New Patient Intake Form

Today's Date ______/______/______

Name | Marital Status: ______________ | Birthdate / /
Age ______
Address ______________________________ ☐ Male ☐ Female
______________________________ Ht ________ Wt ________
Email | Occupation
Home Phone | Work | Cell
Referred by
Reason for visit today | Have you had acupuncture before?
Chinese herbal medicine?
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:

Family Medical History:

☐ Allergies (list) ______________ ______________
☐ Arteriosclerosis
☐ Asthma
☐ Alcoholism
☐ Cancer (type) ______________
☐ Depression
☐ Diabetes (Type:)
☐ Heart Disease
☐ High Blood Pressure
☐ Seizures
☐ Stroke

Your Past Medical History:

☐ AIDs/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma (your own birth)
☐ 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
☐ Thyroid disorders
☐ Cancer type: treatment: ______________ ______________ ______________
☐ Surgery (list) ______________ ______________ ______________
☐ Major trauma (car,fall, pls list) ______________ ______________ ______________
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough
☐ Other

Your Diet:

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

Pharmaceuticals (name and dosage): | *Vitamins/Supplements (name and dosage):*

____
____
____
____
____

Your Lifestyle:

			Regular Exercise	
☐ Alcohol	☐ Marijuana	☐ Stress	Type______________	Frequency_________
☐ Tobacco	☐ Drugs	☐ Occupational hazards	Type______________	Frequency_________

General Symptoms:

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

Head, Eyes, Ears, Nose, Throat

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

Respiratory

☐ Difficulty breathing whi lying down	☐ Tight chest	☐ Cough	☐ Color of phlegm:	☐ Coughing up blood
	☐ Asthma/wheezing	Wet or Dry? _____	______________________	☐ Pneumonia
☐ Shortness of Breath	☐ Difficult inhale? Exhale?	Thick or thin? _____		

Cardiovascular

☐ High blood pressure	☐ Low blood pressure	☐ Chest pain	☐ Tachycardia	☐ Phlebitis
☐ Blood clots	☐ Fainting	☐ Difficulty breathing	☐ Heart palpitations	☐ Irregular heartbeat/ Afib

Gastrointestinal

☐ Nausea	☐ Diarrhea	☐ Intestinal pain/cramps	Bowel movements:	
☐ Vomiting	☐ Constipation	☐ Burning anus		
☐ Acid regurgitation	☐ Black stools	☐ Rectal pain	Frequency____________	Texture/form________________
☐ Gas	☐ Bloody stools	☐ Anal fissures		
☐ Hiccup	☐ Mucous in stools	☐ Laxative use	Color________________	Odor_______________________
☐ Bloating	☐ Hemorrhoid	What kind?		
☐ Bad breath	☐ Itchy anus	How often?		

Musculoskeletal

☐ Neck/shoulder pain	☐ Upper back pain	☐ Joint pain	☐ Limited range of motion	☐ Other
☐ Muscle pain	☐ Low back pain	☐ Rib pain	☐ Limited use	________________

Skin and Hair

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/skin texture	Other (Specify)
☐ Hives	☐ Psoriasis	☐ Itching	☐ Fungal infections	________________
☐ Ulcerations	☐ Acne	☐ Hair Loss		________________

Neuropsychological

☐ Seizures	☐ Poor memory	☐ Irritability	☐ Considered/attempted suicide	Other (Specify)
☐ Numbness	☐ Depression	☐ Easily sressed		________________
☐ Tics	☐ Anxiety	☐ Abuse survivor	☐ Seeing a therapist	________________

Genitourinary

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

Gynecology

☐ Age menses began	☐ Duration of flow	☐ Vaginal discharge	☐ Breast lumps	Date of last PAP
________________	________ days	(color)______________	# Pregnancies_________	______________________
Length of cycle (day 1-day 1)	☐ Irregular periods	☐ Vaginal sores	# Live births________	Date last period began
________________	☐ Painful periods	☐ Vaginal odor	# Premature births______	______________________
	☐ PMS	☐ Clots	Age at menopause______	

PATIENT PROFILE

NAME: ______________________________ DATE: ____________

It is very important in Chinese Medicine to know how long patient has experienced his/her symptoms. It is essential to indicate time on the symptoms.

Please indicate with one check (X) any conditions that you sometimes experience; use two checks for those which often occur and three (XXX) for symptoms that are a major concern.

