Acupuncture Healthcare LLC

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(513)328-5600 www.cincinnatiacupunctureclinic.com

Patient Information

Your accurate confidential health questionnaire is very important, It will help us to determine the best treatment plan for you. Thank you

Name Last________________ First _________________, Middle_______ **Today's date** _____/_______/__________

Gender _____ Female ______Male **Date of Birth** ______/________/_______ **Age** ________________

Email____

Address ___________________________________ City ____________________ state _______ Zip code______________

Telephone Home________________________ Work ____________________________Cell___________________________

Occupation______________________________________ **Employer** ____

If retired, please indicate previous occupation____

Primary physician ___________________________________ Telephone _______________________________________

Chiropractor____Telephone _______________________________________

Emergency Contact Name_______________________________________ Relationship ___________________________,

If minus, Responsible party______________________, Name____

Telephone ____

Referral Resources □ Search internet, □ Friend, □ Relative, □ Newspaper, □ Others______________

Notice of Payment Policies

A. Payment is due at the time of service. We accept cash, checks, and most major credit cards.
B. A $30 fee will be charged for returned checks.
C. We reserve the right to change our fee scale without notice.

Please acknowledge your understanding and acceptance of our privacy and payment practices and policies by signing below.

Patient's Name(print): ____ Date: _______________

Signature: ____

Patient Intake Form

Name______________________________, Age_______________________, Today's date________/________/______________

CURRENT HEALTH HISTORY

Please indicate your Main health concerns for which you are seeking treatment_____________________________

____

When this concern begin ____

Is this the new issue or recurrence ? ____

What are the possible Causes ____
Have you been diagnosed by a physician for these conditions? If So, Please describe

____

Other Concurrent therapies____

What make the main problem worse ____

What make the main problem Better ____

Any family member/relatives have same/similar problem____

Recent Medical Test or procedure (please indicate the result & date)

□ Physical check-up □ Cholesterol, □ Blood test □ Prostate exam

□ Mammogram □ Pap Smear □ HIV/STD □ Others

Test results & date____

____

Have you had Experienced Acupuncture & Oriental Medicine before? Yes_____, No______

If yes, how do you feel about Acupuncture? ____

Please List the medications you have been taking presently (prescription and over-the-counter drugs, vitamins, Herbs)

Medication	Conditions	Dose		Medication	Conditions	Dose

Name_____________________________, Age_______________________, Today's date_______/_______/____________

Do you use any recreational drugs? ☐ Yes ☐ No
If Yes, please indicate specificely____
Please indicate any allergies you have had____

PAST MEDIACAL HISTORY (Please indicate when and who the diagnosis was gave/established **)**
Significant Illnesses, injuries, emotional traumas____
____
Surgeries____
Infectious diseases____
Hospitalized____
☐ HIV/AIDS ☐ Hepatitis B/C ☐ TB

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

☐ Fevers ☐ Tremors ☐ Change in appetite
☐ Chills ☐ Seizures ☐ Peculiar tastes or smells
☐ Fatigue ☐ Night sweats ☐ Sudden energy drops? What time of the day? _______
☐ Poor sleep/ Insomnia ☐ Day sweating ☐ Strong thirst for hot or cold drink___________________
☐ Dream disturbed Sleep ☐ Poor balance ☐ Headaches ☐ Depression
☐ Weight loss ☐ Localized weakness ☐ Mania ☐ Weight gain
☐ Bleeding or bruising ☐ Emotional changes ☐ Poor appetite ☐ Joint pain

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SKIN & HAIR

☐ Rash ☐ Ulceration ☐ dry skin ☐ Hives ☐ Itching ☐ Pimples ☐ dandruff
☐ Eczema ☐ Oily skin ☐ Loss of hair ☐ recent moles ☐ Change of hair/skin color & textures
Others ____

