5 Element Chinese Medicine Patient Information Intake

In order to provide you the best possible holistic care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL

Authenticity Acupuncture

Cell: 919-260-9246
Email: bonnieacupuncture@gmail.com

224 East Street Suite B
Pittsboro NC 27312

Patient Data

Name _____ Date _____ Referred By _____

Address & Contact Information

Address _____ City _____ State _____ Zip _____

Telephone (work) _____ (home) _____ E-Mail _____

Age _____ Birth Date _____ Preferred Name: _____ Number of Children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Health Status _____

Emergency Contact _____ Phone _____

Current Goals to Wellness

What are the concerns for which you are seeking care? (symptoms, diagnosis and date of onset)

1) _____

2) _____

3) _____

What other treatments have you received for any of these conditions? _____

What makes your condition better? (movement, rest, heat, cold, eating, sleeping, crying, screaming, etc)

_____

What makes your condition worse? (fatigue, stress, certain foods or times of day, heat, cold, hunger. Etc)

_____

Significant Trauma, Hospitalizations, Surgery, X-Rays & Special Tests

Please include accidents, falls, illness, as well as emotional history. What month/year?

_____

_____

_____

Allergies

Are you hypersensitive or allergic to any foods, drugs, chemicals or environmental substances?

_____

_____

Exercise, Energy and Diet

How much exercise per week? _____ Length of workout? _____ Activities _____

How is your energy level? _____ When is it lowest? _____ Highest? _____

Typical Diet

Meals per day? _____ # of Snacks _____ Caffeinated Drinks _____ Alcohol per week _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What foods are your weakness? _____

Water intake per day? _____ Prefer warm or cold drinks? _____ Excessively thirsty? _____

Special Diet? _____

Personal History

Please check any symptoms you have now or ever have had

_____Cancer	_____Diabetes	_____Seizures	_____Heart Disease
_____High/Low Blood Pressure	_____Kidney Disease	_____Hepatitis	_____Thyroid Imbalance
_____Asthma	_____Eating Disorder	_____Arthritis	_____Ulcer
_____Chronic Fatigue	_____Alzheimer's	_____Autoimmune	_____Alcohol/Drug Addiction
_____Blood Clotting Disorder	_____Prolapsed Organ	_____Chronic Pain	_____Stroke
_____Anemia			

Do you smoke? (Tobacco or Marijuna) For how long?_____How much a day? _____

Other serious Health Conditions? _____

Sleep

How long do you normally sleep?_____per night.

I have difficulty with (check all that apply) _____Falling Asleep _____Staying Asleep _____Dream -Disturbed Sleep

_____Waking up throughout the night_____Not being able to fall back asleep At what time/s do you wake up? _____

Emotional Health

Have you ever been treated for psychological concern? _____ Have you experienced sexual or physical abuse? _____

Have you ever considered or attempted suicide? _____ Have you ever considered or attempted suicide? _____

Please rate your overall stress level (please circle one) Low Medium High

Are you currently working with a counselor?_____If so, who? _____

If possible, please describe the most challenging emotion you experience. _____

_____

When do you most often feel this emotion?_____

What experiences or activities bring you the most joy and nourishment? _____

Do you have a spiritual practice? _____

What goals do you have for your acupuncture treatments and anything else you would like to discuss?

_____

_____

For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle)_____Number of days of flow _____

Color of flow:	Amount of flow:	# of pads you use per day:	Pain and cramping:
____Pale/Light Red	____Spotting	1st day ____	___No
____Red	____Light	2nd day ____	___Yes
____Bright Red	____Even Throughout	3rd day ____	____Before flow ____Mild
____Dark Red	____Heavy	4th day ____	____During Flow____Moderate
____Dark Red/Brown		+ days ____	____After Flow ____Severe
____Clots			

