NEW PATIENT INTAKE FORM

Today's Date_____/_____/_____

Name SS# Birthdate / /
Marital Status Age
Address ❑ M ❑ F Ht Wt
Email
City, State, Zip Occupation
Home Phone Work Cell
Emergency Contact's Name & Phone
Referred by
Reason for visit today Have you had acupuncture before? ❑ Yes ❑ No Chinese herbal medicine? ❑ Yes ❑ No
How long have you had this condition?
Is it getting worse? Does it bother your ❑ Sleep ❑ Work ❑ Other (specify)
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? ❑ Yes ❑ No If yes, for what?
Physician's name Physician's phone
Other concurrent therapies

Health Insurance Info:
Insurance Co. Name Policy #
Address Phone
City, State, Zip

Medicare Info:
Insurance Co. Name Policy #
Address Phone
City, State, Zip

Family Medical History

❑ Allergies (list) _____ _____
❑ Arteriosclerosis ❑ Asthma ❑ Alcoholism
❑ Cancer (type) _____ ❑ Depression
❑ Diabetes (Type:) ❑ Heart disease ❑ High blood pressure
❑ Seizures ❑ Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

❑ AIDs/HIV
❑ Alcoholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth trauma (your own birth)
❑ Cancer
❑ Chicken pox
❑ Diabetes (Type:)
❑ Emphysema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart disease
❑ Hepatitis (Type:)
❑ Herpes (Type:)
❑ High blood pressure
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker (Date:)
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Stroke
❑ Surgery (list) _____ _____ _____
❑ Thyroid disorders
❑ Major trauma (Car, fall, etc--list) _____ _____ _____
❑ Tuberculosis
❑ Typhoid fever
❑ Ulcers
❑ Venereal disease
❑ Whooping cough
❑ Other (Specify) _____ _____ _____ _____

Your Diet

Appetite ❑ Low ❑ High
❑ Coffee/Tea ❑ Soft Drinks/Fruit Juices
Protein Intake ❑ Low ❑ High
❑ Artificial Sweeteners
❑ Sugar ❑ Salty foods
Thirst for water: # glasses per day:_____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in the last 2 months:
Vitamins/supplements taken in the last 2 months:

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (Describe)

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses (What age:)
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Myopia or Presbyopia
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm
  Color:
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nosebleeds
- ❑ Ringing in ears (High or Low?)
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions

Other head or neck problems

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Difficult inhalation? exhalation?
- ❑ Cough
  Wet or Dry?_____
  Thick or thin?_____

Color of phlegm_____

- ❑ Coughing up blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Hemorrhoid
- ❑ Itchy anus
- ❑ Intestinal pain or cramping
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Anal fissures
- ❑ Laxative use
  What kind?
  How often?

Bowel movements:
Frequency_____ Texture/form_____
Color_____ Odor_____

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other (Describe)

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections

Other hair or skin problems

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing a therapist

Other (Specify)

Genitourinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began _____
- Length of cycle (day 1 to day 1) _____
- ❑ Duration of flow _____
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge (color)_____
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps
- # Pregnancies_____
- # Live births_____
- # Premature births_____
- Age at menopause_____

