New Patient Intake Form

Today's Date ____/____/____

Name | Birth date / / Age | Martial Status M W D S Blood Type A B AB O

Address | ☐ Male ☐ Female | Ht Wt

City, State, Zip | Cell Phone | Occupation

Home Phone | Work Phone | Email Address

Referred by: | Emergency Contact: Name & Phone

Reason for today's visit | 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 (what)?

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 so, for what?

Who is your physician? | Physician's Phone

Other current therapies:

Family Medical History

☐ Allergies (List)	☐ Arteriosclerosis	☐ Cancer (List)	☐ Diabetes	☐ Seizures
_____	☐ Asthma	_____	☐ Heart Disease	☐ Stroke
_____	☐ Alcoholism	_____	☐ High Blood Pressure	

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	☐ Diabetes	☐ Multiple Sclerosis	☐ Surgery (List)	☐ Tuberculosis
☐ Alcoholism	☐ Emphysema	☐ Mumps	_____	☐ Typhoid Fever
☐ Allergies	☐ Epilepsy	☐ Pacemaker	_____	☐ Ulcers
☐ Appendicitis	☐ Goiter	☐ Pleurisy	_____	☐ Venereal Disease
☐ Arteriosclerosis	☐ Gout	☐ Pneumonia	☐ Thyroid Disorders	☐ Whooping Cough
☐ Asthma	☐ Heart Disease	☐ Polio	☐ Major Trauma	☐ Other (Specify)
☐ Birth Trauma	☐ Hepatitis	☐ Rheumatic Fever	(car, fall, etc.-List)	_____
(your own birth)	☐ Herpes	☐ Scarlet Fever	_____	_____
☐ Cancer	☐ High Blood Pressure	☐ Seizures	_____	_____
☐ Chicken Pox	☐ Measles	☐ Stroke	_____	_____

Your Diet

Appetite ☐ Low	☐ Coffee	☐ Artificial	☐ Sugar	☐ Thirst for water
☐ High	☐ Soft Drinks	Sweetener	☐ Salty Foods	# of glasses per day _____

Average Daily Menu

[An accurate assessment of your condition will be helped greatly by the details you can provide in this section. Please be as specific and as thorough as possible. Where appropriate, please indicate now the foods were prepared (fried, broiled, barbequed, raw, etc.)]

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in the last 2 months:

Vitamins/Minerals taken in the last 2 months:

Over Please ⇒

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Stress
- ☐ Marijuana
- ☐ Street Drugs
- ☐ 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
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Spots in eyes
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Night Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth Problems
- ☐ Grinding Teeth
- ☐ TMJ
- ☐ Facial Pain
- ☐ Gum Problems
- ☐ Sores on lips or tongue
- ☐ Dry Mouth
- ☐ Excessive Salvia
- ☐ Sinus Problems
- ☐ Excessive Phlegm
- ☐ Recurrent sore throat
- ☐ Swollen Glands
- ☐ Lumps in Throat
- ☐ Enlarged Thyroid
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Other head or neck problems: _____

Respiratory

- ☐ Difficulty Breathing when laying down
- ☐ Shortness of Breath
- ☐ Tight Chest
- ☐ Asthma/Wheezing
- ☐ Cough

  Wet or Dry ?

  Thick or Thin ?

Color of Phlegm _____

- ☐ Pneumonia
- ☐ Coughing Blood

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
- ☐ Flatulence (gas)
- ☐ Hiccup
- ☐ Bloating
- ☐ Bad Breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative Use
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Mucus in Stools
- ☐ Anal Fissures
- ☐ Intestinal Pain or Cramping
- ☐ Itchy Anus
- ☐ Burning Anus
- ☐ Rectal Pain
- ☐ Hemorrhoid

Bowel Movements:

Frequency: _____ Texture/form: _____

Color: _____ Odor: _____

Musculoskeletal

- ☐ Neck/Shoulder Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Muscle Pain
- ☐ Rib Pain
- ☐ Joint 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) _____

Genito-urinary

- ☐ 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 Stones
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Nocturnal emission

Gynecology

Age Menses Began _____

Length of Cycle (day 1 to day 1) _____

Duration of Flow _____

- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ PMS
- ☐ Vaginal Discharge (color) _____
- ☐ Vaginal Odor
- ☐ Vaginal Sores
- ☐ Clots
- ☐ Breast Lumps

# of Pregnancies _____

# of Live Births _____

Premature Births _____

Age at Menopause _____

Date of Last PAP _____

Date Last Period Began _____

Other:

Professional Acupuncture and Physical Therapy

205 West 2nd Street • Duluth, MN 55802

Privacy Policy

(effective 04/14/2016)

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.

What information do we collect and how do we use it?

We collect information about you that is necessary to provide you with health care, maintain your health record, or to process payment of your health claims. This information is known as "protected health information" (PHI) and includes any type of health information that identifies you and is stored or transmitted on paper or electronically. This includes name, age, sex, ethnicity, other demographic information, activity within your account, Social Security number, and health insurance identification number. It also includes medical reports from physicians or other health care personnel and information needed to bill claims and receive payment from insurance companies on your behalf.

What information do we disclose and to whom?

We disclose your information only as is necessary in order to conduct our business, as permitted by law, to:
1) Employees, agents, representatives or third parties who provide health care services on your behalf and have been trained to handle PHI in conformity with this notice. These include office personnel, health insurance representatives, physicians and other health care providers for purposes of sharing information related to specific health care operations (including case utilization review or audit).
2) Other business associates who perform functions on our behalf, such as billing or transcription services.
3) Law enforcement and public health officials.