Other symptoms related to menses

___Discharge	___Nausea	___Swollen Breasts	___Diarrhea
___PMS	___Diarrhea	___Mood Swings	___Insomnia

Attempting pregnancy currently?_____If so, for how long? _____

Currently pregnant?_____If so, how far along? _____

Currently breastfeeding?_____If so, how long?_____Difficulty, scanty or painful lactation?_____

Postpartum difficulties?_____Premature deliveries?_____Difficult deliveries? _____

Please, describe _____

Symptom Survey

Please check the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
_____excessive appetite	_____insomnia	_____cough	_____low back pain	_____eye problems
_____loose stool/diarrhea	_____palpitations	_____shortness of breath	_____knee problems	_____jaundice
_____digestive problems, indigestion	_____cold hands and feet	_____decreased sense of smell	_____hearing impairment	_____difficulty digesting oily foods
_____vomiting	_____nightmares	_____nasal problems	_____ear ringing	_____gall stones
_____belching, burping	_____mentally restless	_____skin problems	_____kidney stones	_____light-colored stool
_____heartburn/reflux	_____sadness	_____claustrophobia	_____hair loss	_____soft or brittle nails
_____stomach bloating	_____chest pains	_____constipation	_____urinary problems	_____easily angered
_____obsession in work, relationship, etc.	_____laughing for no reason	_____recent use of antibiotics	_____decreased sex drive	_____difficulty in making decisions
_____lack of appetite	_____sadness	_____blood in stool	_____easily bruised	_____high cholesterol
	_____poor memory	_____hemorrhoids	_____dental problems	_____bitter taste
		_____colitis /diverticulitis		

_____fatigue	_____get sick easily	_____headaches
_____edema	_____I usually feel warm	_____I usually feel chilled
_____asthma	_____dizziness	_____allergies

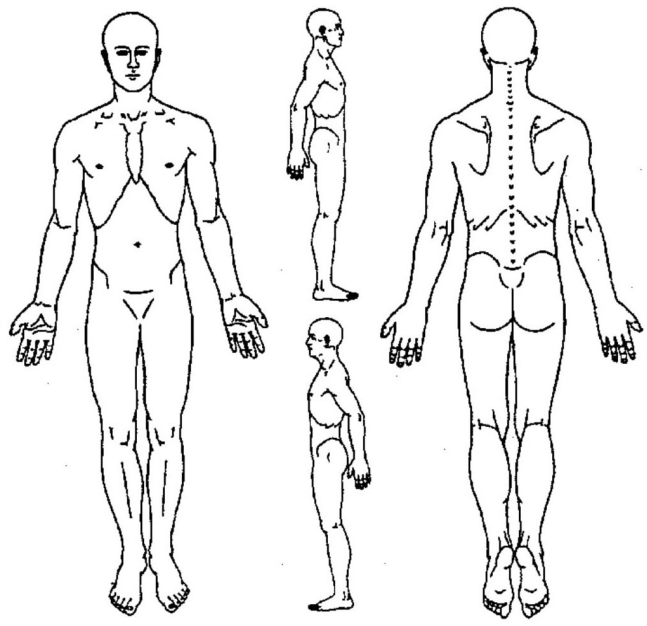
Muscle, Joints and Bones

Do you have pain or tightness?_____Where? _____

Recent Injuries?_____Was this from an auto accident or work related? _____

The pain is (check all that apply):

_____Sharp	_____Deep Pain
_____Numb	_____Superficial Pain
_____Burning	_____Tingling
_____Aching	_____Shooting
_____Dull	_____Pain worse with moveme
	_____Pain in am/pm



I have (check all that apply):

_____Swollen Joints	_____Arthritis/Joint Pain
_____Tendonitis	_____Bone Pain
_____Muscle Cramps	_____Muscle Pain
_____Strain Injury	

Have you fractured bones and have you had any surgery's? _____

Notice of Privacy Practices and Patient Rights

The confidentiality of patient health information is of the upmost importance at this clinic. All information of a personal nature with which this practice has been entrusted in the course of treatment has been and will continue to be kept confidential, consistent with the rule of the law and the standards of professional practice. The purpose of this notice is to inform you as to how your health information may be used and disclosed and how you can get access to this information, and also to inform you the new federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was designed to protect the confidentiality of your health information.

