

INITIAL INTAKE FORM

NAME: _____ DATE: _____

Gender: M F Birth date: _____ Age: _____

PHONE NUMBERS: [1.] home work cell _____ best time: _____

(in order of preference) [2.] home work cell _____ best time: _____

Please circle [3.] home work cell _____ best time: _____

Is it okay to leave a detailed message concerning your appointment at these numbers? (please circle) Y N

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

Occupation: _____ Employer: _____

Emergency contact & relation to self: _____ Phone: _____

E-mail address: _____

Would you like to receive electronic updates? Y or N (circle) Your address is confidential!

Please list health concerns that have brought you to this clinic for treatment:

[1.] _____ [2.] _____

[3.] _____ [4.] _____

Please list medications, supplements, vitamins and herbs that you have been prescribed and /or are currently taking: _____

When did you last receive medical care? _____

Please list prior surgeries, injuries or traumatic events: _____

Do you have any contagious diseases? _____

Allergies: _____

Family History (i.e. heart disease, diabetes, cancer etc.) _____

Current weight _____ Height _____ Past Maximum Weight _____ Last Blood Pressure Reading _____ / _____

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH EXCELLENT AND AFFORDABLE HEALTH CARE.

The following policy is designed to help us continue to do so.

BILLING: Published rates reflect a 20% cash at time of service discount. House-calls and insurance billing are available but are not eligible for a cash at time of service discount. If you would like your insurance to be billed, please present your insurance card to the front desk to be photocopied so benefits can be verified. Copayments are due at time of service and pharmacy items such as herbs and supplements must also be paid for upon receipt. Payment can be in the form of cash, check, visa or mastercard only.

INSURANCE: Insurance billing is available as mentioned above. You can also pay in full at the time of service to receive the 20% cash at time of service discount and then bill your insurance yourself to receive reimbursement if that is your preference. All receipts for cash at time of service payment include all the proper codes necessary for insurance reimbursement.

Again, if you want your insurance billed directly by All Ways Well, LLC please present your insurance card to your first treatment so benefits can be verified. Also please note that you will be responsible for paying any balances due for treatment that your insurance deems not medically necessary or not covered.

CANCELLATIONS: If unable to keep an appointment, please give us 24 hours notice. IF YOU FAIL TO KEEP YOUR APPOINTMENT OR CANCEL WITHOUT PRIOR NOTICE, THERE WILL BE A FULL OFFICE FEE.

I have read and understand the above information and agree to the conditions set forth.

SIGNATURE: _____ DATE: _____

Symptom Review

NAME: _____

DATE: _____

Please rate your symptoms on a scale of 1-3. **ONE** indicates a symptom that you sometimes experience, **TWO** indicates a symptom that you often experience, **THREE** indicates a symptom that is a major concern. If you have never experienced the symptom, do not make a mark.

HEAD and FACE

Headaches 1 2 3
 Dizziness 1 2 3
 Memory Loss 1 2 3
 Other _____

EYES

Poor Vision 1 2 3
 Eye Pain 1 2 3
 Inflammation 1 2 3
 Other _____

EARS

Poor Hearing 1 2 3
 Earaches 1 2 3
 Discharge 1 2 3
 Ringing 1 2 3
 Other _____

NOSE

Frequent Colds 1 2 3
 Sinus Trouble 1 2 3
 Bleeding 1 2 3
 Difficulty Breathing 1 2 3
 Other _____

MOUTH

Gum Problems 1 2 3
 Teeth Problems 1 2 3
 Jaw Problems 1 2 3
 Unusual Tastes 1 2 3
 Other _____

THROAT

Sore Throat 1 2 3
 Hoarseness 1 2 3
 Difficulty Swallowing 1 2 3
 Other _____

HEART and CHEST

Palpitations 1 2 3
 High Blood Pressure 1 2 3
 Tightness in Chest 1 2 3
 Low Blood Pressure 1 2 3
 Difficulty Laying Flat 1 2 3
 Other _____

CIRCULATION

Bruise Easily 1 2 3
 Bleed Easily 1 2 3
 Slow Wound Healing 1 2 3
 Cold Limbs 1 2 3
 Other _____

