Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name		Sex ☐ F ☐ M	Date
Date of birth	Age	Cell Phone #	
Other Phone #		Allow text contact by Optimal Health?	Yes No
E-mail address		Allow email contact by Optimal Health?	☐Yes ☐No
Address: Street		City State	Zip
Relationship status	# of children	Family physician	Chiropractor
Occupation?			
Who is your employer?			
Emergency contact name		phone	
How did you find out about our clinic? ☐ *Friends/Relatives(name)*_____ ☐ *Direct mail* ☐ *Location or walk by* ☐ *Website* ☐ *Referred by*_____ ☐ *Yellow Pages* ☐ *Periodicals* ☐ *Other (please specify)*			

Main problem(s): _____.

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____ Remarks and additional information:

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: _____Hospitalization: _____

Significant trauma: (auto accidents, sports injuries, etc) **_____**

Allergies: (drugs, chemicals, foods, environmental):_____

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer (what type)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

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

_____

Occupation : _____ Do you usually work □ indoors □ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal Height_____ Weight now_____ Weight one year ago_____

Weight maximum _____@Year _____

Habits Do you smoke ? □ Yes □ No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly □ Yes □ No Please describe your exercise program: _____

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

Diet How much coffee do you drink? _____cups/day Colas _____number/day Tea _____ cups/day

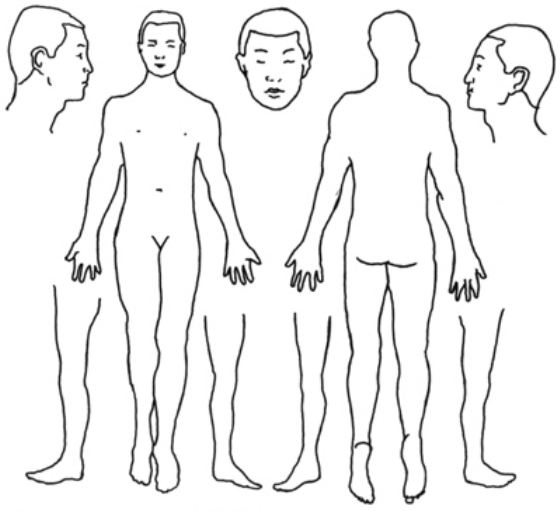
What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food? Yes No

Remarks and additional information (e.g. diet) _____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General □ Poor appetite □ Poor sleep □ Fatigue □ Fevers □ Chills
□ Night sweats □ Sweat easily □ Tremors □ Cravings □ Change in appetite
□ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weight loss □ Weight gain
□ Peculiar tastes □ Desire hot food □ Desire cold food □ Strong thirst (cold or hot drinks)
□ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema
□ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles □ Loss of hair
□ Purpura □ Change in hair or skin texture □ Other?

Musculoskeletal □ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Tremors
□ Cold hands/feet □ Difficulty walking □ Swelling of hands/feet □ Spinal curvature □ Back pain □ Hernia
□ Numbness □ Tingling □ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain
□ Hand/wrist pain □ Hip pain □ Knee pain □ Joint Sprain □ Other?

Head, eyes, ears, nose, and throat □ Dizziness □ Concussions □ Migraines □ Glasses/lens
□ Eye strain □ Eye pain □ Color blindness □ Night blindness □ Poor vision □ Cataracts
□ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing □ Spots in front of eyes
□ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain
□ Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other?

Cardiovascular □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting
□ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other?

Respiratory □ Cough □ Coughing blood □ Wheezing □ Difficulty breathing
□ Bronchitis □ Pneumonia □ Chest pain □ Production of phlegm – What color? _____

Gastrointestinal □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas
□ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain
□ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological □ Loss of balance □ Lack of coordination □ Concussion
□ Depression □ Anxiety □ Stress □ Bad temper □ Bi-polar

Genital-urinary □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate
□ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection
□ Genital pain □ Genital itching □Genital rashes □ STD □ Other?

Female □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge

□ Fibroids □ Ovarian cysts □ Irregular periods □ Clots □ Pain/cramps prior/during periods

□ Breast tenderness □ Breast Lumps □ Fertility Problems □ Hot flashes □ Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? □ Yes □ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems

□ Frequent seminal emission □ Fertility problems □ Painful/swollen testicles □ Other

I have completed this form correctly to the best of my knowledge.

Signature:

□ Adult Patient □ Parent or Guardian □ Spouse

Are there any other health issues you want to discuss with us?

Signature **Date**

Notice of Privacy Practices

This notice describes how medical information about you may be used an disclosed and how you can get access to this information.

Uses & Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail or other methods.

We may use or disclose indentifiable health information about you without your authorization for specific reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses or disclosures.

We may change our policies at any time. Before we make significant changes to our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorize it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, please contact Keisha McDaniel at Optimal Health Acupuncture, LLC, 1344 Woodhurst, Springfield, MO 65804. You may also send a written complaint to the US Department of Health and Human Services.

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Optimal Health Acupuncture (OHA) "Notice of Privacy Practices". I understand that I have the right to review OHA's "Notice of Privacy Practices" prior to signing this document.

I understand that OHA staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

I also understand that my clinical information may be used for educational and/or research purposes by OHA or individuals authorized by OHA. All information that can identify me personally will be removed.

By signing this form, I am giving OHA authorization to contact me and am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at OHA will be held confidential except in the instance where my safety or the safety of others may be at risk

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature OHA Privacy Rep/Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Optimal Health Acupuncture the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Signature Date

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

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 acupuncturists on staff at Optimal Health Acupuncture who now or in the future treat me while employed by, working or associated with or substituting for OHA, 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 and/or moxibustion; 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 Licensed Acupuncturist 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 judgment, 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 affect 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 Optimal Health Acupuncture.

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