Date of last PAP _____
Date last period began _____

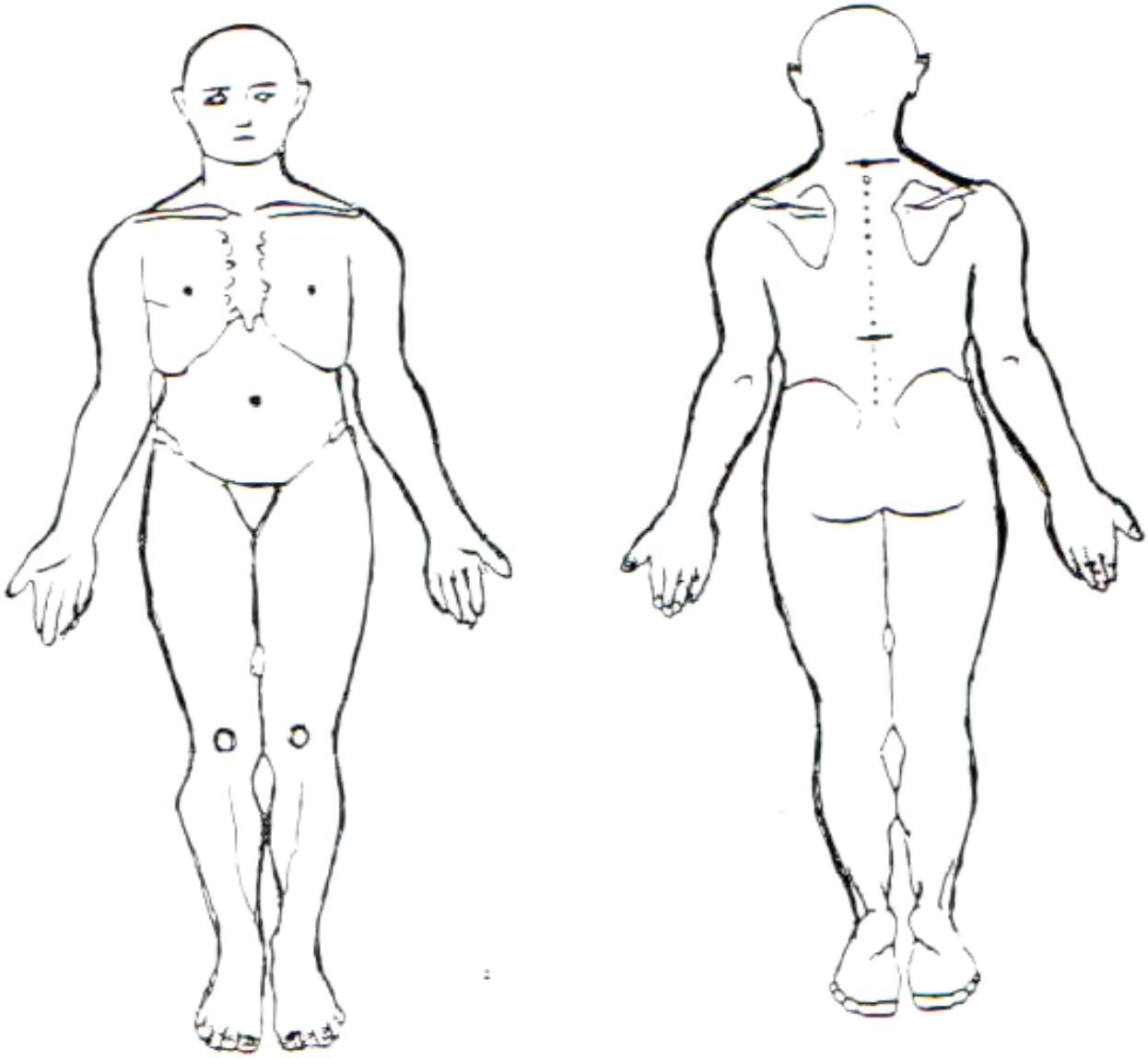
Other

Accredited Acupuncture Of Sacramento, Mark Fields, L.Ac. 87 Scripps Drive #212, Sacramento, CA 95825 (916)924-7911

Mark Fields, L.Ac. **Accredited Acupuncture Of Sacramento** (916) 924-7911

Draw the location of your pain of the body outline with the following codes and mark how severe it is on the pain line at the bottom of the page.

ACHE = ///	BURNING = BBBB	NUMBNESS = XXXX
PIN & NEEDLES = = = = =	STABBING = ZZZZ	OTHER = OOOO



NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN

(Circle your estimate)

Other comments about your illness:_____

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Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been 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 during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and 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, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about 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.

_____	Mark Fields L.Ac.
Print Name of Patient	Print Name of Acupuncturist
_____	_____
Signature of Patient (or Representative)	Signature of Acupuncturist
_____	Terri Richmond
(Print Name of Patient Representative)	(Print Name of Witness/Translator)
_____	_____
Date Consent Completed	(Signature of Witness/Translator)

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA proves penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- TREATMENT means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- PAYMENT means such activities as obtaining reimbursement for services including third-party payers, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES stated above.

PRINT PATIENT'S OR GUARDIAN'S NAME	SIGNATURE OF PATIENT/GUARDIAN	DATE

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Notice to our Patients Regarding Cancelled or Missed Appointments

Accredited Acupuncture of Sacramento has always had a policy of requesting that our patients give us at least one day's notice if they need to cancel an appointment. This has been a courtesy request so that we may make that time slot available to another patient. We also have had a long-standing policy that we may charge the patient for a missed or cancelled appointment without sufficient notice.

At this time we are going to begin to enforce our existing policies:

> There will be a $25.00 charge for appointments missed or cancelled with less than a day's notice.
>
> The missed/cancelled appointment fee is due directly from the patient, and will not be billed to any Third Party such as Private Health Insurance, Workers Compensation, Auto Med-pay, or any other Third Party Payer source.

It is important that you stay with your Treatment Plan in order to get the maximum benefit from your Acupuncture care. You have come to our office for treatment results, and if you do not follow through by keeping your appointments, then you have not given us the chance to best help you.

To summarize, we wish to be understanding and compassionate towards our patients, and we do expect courtesy and consideration in return.

I have read and understand the clinic's Policy regarding cancelled or missed appointments, and agree to the terms stated above.

_____	_____	_____
Print Patient or Guardian's Name	Signature	Date