GASTROINTESTINAL

Excess Thirst 1 2 3
 Never Thirsty 1 2 3
 Excess Appetite 1 2 3
 Digestive Pain 1 2 3
 Nausea 1 2 3
 Vomiting 1 2 3
 Diarrhea 1 2 3
 Constipation 1 2 3
 Blood in Stool 1 2 3
 Colon Problems 1 2 3
 Hemorrhoids 1 2 3
 Other _____

URINATION

Frequent 1 2 3
 Difficulty 1 2 3
 Painful 1 2 3
 Nighttime 1 2 3
 Bleeding 1 2 3
 Pain (Describe) 1 2 3
 Other _____

SKIN

Rashes 1 2 3
 Dryness 1 2 3
 Moles or Lumps 1 2 3
 Excess Sweat 1 2 3
 Night Sweat 1 2 3
 Rarely Sweat 1 2 3
 Other _____

NEUROLOGICAL

Nervousness 1 2 3
 Tremors 1 2 3
 Convulsions 1 2 3
 Numbness/tingling 1 2 3
 Loss of Balance 1 2 3
 Nerve Pain 1 2 3
 Other _____

SLEEP

Insomnia 1 2 3
 Drowsiness 1 2 3
 Dreams 1 2 3
 Other _____

ENERGY

Low 1 2 3
 High 1 2 3
 Other _____

Symptom Review Continued

NAME: _____

DATE: _____

WOMEN:

Are you pregnant? (Circle One) Yes No Not Sure If yes, what month?

What method of birth control do you use?

Number of Pregnancies (if any): _____ Number of live births: _____

Number of miscarriages (if any): _____ Number of abortions (if any): _____

Abnormal pregnancy, labor or delivery? Yes No If yes, please explain:

Please rate your symptoms on a scale of 1-3. **ONE** indicates a symptom that you sometimes experience, **TWO** indicates a symptom that you often experience, **THREE** indicates a symptom that is a major concern. If you have never experienced the symptom, do not make a mark.

MENSTRUAL CYCLE

Irregular 1 2 3
 Excess Blood 1 2 3
 Lack of Blood 1 2 3
 Dark Colored Blood 1 2 3
 Light Colored Blood 1 2 3
 Other _____

Clotting 1 2 3
 Water Retention 1 2 3
 Breast Tenderness 1 2 3
 Emotional Changes 1 2 3
 Painful (cramping) 1 2 3

GYNECOLOGICAL

Bleeding Between Cycles 1 2 3
 Menopausal Symptoms 1 2 3
 Vaginal Discharge 1 2 3
 Difficulty Conceiving 1 2 3
 Sexual Difficulties 1 2 3
 Pelvic Pain 1 2 3

MEN:

Please rate your symptoms on a scale of 1-3. **ONE** indicates a symptom that you sometimes experience, **TWO** indicates a symptom that you often experience, **THREE** indicates a symptom that is a major concern. If you have never experienced the symptom, do not make a mark.

MALE REPRODUCTIVE

Erectile Dysfunction 1 2 3
 Sexual Difficulties 1 2 3
 Testicular Pain 1 2 3
 Testicular Swelling 1 2 3
 Prostate Problems 1 2 3
 Penile Discharge 1 2 3
 Other: _____

The information contained within this box is confidential and may not be released under any circumstances unless the patient has signed a special release specific to this information.

MENTAL HEALTH

Depression 1 2 3
 Schizophrenia 1 2 3
 Manic-Depression 1 2 3
 Anxiety 1 2 3

Recreational drug use (past and present): _____
 Have you ever been treated for chemical dependency? Yes No
 Do you have any history of abuse (physical, psychological, substance)? Yes No
 If yes, briefly explain: _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain **presently** prevents you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____

DATE _____

SCORE _____ [60]

BENCHMARK = 5 _____

Consent to Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks 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 clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred, or carried out at this practice.

Patient Signature

Date

HIPPA Receipt of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that is posted in the providers office and is available for you to take home upon request.

I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of patient or representative

Date

Print patient name

Patient Birth Date