HEAD, EAR, NOSE & THROAT

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

RESPIRATORY

☐ Cough Pain w/Deep Breaths ☐ Difficulty in Breathe ☐ Asthma Bronchitis ☐ Shortness of Breath
☐ Coughing Blood ☐ Sinus problem ☐ Production of phlegm, please indicate Color __________

CARDIOVASCULAR

☐ Dizziness ☐ Blood clots ☐ Difficulty in breathe ☐ Fainting ☐ Low blood pressure
☐ Cold sweats ☐ Chest pain ☐ swelling of hands ☐ Irregular heartbeat
☐ Cold hands/Feet ☐ Palpitations ☐ High blood pressure ☐ swelling of feet phlebitis

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GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Parasites ☐ Constipation ☐ Indigestion
☐ Belching ☐ Diarrhea ☐ Ulcers ☐ Bad breath ☐ Blood in stools
☐ Abdominal Pain/cramps ☐ Digestive disorders ☐ Hernia hemorrhoids

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Name_____________________________, Age_______________________, Today's date_______/_______/_____________

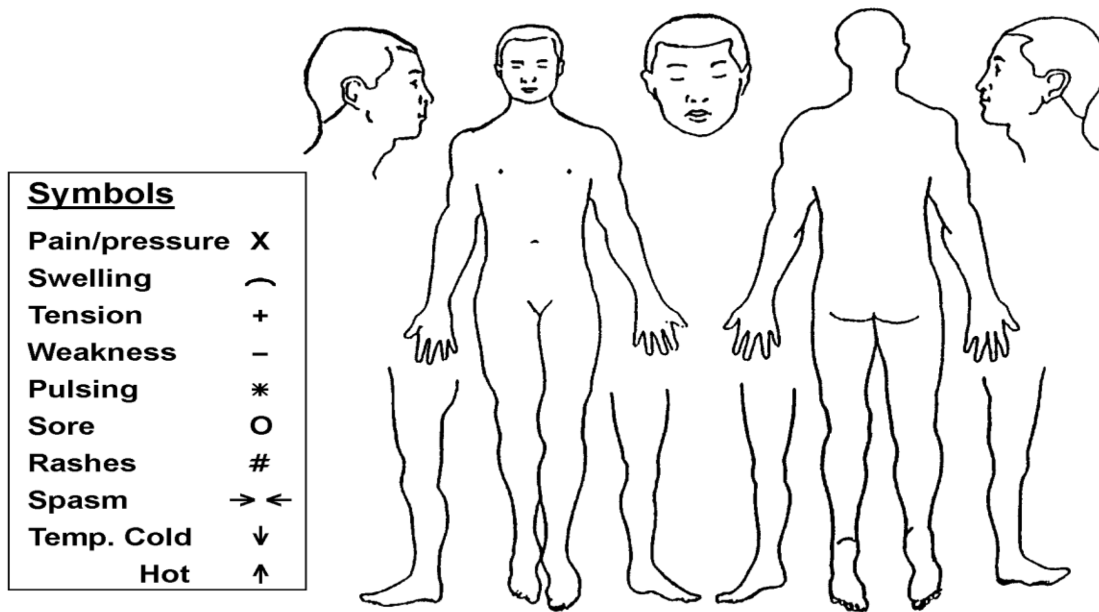
NEUROPSYCHOLOGICAL

□ Seizures □ Dizziness □ Headaches □ Concussion □ Depression □ Anxiety
□ Migraines □ Disorientation □ Mania □ Loss of balance □ Areas of numbness □ Fainting
□ Poor memory □ Easily Angered □ Lack of coordination □ Easily susceptible to stress
□ Bipolar □ Considered/ attempted suicide □ Significant trauma (Auto accidents, falls, loss etc.)

