Ashland Family Acupuncture

NEW PATIENT HEALTH HISTORY

Please complete this document as thoroughly as possible. Some of the questions may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. ***All information is strictly confidential.***

PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email _____

Date of Birth _____ Age _____ Gender _____ Marital Status _____

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Name of Primary Physician_____

How did you hear about us? _____ Referred by_____

Indicate if your visit is: ☐ Worker's Comp ☐ Car Accident Claim ☐ Health Insurance Claim

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CONDITIONS

What is your primary health concern? _____

When did this problem begin? _____

Does this condition impair your daily activities? If so, please explain: _____

_____

What makes it better or worse? _____

Has this condition been diagnosed by your physician? If so, what was the diagnosis?

_____

List any other health concerns that you wish to address:

_____ _____

_____ _____

_____ _____

PERSONAL HEALTH HISTORY

Check all of the illness or conditions that you currently have or have had in the past:

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
☐	☐	Allergies	☐	☐	Heart Disease	☐	☐	Obesity
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Pneumonia
☐	☐	Alcoholism	☐	☐	High Fever	☐	☐	Polio
☐	☐	Autoimmune	☐	☐	HIV	☐	☐	Stroke
☐	☐	Bruise Easily	☐	☐	Kidney Disease	☐	☐	Thyroid Issue
☐	☐	Cancer	☐	☐	Lyme's	☐	☐	Other_____
☐	☐	Diabetes	☐	☐	Migraines	☐	☐	Other_____
☐	☐	Drug Abuse	☐	☐	Mono	☐	☐	Other_____
☐	☐	Epilepsy	☐	☐	Mental Illness	☐	☐	Other_____

Do you have any addictions to ☐ Nicotine ☐ Prescription Medication ☐ Alcohol ☐ Other

Are you taking coumadin or warfarin? ☐ Yes ☐ No

Do you currently have an infectious disease? ☐ Yes ☐ No ☐ Possibly

If yes, please identify: _____

Known or suspected food allergies, sensitivities or intolerances and your reaction:

_____

Surgeries, Hospitalizations, Trauma (ex. car accident, fall, loss of loved one). Include dates:

_____

_____

CURRENT PERSONAL HEALTH REVIEW

Please put a check mark (√) by the symptoms that you have now or in the past few weeks.

GENERAL
- ☐ low energy
- ☐ catch colds easily
- ☐ difficult to concentrate
- ☐ dizziness
- ☐ dream disturbed sleep
- ☐ dry skin
- ☐ fatigue
- ☐ flushed in the afternoon
- ☐ general weakness
- ☐ mental confusion
- ☐ night sweats
- ☐ restlessness
- ☐ sores on tip tongue
- ☐ sweat easily
- ☐ feel worse after exercise
- ☐ see floating black spots

RESPIRATORY
- ☐ allergies
- ☐ cough
- ☐ difficulty breathing
- ☐ dry mouth, throat, nose
- ☐ nasal discharge
- ☐ nose bleeds
- ☐ phlegm
- ☐ shortness of breath
- ☐ sinus congestion
- ☐ sneezing
- ☐ sore throat
- ☐ sleep apnea

HEART
- ☐ cold hands/feet
- ☐ chest pain
- ☐ edema
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ palpitations
- ☐ stroke
- ☐ heart murmur
- ☐ high cholesterol

MOOD & SLEEP
- ☐ anxiety
- ☐ depression
- ☐ mood swings
- ☐ panic attacks
- ☐ easily angered
- ☐ easily stressed
- ☐ seeing a therapist
- ☐ insomnia
- ☐ difficult to fall asleep
- ☐ difficult to stay asleep

☐ busy mind
☐ nightmares
☐ night sweats

DIGESTION
☐ bloating/gas after eating
☐ belching
☐ constipation
☐ diarrhea
☐ diarrhea alternates with constipation
☐ fatigue after eating
☐ gas
☐ hemorrhoids
☐ laxative use
☐ loose stool
☐ low appetite
☐ mentally sluggish, foggy
☐ nausea
☐ prolapsed organs
☐ rectal pain
☐ swollen feet
☐ swollen hands
☐ bruise easily
☐ heartburn
☐ large appetite
☐ mouth sores
☐ stomach pain

HEAD, EARS, EYES, THROAT
☐ feel lump in throat
☐ migraine
☐ headaches
☐ muscle spasms, twitches
☐ seizures
☐ jaw pain
☐ facial pain
☐ grinding teeth
☐ red eyes
☐ itchy eyes
☐ ringing in ears

KIDNEY/BLADDER
☐ frequent urination
☐ lack of bladder control
☐ frequent night urination
☐ painful urination

SKIN
☐ rash
☐ dry skin
☐ eczema
☐ acne
☐ itchy skin
☐ psoriasis

PAIN

Please answer the following questions if you have pain.

☐ neck pain
☐ shoulder pain
☐ back pain
☐ hip pain
☐ sciatica
☐ knee pain
☐ muscle weakness
☐ joint pain
☐ tremors
☐ tingling
☐ numbness
☐ seizures
☐ arthritis

What does your pain feel like:

☐ Dull
☐ Sharp
☐ Stabbing
☐ Achy
☐ Burning
☐ Comes and Goes
☐ Constant
☐ Fixed
☐ Moves About

Does the pain radiate? ☐ Yes ☐ No If so, where?_____

What helps the pain?

☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Massage ☐ Nothing ☐ Medications

What makes the pain worse?

☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Massage ☐ Nothing ☐ Working

Please rate your pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Other treatments that you have had for this pain: _____

WOMEN'S HEALTH

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Are you taking the birth control pill? ☐ Yes ☐ No If yes, which one? _____

Are you on hormone therapy? ☐ Yes ☐ No If yes, which one? _____

Age of First Menses: _____ Date of Last Menses: _____ Age of Menopause:_____

Typical Length of Menses (Days you bleed): _____

Typical Length of Cycle (from 1st day of one cycle to 1st of the next): _____

Number of Pregnancies:_____ Number of Births:_____ Hysterectomy: ☐ Yes ☐ No

Check all that apply to you:

☐ scanty flow	☐ painful periods	☐ low libido
☐ heavy flow	☐ breast tenderness	☐ painful intercourse
☐ clotting	☐ breast lumps	☐ infertility
☐ vaginal discharge	☐ nipple discharge	☐ fibroids
☐ menopausal symptoms	☐ bleeding between cycles	☐ endometriosis
☐ PMS	☐ irregular cycles	☐ ovarian cysts

MEDICATIONS

Please list medications, herbal supplements, and vitamins that you are currently taking:

Drug/Supplement/Vitamin	Reason For Taking	For How Long	Dosage	Frequency

FAMILY HISTORY

How do you feel about the following areas of your life in the past month:

Significant Other: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A
Family: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A
Self: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A
Work: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A

*Check illnesses that have occurred in any of your **blood relatives**:*

☐ Alcoholism	☐ Diabetes	☐ Kidney Disease
☐ Allergies	☐ Epilepsy	☐ Mental Illness
☐ Autoimmune Disease	☐ Heart Disease	☐ Obesity
☐ Cancer	☐ High Blood Pressure	☐ Stroke

LIFESTYLE

Are you vegetarian or vegan? ☐ Yes ☐ No If so, for how long?_____

Are you on a restricted diet? If so, which one? _____

Daily Water Intake: _____ Daily Caffeine Intake _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, what kind? _____

Do you exercise? ☐ Yes ☐ No If so, how often? _____ What kind? _____

How would you rate your stress level on a scale of 1 to 10 (10 is high stress)? _____

How many hours per night do you sleep?_____ When do you go to bed?_____

Ashland Family Acupuncture

OFFICE & FINANCIAL POLICIES

Welcome to Ashland Family Acupuncture! We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

PAYMENT OF SERVICES

- Payments and co-pays are due at the time of service unless arrangements are made in advance.
- Payment can be made with cash, check, or credit card.
- Please note that there will be a $25 charge for checks returned due to insufficient funds.
- If you foresee any financial challenges, please address them prior to your appointment.

INSURANCE COVERAGE

- We are an in-network provider for *Regence BCBS of Oregon*. Policies can differ greatly in terms of deductibles, conditions covered, and percentage covered for acupuncture. We can verify coverage and submit your claim provided you sign the financial agreement below.
- For all other insurance companies, we are out-of-network and require payment at the time of service. We can provide super bills with the proper coding for you to submit to your insurance company.

RELEASE OF MEDICAL INFORMATION

- If your insurance is being billed, your insurance company may require medical reports to document our treatment and progress. Signing below authorizes the release of medical information necessary to process your claim.

APPOINTMENT CHANGES AND CANCELLATIONS

- As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment.
- Please note that there will be a charge of $25 for all missed appointments and for all appointments canceled or changed without 24 hours notice for all non-emergency situations.

FINANCIAL AGREEMENT

I am receiving or about to receive health care services in this office. I understand that I am responsible for the full payment of all non-insurance related fees at the time services are rendered. If I choose to use my insurance, I understand that I will be responsible for all "non-covered" services, co-insurance, and co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Ashland Family Acupuncture, LLC, Nicole Peterson, LAc.

By signing below, I agree to comply with the office policies stated above which I have read and understand. I also authorize the use of this signature on all insurance submissions.

Name_____

Signature_____ Date_____

Ashland Family Acupuncture

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or patient named below for whom I am legally responsible) by acupuncturist Nicole Peterson, LAc, MAcOM and/or acupuncturist who now or in the future treats me while employed by, working or associated with, or serving as back-up for Nicole Peterson, LAc, MAcOM including those working at Ashland Family Acupuncture or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, massage, applied kinesiology, herbal medicine, nutritional counseling and nutritional supplements. I understand that the herbs or supplements need to be consumed according to the instructions provided orally and/or in writing. The herbs or supplements may have an unpleasant smell or taste. I will notify the office immediately of any unanticipated or unpleasant effects associated with the consumption of herbs or nutritional supplements.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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; however, this clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion, cupping, and heat lamps.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that are recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate for pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Nicole Peterson, LAc, MAcOM if I become pregnant.

I do not expect the acupuncturist or clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist and clinical staff to exercise judgment during the course of treatment which the acupuncturist and staff thinks at the time, based on the facts then known, is in my best interest. I understand that results are not guaranteed.

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

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and I 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.

Name_____

Signature_____ Date_____

Dependent's/Minor's Name_____Relationship_____

Health Information Patient Privacy Act (HIPPA) Notice

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

Each time you visit a health care provider, a record of your visit (containing your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments) is made. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of Information for public health officials
- An outcomes tool with which we can improve the care we deliver

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

Understanding Your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of Information practices upon request
- Inspect and obtain a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health Information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health Information except to the extent that action has already been taken.

We are required to:

- Maintain privacy of your health Information and abide by the terms of this notice
- Provide you with a notice as to our legal duties & privacy practices with respect to your information.
- Notify you if unable to fulfill a requested restriction on disclosure or amendment to record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations.

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment. If you have questions and would like additional information, you may contact the office. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

I understand that Ashland Family Acupuncture, LLC will use and disclose health information about me in the course of providing care to me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and my include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By signing below, I agree that I have reviewed this privacy practice and agree to these conditions. I will be offered a copy of this form and may request a copy at any time.

Name_____

Signature_____ Date_____