

Healing Care Acupuncture

1030 Xenia Avenue
Yellow Springs, OH 45387

937.532.5773
www.HealingCareAcupuncture.com

Patient Intake Form

Please help me to provide you with the best possible care by taking the time to fill out this form as accurately as you can.
All information provided is confidential. Please feel free to ask if you have any questions. Thank you.

Name _____ Date _____ Gender: F M Married Single Other
Date of Birth _____ Age _____ Height _____ Weight _____
Address _____ Home Phone (____) _____
City _____ Mobile Phone (____) _____
State _____ Zip Code _____ Email _____ Work Phone (____) _____
Occupation _____ Employer _____
Emergency Contact _____ Phone _____ Relationship _____

Primary Physician _____ Phone _____ Referred by _____
Main reason you are seeking acupuncture _____
Have you been given a diagnosis for this problem? _____ What was the diagnosis? _____
How long have you had this problem? _____
What kinds of treatments have you tried? _____
Have you been treated by acupuncture before? _____

Family History

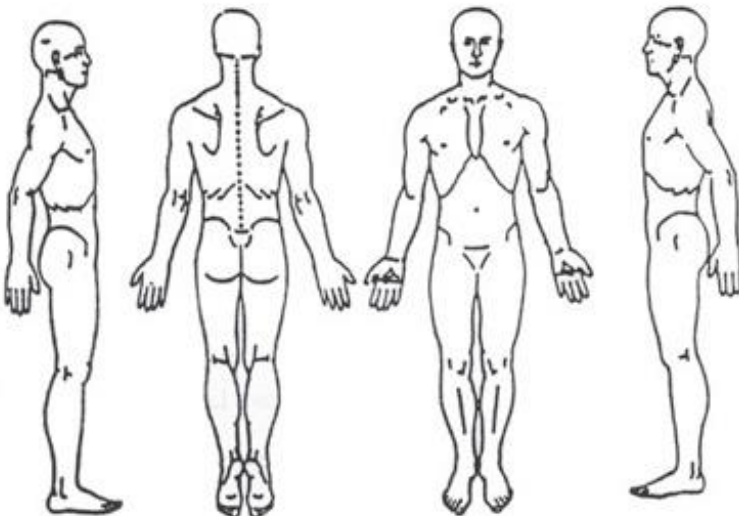
Mother's Side _____
Father's Side _____
Siblings _____
If any of the above is deceased, what was the cause? _____

Personal Lifestyle Habits

Coffee/Tea (cups per day) _____ Cigarettes (packs per day) _____
Soda (regular or diet) _____ Alcohol (drinks per week) _____
Exercise (how often) _____ Drug use (recreational) _____
Current Predominant Emotion _____ Stress level: Low: Moderate: High:
Best time of year _____ Energy level: Low: Moderate: High:

Please indicate on the diagram any type of pain or injury and describe _____

Circle all that applies: Sharp Numb Dull Stabbing Aching Burning **Better with:** Heat Cold Pressure



Please describe any medical devices or implants and indicate on the diagram

Past Medical History

Please indicate/describe all that applies if you have experienced in the Past (P) and Currently (C) any of the following:

Significant Illnesses

- AIDS/HIV
- Alcoholism
- Allergies (medications, foods, latex) _____
- Bleeding disorders _____
- Cancer _____
- Diabetes
- Fibromyalgia
- Hepatitis Type ____
- Herpes Type ____
- High cholesterol
- Multiple Sclerosis
- Rheumatic fever
- Stroke
- STD _____
- Thyroid disorders
- Tuberculosis
- Other _____

General

- Insomnia/Poor sleep
- Dreams-disturbed sleep
- Difficulty falling asleep
- Difficulty staying asleep
- Hours of sleep _____
- Fatigue
- Recent weight loss/gain
- Strongly like cold drinks
- Strongly like hot drinks
- Tendency to be cold
- Tendency to be warm
- Sweat easily
- Night sweats
- Chills
- Fever
- Sudden energy drops
- Peculiar tastes or smell
- Other _____

