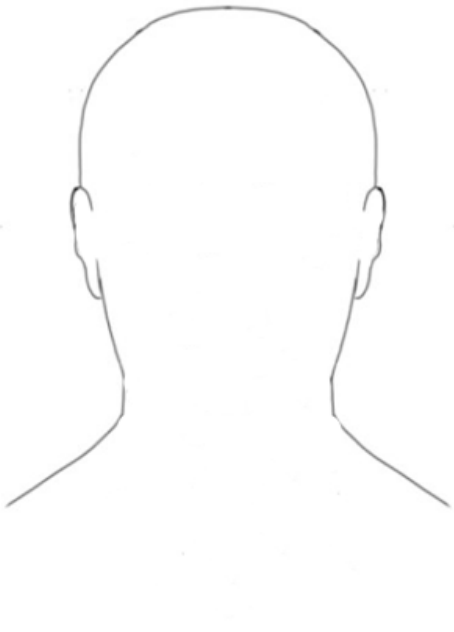


Headache and facial pain patients, please indicate your pain areas here.

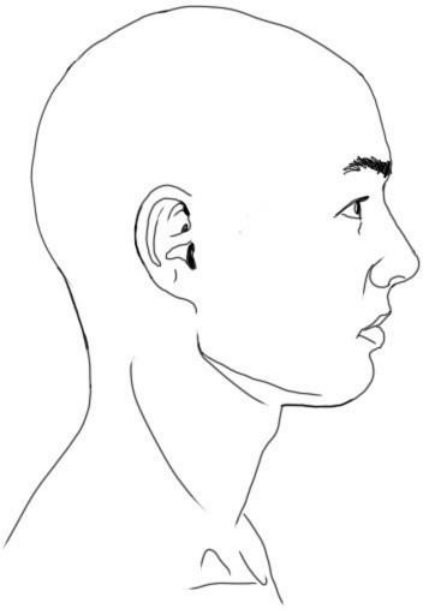
Front



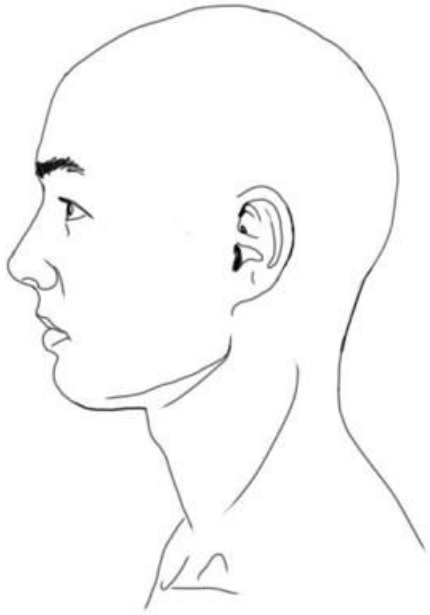
Back



Right side



Left side



INFORMED CONSENT TO ORIENTAL MEDICAL HEALTHCARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist(s) on staff at Elements Healing Arts Center (EHAC) who now or in the future treat me while employed by, working or associated with or substituting for EHAC, including those working at this clinic or any other associated clinics: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy, and electrical and/or magnetic stimulation; cupping; moxibustion; medical qigong; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioner the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgement, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic effect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures and conditions of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Elements Healing Arts Center.

Patient's name (please print)	Patient's signature
Name of Patient's Representative	Relationship or Authority of Patient's Rep
Signature of Patient's Rep (if applicable)	Date Signed

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

Legal Responsibilities of Cynthia Edmunds, Lac, and Elements Healing Arts Center: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you. However, this information will *not* be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Process: We may use and disclose your protected healthcare information in relation with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but *only with your authorization*.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated, or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counterintelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice. We will only do this with your written authorization. There is a form in your initial paperwork authorizing this. If you change your mind at any time, you may withdraw this authorization, but you must do so in writing.

Patient Rights Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access by submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.50 per page for the first 30 pages and $0.30 for every page after that plus $10.00 for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost-based fee for that format. An explanation of fees can be made available upon request.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell our other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints
If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Services, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

Contact Person's Name:	Athena Bernal
Telephone:	252-631-5281
Address:	1916 S. Glenburnie Rd. #9
City, State, Zip:	New Bern, NC 28562

I have read and understand the HIPPA privacy policies of Elements Healing Arts Center.

_____ _____

Patient signature Date

_____

Patient printed name

_____

Patient representative's signature (if patient is a minor)

_____

Patient representative's printed name

_____

Relationship to patient/Authorization to act for patient