What is our Information Security Policy?

Professional Acupuncture and Physical Therapy considers your information to be confidential. Only those individuals who need your information to perform their jobs are authorized to have access to that information. We also maintain physical, electronic and procedural safeguards with respect to your information, which comply with Federal standards.

We will not use or disclose PHI for any other purpose without obtaining your specific authorization. You may revoke your authorization of disclosure at any time by written notice to Professional Acupuncture and Physical Therapy.

What are your rights under the Health Insurance Portability and Accountability Act?

You have the right to:

1) Request restrictions on certain uses and disclosures of your information.
2) Request and obtain copies of your medical and pertinent financial records and request changes if appropriate.
3) Receive an accounting of how your health information was used.
4) Receive confidential communications from Professional Acupuncture and Physical Therapy.
5) File a complaint if you feel your privacy rights have been violated, knowing that Professional Acupuncture and Physical Therapy will NOT retaliate against you for filing a complaint.
6) Request further information regarding privacy policy and procedures.

Contact - Heidi LaBore Smith at (218) 724-3400 or write to:
Professional Acupuncture and Physical Therapy
205 W. 2nd St., Suite 502 Duluth, MN 55812

Professional Acupuncture and Physical Therapy is legally obligated to maintain the privacy of PHI, provide this notice of privacy practices and abide by the terms of this notice. Professional Acupuncture and Physical Therapy reserves the right to revise its privacy practices to PHI.

Professional Acupuncture and Physical Therapy
205 W. 2nd St. Suite 502 Duluth, MN 55802
Heidi LaBore Smith, MS, L.Ac.. PT

Receipt of Privacy Policy

I acknowledge receipt of Professional Acupuncture and Physical Therapy 's privacy policy and my rights under it as established by the Health Insurance Portability and Accountability (HIPAA).

_____

Signature

_____

Date

Qualifications of Heidi LaBore Smith:
Bachelor of Science in Physical Therapy, U of MN, 1980
Graduate training in Holistic Therapies, College of St. Catherine, 1990
Three year professional program in Traditional Chinese Medicine,
Texas College of Traditional Chinese Medicine, 1993-1996
Diplomate in Acupuncture, NCCAOM, 1996
Master of Science, Oriental Medicine , Texas College of Traditional Chinese Medicine, 1997

Minnesota License information: *Physical Therapy - PT #2114* *Acupuncture - AC #1094*

The Minnesota acupuncturist scope of practice includes, but is not limited to the following: using Oriental medical theory to assess and diagnosis a patient, and using Oriental medical theory to develop a plan to treat a patient. The treatment techniques that may be chosen include: insertion of sterile acupuncture needles through the skin, acupuncture point stimulation including, but not limited to electrical stimulation, the application of heat, cupping, acupressure, herbal therapies, dietary counseling based on Traditional Chinese Medical principles, breathing techniques, exercise according to Oriental medical practices, and bleeding.

I have been informed that side effects involved in receiving acupuncture, while not common, may include: some pain in the treatment area, or temporary worsening of symptoms 24-48 hours before improvement begins. minor bruising, temporary faintness, infection, needle sickness (a temporary state of nausea or dizziness after needle insertion) and broken needles.

- I understand that it is appropriate for me to consult my primary care physician about the acupuncture treatment if I choose to do so, if circumstances warrant, or if my acupuncturist recommends such consultation.
- I understand that I should inform my acupuncturist whether or not a licensed physician, chiropractor, podiatrist or dentist has examined me with regard to my presenting complaint, and if so, what the Western medical diagnosis is.
- I should also report whether I have any serious illness, a bleeding disorder, or a pace maker.
- I have made a personal choice to receive treatments from Heidi LaBore Smith, MS, L.Ac., PT.
- I understand that no promises or guarantees can be made regarding the outcome of treatment because of the uniqueness of each individual.
- I understand that payment for services is due at the time of treatment. Check, cash, VISA and MasterCard are accepted.
- I give my full, informed consent for treatment..

****Acupuncture is <u>not</u> a 'quick fix.' Although some people may experience immediate relief of acute symptoms, most people require a series of treatments over a period of time to correct the initial imbalances that create their symptoms. For optimal results, treatment by this method requires a commitment.**

SIGNATURE OF RESPONSIBLE PARTY DATE

Thank you for choosing Professional Acupuncture and Physical Therapy. Please read carefully the following and indicate your understanding and acceptance by signing and dating where indicated at the bottom of the form. Please feel free to ask any and all questions.

Acupuncture Payment Policy

We request same day payment in order to keep costs down. We do not submit claims to any insurance companies, nor are we able to communicate in any way with third party payers.

1. ***I understand that payment for all services received at Professional Acupuncture and Physical Therapy is due in full at the time of treatment. (We accept cash, check , VISA or MasterCard)***

Attendance Policy

Please contact us at least 24 hours in advance to cancel or reschedule your appointment. We enforce a strict attendance policy and you may be charged the full amount for your scheduled appointment if cancellation is less than 24 hours or if you do not show up for your appointment. Thank you for your time and understanding.

I, _____, (please print name), have read the above policies and acknowledge them.

_____

SIGNATURE OF RESPONSIBLE PARTY

_____

DATE