First of all, the standards set forth in this clinic are intended to assure that the treatment services are in all cases performed in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

What has changed? We have always endeavored to keep your health information confidential. What is new is that the HIPAA new standards for protecting health information privacy has challenged us to review how patient information is used not only in medical records but also with the telephone, faxes and mailings. Part of this information sheet is designed to inform you about policies and procedures we use to ensure your health information will not be shared with anyone who does not require it and also to inform you of your rights as a patient.

What is "health information"? According to HIPAA law, your "protected health information" is any information that can identify you. This includes such things as your name, telephone number, address, and dates such as birthday, start of treatment and appointments.

How your health information may be used: Your health information will be used only for the purposes of providing your treatment, obtaining payment and conducting our clinic. Your health information may be shared, with your permission, with referring physicians, pharmacies, or other health care practitioners providing you with treatment. Health information will not be used for any other purposes, unless you have signed written permission for us to do so. In order for you to obtain insurance reimbursement, we will provide you with an itemized receipt for you to submit to your insurance company, where appropriate.

It is also possible that health information will be disclosed during audits by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, accreditation or credentialing activities.

Other circumstances where health information may be shared: Government authorities may be notified if there is reason to believe that a patient is the "victim" of abuse, neglect or domestic violence. This disclosure will be made only when we are compelled by ethical judgment, when there is reason to believe we are specifically required or authorized by law, or with the patient's agreement.

We may also be required to disclose to government officials health information necessary to complete an investigation related to public health. We may share your health information, only with your permission, with those you tell us will be helping you with your care. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information and only we it will be important to those participating in providing your care.

Other than what has been stated above, or where Federal, State or Local law requires us, we will not disclose your health information.

Health Records: Your health information is kept in your file in a locked filing cabinet. The only person having access to this information (except as otherwise stated above) is your practitioner. Other than by your specific request, as in the case of Bill for Service Rendered or Receipt for Services Rendered, none of your health information is shared without your written consent. No faxes or emails containing your health information will be sent to anyone unless you specifically request it.

Patient Rights Regarding Health Records: You have the right to request reasonable restrictions on certain uses and disclosures of your health information, and we will make every effort to honor your requests. For example, you have the right to review and make a copy of your health information, including your chart. Duplication of this material may involve a small fee. In addition, you have the right to request that we communicate with you in a certain way. You may wish us, for example, to only contact you at a specific number, etc. You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment or payment. You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. We encourage you to express any concerns you may have regarding the privacy of your health information. You have the right to file a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised.

Authenticity Acupuncture Policies

Payment of Services
Full payment is due at the time of service. I accept cash only.

Cancellation of Appointments
Any cancellation within the 24 hour period before the patient's scheduled appointment will make the patient responsible for the FULL payment of the originally scheduled appointment. No Shows and/or Missed appointments also make the patient responsible for the FULL payment for the originally scheduled appointment.

Late Arrivals
Please arrive a few minutes before the scheduled time of your appointment. Please understand that in the event the patient is late to the appointment, the patient will not receive the full amount of time of treatment and the patient will be responsible for the FULL payment of the originally scheduled amount of time on the table.

Inter-Office Courtesy
Please quietly enter the office building, I request that cell phones be turned off before entering the building and during the course of the acupuncture treatment.

Prior To Your Appointment Policy
Please refrain from wearing fragrances or heavy makeup for your appointment. We also ask that you avoid coffee or other stimulants prior to your appointment and please eat something before your appointment.

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Rights and have had the opportunity to ask any questions I had regarding related operations in this clinic.

By signing this form, I am acknowledging I have received and accepted the terms of Payment of Services, Cancellation of Appointments, Late Arrivals, Inter-Office Courtesy and Prior to Your Appointment policy.

_____

Patient Printed Name

_____ _____

Patient or Legal Guardian Signature Date signed