Head and Neck

- Headaches
- Migraines
- Stiff neck
- Swollen glands
- Other _____

Ears

- Hearing aids
- Hearing loss: L_ R_ Both_
- Ringing: L_ R_ Both_
- Earache
- Ear infection
- Ear drainage
- Other _____

Eyes

- Glasses/contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts
- "Lazy" eye
- Itchy eyes
- Dry eyes
- Excessive tearing
- Eye pain
- Eye strain
- How often checked? _____
- Other _____

Nose, Throat, and Mouth

- Sinus problems
- Hay fever/allergies
- Frequent colds
- Frequent sore throat
- Difficulty swallowing
- Sores on lips, tongue, mouth
- Nosebleed
- Dry nose
- Nasal drainage
- Nasal congestion
- Hoarseness
- Thirst
- Excessive saliva
- Facial pain
- Dry mouth
- Dental problems
- Grinding teeth
- Other _____

Skin

- Hives
- Rashes
- Eczema
- Dry skin
- Itching
- Bruise easily
- Acne
- Other _____

Respiratory

- Difficulty breathing
- Difficulty when reclining
- Asthma
- Chronic cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Pneumonia
- Other _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Cold hands and feet
- Swollen hands and feet
- Swollen ankle
- Phlebitis
- Varicose veins
- Anemia
- History of heart disease
- Heart murmur
- Other _____

Gastrointestinal

- Cravings _____
- Bad breath
- Nausea
- Indigestion
- Stomach pain
- Abdominal pain
- Gallbladder problems
- Hernia
- Diarrhea
- Loose stools
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Bloating
- Gas
- Hiccups
- Acid reflux
- Hemorrhoids
- Bloody stool
- Bowel movements
____ x per day
- Other _____

Musculoskeletal

- Joint pain/swelling _____
- Arthritis
- Muscle cramps
- Muscle weakness
- Muscle soreness
- Herniated disc
- Osteoporosis
- Pain (see diagram)
- Injury (see diagram)
- Other _____

Neurological

- ___ Concussions
- ___ Fainting
- ___ Dizziness
- ___ Seizures
- ___ Tremors
- ___ Numbness or tingling
- ___ Paralysis
- ___ Poor coordination/balance
- ___ Vertigo
- ___ Poor memory
- ___ Other _____

Mental/Emotional

- ___ Depression
- ___ Mood swings
- ___ Irritability
- ___ Easily angered
- ___ Panic attacks
- ___ Difficulty relaxing
- ___ Difficulty making decisions
- ___ Loneliness
- ___ Sadness
- ___ Sensitive
- ___ Shyness
- ___ Nervousness
- ___ Frequent crying
- ___ Frequent worrying
- ___ Compulsive behaviors
- ___ Difficulty focusing
- ___ Hopelessness
- ___ Suicidal thoughts
- ___ Frustration
- ___ PTSD
- ___ Other _____

Urinary

- ___ Pain with urination
- ___ Frequent/urgent urination
- ___ Incomplete urination
- ___ Incontinence
- ___ Bedwetting
- ___ Waking to urinate ___ x night
- ___ Blood in urine
- ___ Cloudy urine
- ___ History of UTI
- ___ Bladder infections
- ___ Kidney problems
- ___ Other _____

Male Genital

- ___ Fertility problems
- ___ Impotence
- ___ Premature ejaculation
- ___ Nocturnal emission
- ___ Groin pain
- ___ Pain/itching of genitalia
- ___ Prostate problems
- ___ Increased libido
- ___ Decreased libido
- ___ Other _____

Gynecology (Women Only)

- ___ Fertility problems
- ___ Currently pregnant
- ___ # of Pregnancies
- ___ # of Live births
- ___ # of Caesarian births
- ___ # of Miscarriages
- ___ # of Abortions
- ___ Menopause
- ___ Bearing down sensation
- ___ Last menstrual period _____
- ___ Birth control _____
- ___ PMS
- ___ Missed/Irregular periods
- ___ Menstrual cramps
- ___ Excessive blood flow
- ___ Menstrual blood clots
- ___ Breast tenderness
- ___ Abnormal pap smear
- ___ Vaginal infections
- ___ Vaginal pain/itching
- ___ Vaginal dryness
- ___ Uterine fibroids
- ___ Ovarian cysts
- ___ Endometriosis
- ___ Breast lumps, cysts
- ___ Increased libido
- ___ Decreased libido
- ___ Other _____