MUSCULOSKELETAL

□ Neck pain □ Limb pain □ Back pain □ Shoulder pain □ Hand/feet pain □ Muscles pain
□ Knee pain □ wrist pain □ hip pain □ elbow pain □ Ankle pain □ Recent sprains
□ Injuries or fall □ Muscle cramps □ Arthritis □ Joint Instability □ Muscular spasms
□ Muscular weakness □ Muscular Atrophy □ General aches

Pl ease mark exactly pains, injured or abnormal feeling locations



PHYSICAL PAIN QUALITY

□ Dull/achy □ Sharp/stabbing □ Burning □ Electrical □ Tingling /numbness
□ Continuous □ Comes and goes □ Fixed location □ Moves around □ Shooting/ radiating
□ Better /worse with heat □ Better/worse with cold
□Better/worse with movement □ Better/worse with pressure

GENITO-URINARY

□ Pain on urination □ Decrease in urine □ Frequent Urination □ Urgent urination □ Blood in urine
□ Genital Sores □ Unable to hold urine □ Waking up to urinate □ Impotency/ infertility □ Kidney sores

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Name______________________________, Age________________________, Today's date________/________/______________

FOR WOMEN ONLY (check all that apply)

Age at first menses______, # Pregnancies_______, # children_______, # miscarriage_______ , #abortion__________
days period flow________, #days between periods _______, Last PAP________ Last menses ____________________

□ Birth control □ Premature births □ Menopause, age was_______ Others _________________________________

Menstrual cycle □ Irregular □ Painful □ Heavy clots □ Excess/Defic. bleeding
□Water retention □ Dark/light color □ Painful breast
□ Feel better before menstrual flow □ Feel better after menstrual flow

Vaginal discharge □ Liquid □ White □ Yellow □ Thick □ Bad odor

Other____

Please indicate if you experience any of these other gynecological symptoms:
□ Vaginal dryness □ Profuse vaginal discharge □ Yeast infections □ Urinary tract infections

____

Please indicate if you have been diagnosed with any of the following:
□ Fibroids □ Fibrocystic breasts □ Endometriosis
□ Polycystic Ovary Syndrome □ Ovarian Cysts □ Pelvic Inflammatory disorder

Please list any STDs you have: ____

Are you currently pregnant? ___Yes ___No Are you try to get pregnant in near future? ____Yes ____No

FOR MEN ONLY (check all that apply)

□ Reduced sexual energies □ Pain with urination □ Groin pain □ Impotence
□ Premature ejaculation □ Prostate problems □Infertility □ Seminal emission □ Other

____

____

FAMILY MEDICAL HISTORY

Mother side: □ Hypertension □ Heart diseases □ Cancer □ Diabetes □ Stroke □ Seizures □ Asthma
□Alcoholism □ Other____

Father side: □ Hypertension □ Heart diseases □ Cancer □ Diabetics □ Stroke □ Seizures □ Asthma
□Alcoholism □ Other____

Siblings : □ Hypertension □ Heart diseases □ Cancer □ Diabetes □ Stroke □ Seizures □ Asthma

□Alcoholism □ Other____

LIFE STYLES

Your Height___________ Ft __________Inch Weight ____________LB , Weight of last year________________LB

Is there any noticeable weight change in last 3 months? ____

How many hours of sleep do you get each night?____________ Do you experience: □ Difficulty falling asleep
□ Staying asleep □ Interrupted sleep □ Nightmares □ Vivid dreams □ Wake up not well-rested/groggy

How many bowel movements do you have in a day or week____

Name____________________________, Age______________________, Today's date_______/_______/_____________

Are your bowel movements: □ Well-formed □ Loose □ Small pebbles □ Tan □ Almost black

□ Easy to pass □ Difficult to pass □ Sticky, likely you have to wipe a lot

How would you rate your energy level on a scale of 1-10, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

How would you rate your stress level on a scale of 1-10, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

How many hours do you work each week? ________hours, Your work is □ indoor, □ outdoor

Please list your primary sources of stress: ____

How much do you think about them? How much do they impact your life ___________________________________

What do you do in order to manage your stress and take care of yourself?___________________________________