WATER ELEMENT

_____Hearing Loss
_____Dizziness
_____Lower Back Pain/Neck Pain
_____Sinus Congestion
_____Edema
_____Rapid Weight Change
_____Darkness Under the Eyes
_____Emotional Instability
_____Aversion to Cold
_____Pre-Mature Aging
_____Frequent Urination
_____Kidney Stones
_____Perspire very easily
_____Weakness of the legs/knees
_____Reduced Sexual Energy
_____Thyroid Problems
_____Diabetes
_____Hair Thinning or Loss
_____Asthmatic Cough

WOOD ELEMENT

_____Headache
_____Migraines
_____Ulcer
_____Ringing in the Ears
_____Indecisiveness
_____Vomiting
_____Gallstones
_____Constipation
_____Hemorrhoids
_____Hepatitis
_____Poor eyesight
_____Eye Infections
_____Dry Eyes
_____Eczema
_____Shingles
_____Herpes Simplex
_____Nervousness
_____Convulsions/Spasms
_____Irritability
_____Painful Menstration
_____Irregular Menstration

WOOD ELEMENT CONT.

_____Fullness Below Ribs
_____Shoulder/Neck Tension
_____Insomnia 11pm- 3 am
_____Warts

FIRE ELEMENT

_____Dry Scalp
_____Skin Eruptions/Rashes
_____Cysts/Tumors
_____Sore Throat/Tonsillitis
_____Lymphatic Swelling
_____Hot Palms and Soles
_____Heart Palpitations
_____Aversion to Heat
_____Facial Redness
_____Itching/Burning Skin
_____Hot Hands/Feet
_____Thirst
_____Dark Urine
_____Night Sweats
_____Ear Infections
_____Headache
_____Bitter Taste in Mouth
_____Nose Bleeds
_____Gum Problems

EARTH ELEMENTS

_____Indigestion
_____Strong Appetite
_____Flatulence
_____Food Allergy
_____Stomach Ache/Ulcer
_____Diarrhea
_____Anemia
_____Halitosis
_____Mouth Sores
_____Heartburn
_____Nausea
_____Abdominal Bloating
_____Low Body Weight

METAL ELEMENT

_____Bronchitis
_____Asthma
_____Shallow Breathing
_____Cough
_____Sinus Congestion
_____Nasal Infections

OTHER

_____Fatigue
_____Arthralgia
_____Sciatica
_____Nerve Pain
_____Cold Hands/Feet
_____Bursitis

Pain (please describe):

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Other comments:

____
____
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Acupuncture & Herbs, feeling well naturally

Dr. Andrea Murphy, AP, DOM

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above 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, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, cosmetic acupuncture, homeopathy, gua sha, acupuncture injection therapy. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional supplement.

I have been informed that acupuncture and acupuncture injection therapy are generally safe methods 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. Burns and /or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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, although the clinic uses sterile disposable needles and maintains a clean and safe environment, at all times.

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, animal and mineral 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 will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon 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 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 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.

PATIENT SIGNATURE ______________________________ *DATE* ______________

Andrea Murphy, DOM

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require all patients to read and sign below before any treatment.

Full payment is due at time of service. We accept credit card, cash, and checks.

Regarding Insurance:

At this time our office is not set up to file your insurance for you unless you have been in an accident. We will be glad to supply you with all the necessary forms to file with your insurance company. You are responsible for payment of each treatment at the time of treatment.

By signing this document, you are authorizing the release of any information requested by any insurance company, adjuster or attorney that will assist in the payment of a claim.

Usual and customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some, and at times, perhaps all the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective and the original.

X____DATE______________________________

Signature of Patient or Responsible Party

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:____
Printed Name - Patient or Representative

____
Signature

Relationship to Patient (if other than patient):______________________________
Date:__/__/____

Witness ____
Printed name - Practice representative

Date:__/__/____

Consent for Communication and/or Disclosure

1. May our Patient Care Coordinator contact you:

   At home? Yes No
   If yes, may we leave the following information on your home voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

   At work? Yes No
   If yes, may we leave the following information on your work voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

2. Please indicate the number you wish us to use to contact you:
   Home:____________________ Work:____________________ Cell:__________________

3. Please print the names of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and heath care operation):

   o NONE
   Name____Phone____________________
   Name____Phone____________________
   Name____Phone____________________

4. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:
   Name____Phone____________________

5. Please print the address where you wish billing statements and/or correspondence from our office to be sent.
   o Use my home address
   o Use this one: ____

6. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? Yes No

7. May we send you email messages, such as newsletters and Family Healing Center updates, events and specials?
   Yes, at this email__________________________________ No

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Family Healing Center and give my permission to share the information as indicated with the person(s) named above.

____ ________________________

PATIENT SIGNATURE ***DATE***