Surgeries (type and date)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Trauma, Injuries (type and date)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Medications, Supplements, and Vitamins (dosage and for what condition)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Other information

- _____
- _____
- _____
- _____
- _____

Acupuncture Clinic Fees

First Visit Clinic Fee
 Traditional Chinese Medicine
 Diagnosis and Treatment \$125.00

Follow-up Visit Clinic Fee
 Treatment \$90.00

All payments are due at time of service. Accepted payments include cash, checks, and credit cards.

Appointment Reminders

Healing Care Acupuncture understands that it is not always possible to keep scheduled appointments. In order to help reduce Late Cancellation or No Show, please indicate how you would like to be reminded of your appointment:

- Phone Call: _____
- Text: _____
- Email: _____

 Signature of Patient or Legal Representative

 Date

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby voluntarily request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of an acupuncturist to be performed by *Sharmine N. Lynch, L.Ac.*, representing Healing Care Acupuncture, on me (or on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Gua-Sha, and supplemental techniques.

I understand that acupuncture is a generally safe method of treatment, but that it may have some side effects that include, but are not limited to, unusual dizziness or fainting, temporary bruising, pain or discomfort, soreness, swelling, bleeding, numbness or tingling near the needling sites that may last a few days. Burns, blistering, or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify the acupuncturist if I am or become pregnant or if I am in the process of trying to become pregnant.

While I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, to be in my best interest.

I understand that acupuncture is not a substitute of conventional medical diagnosis and treatment and that I have the opportunity to discuss the nature and purpose of acupuncture and treatments with the practitioner at any time during my care. I understand that there is no implied or stated guarantee of cure or improvement of my condition.

I understand the acupuncturist may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that scheduling an appointment reserves a time specifically for me, and that consequently, a minimum of 24 hour notice is required to reschedule or cancel an appointment. If I do not call or show up, I will be responsible for the missed session fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent for treatment, acknowledge the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Patient's Name (Please Print)

Patient's Signature

Date

Print Name of Patient's Representative (If Applicable)

Relationship to Patient

Signature of Patient's Representative (If Applicable)

Date

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**FOR PATIENT REVIEW REGARDING DIAGNOSTIC EXAM
PLEASE SIGN ONE OF THE TWO OPTIONS LISTED BELOW:**

Option 1:

I have received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment.

Patient's Signature

Date

Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that you receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking treatment.

I understand this recommendation.

Patient's Signature

Date

Licensed Acupuncturist Signature

Date

Healing Care Acupuncture

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Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call during regular business hours at 937-532-5773.

Signature of Patient or Legal Representative

Date

Printed Name and Relationship to Patient

Healing Care Acupuncture

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Acknowledgment of Receipt of Privacy Practices

I consent to the use or disclosure of my identifiable health information by *Healing Care Acupuncture* for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Healing Care Acupuncture* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *Healing Care Acupuncture* is not required to agree to the restrictions that I may request. However, if *Healing Care Acupuncture* agrees to a restriction that I request, the restriction is binding upon *Healing Care Acupuncture*.

I have the right to revoke this consent, in writing, at any time except to the extent that *Healing Care Acupuncture* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review *Healing Care Acupuncture's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.HealingCareAcupuncture.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and *Healing Care Acupuncture* with respect to my identifiable health information.

Healing Care Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Legal Representative

Date

Printed Name and Relationship to Patient

Acupuncture Treatment Patient Referral Form

Date ____ / ____ / ____

Name of Patient _____ D.O.B. _____

Condition to be treated _____

Primary
Diagnosis _____

ICD-10 Diagnosis _____ ICD-10 Code _____

Secondary Diagnosis _____

ICD-10 Diagnosis _____ ICD-10 Code _____

Instructions or Precautions (if any): _____

Name of Referring Physician or Specialist _____

Address _____

Phone Number _____

Signature _____

Please return this form to:

Att: Sharmine Lynch, L.Ac.

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medsnl@hughes.net