____

Please indicate the main food resources you consume daily (check all that apply and indicate the percentage % portion of your diet)

□ White meats_____ □ Red meats____ □ Eggs____ □ Beans____ □ snacks_____ □ Sweets_____ □ Fry foods______

□ White flour products_____ □ Rice____ □ Vegetables____ □ Fruits____ □ Dairy products____ □ Others_______

____

Please indicate the frequency & amounts you consume the following activity /drinks

□ Exercises___________________________ □ Tobacco ________________________□ Alcohol _______________

□ Soda________________________________ □ Caffeine_________________________ □ Water ________________

Do you want to quit smoking/alcohol? □ Yes □ No

If Yes, Please indicate your desire for quitting, 10 is the highest desire and 1 is the lowest. 1 ,2, 3, 4, 5, 6, 7 ,8, 9, 10

Notes (Please add any other information you feel important)

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I understand the above information and guarantee this form was completed correctly to the best of my knowledge

Signature____

By □ Adult patient □ Parent or Guardian □ Spouse

Notice of Privacy Practices
Acupuncture Healthcare L.L.C.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. We are required by law to give you notice of our privacy practices. Please review carefully.

Right to Notice
As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Acupuncture Healthcare L.L.C. can use your protected health information
for treatment, payment, and health care operations.

A. Treatment – We may use or disclose your health information to a physician or other health care provider providing treatment to you.

B. Payment – We may use and disclose your health information to obtain payment for services that we provide to you.

C. Health care operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization
Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations
In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using our professional judgment. We will only disclose health care information that is directly relevant to the person's involvement in your health care.

Marketing
We will not use your health information for marketing communications without your written authorization.

Required by Law
We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health and safety.

Please Continue on Reverse Side

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

Your Rights as a Patient

A. You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment, or health care operations.

B. You have the right to request in writing and receive confidential communications regarding your protected health care information.

C. You have the right to inspect and copy your protected health information (PHI). Requests for copies of PHI must be made in writing to our office and will be available for review within 30 days of the date of the request.

D. You have the right to amend/update your protected health information. To provide the best health care possible, it is always recommended that you keep us up-to-date on ALL of your health information/conditions.

E. You have the right to receive an account of disclosures of your protected health information. Our office will provide within 30 days of a written request

F. You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Acupuncture Healthcare L.L.C. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted within our office or on our website.

Complaints

It is always our utmost goal to treat our patients with care and respect. If, however, you have complaints regarding the way that your protected health information is handled, you may submit a complaint to our office. We hope that you always let us know what we may do to improve your patient care.

Contact Information

☐ Please acknowledge your understanding and acceptance of our privacy and policies by signing below.

Patient's Name: ________________________________ Date: ________________

Signature: ____________________________________

Physician Care Form

Date_____/_________/_________

I have been diagnosed with the following condition(s):
(check all that apply)

_____ Hypertension(High blood pressure)
_____ Cardiac condition
_____ Acute, severe abdominal pain
_____ Undiagnosed neurological changes
_____ Unexpected weight loss or gain more than
15% of body weght in last 3 months
_____ Unsuspected bone fracture or dislocation
_____ Unsuspected systematic infection
_____ Serious hemorrhagic(bleeding) disorder
_____ Pregnancy
_____ Others

I am currently under the care of physician for:
(check all that apply)

_______ Hypertension(High blood pressure)
_______ Cardiac condition
_______ Acute, severe abdominal pain
_______ Undiagnosed neurological changes
_______ Unexpected weight loss or gain more than
15% of body weght in last 3 months
_______ Unsuspected bone fracture or dislocation
_______ Unsuspected systematic infection
_______ Serious hemorrhagic(bleeding) disorder
_______ Pregnancy
_______ Others

I am aware that I should not replace treatment from physician with acupuncture, or any other oriental medicine modality.

Primary care physician name____

Primary care physician phone # ____

Your name (print) ____

Your Signature ____

Date ____