Natural Health Improvement Center
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date_____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Shipping Address _____

_____

Home Phone (_____) ____-_____Cell: (____) ____-_____ Work Phone (____) ___-_____

e-mail address: _____

REFERRED BY:_____

Occupation _____ Employer_____

Date of Birth _____ Age ____Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint: _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals? (If yes, please print name and date of last visit):

_____

Current medications/drugs being taken: (use separate sheet if needed): _____

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol_____

_____

Office Use Only:

Natural Health Improvement Center
NEW PATIENT INFORMATION FORM

List any major illnesses (with approx date): _____

_____

List any surgery or operations (with approx date):_____

_____

Past Accidents or injuries: _____

_____

Any scars from injuries, surgeries, piercings, tattoos, childbirth? Yes ___ No___

(if yes, please note their location on diagram – see separate page)

Type of diet: Varied_____; Vegan/vegetarian _____; Paleo/ketogenic_____

Type of water you drink? _____

Any known allergies? _____

Any recent vaccines? _____

_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other: _____

Any family members or close associates with recent vaccines?

_____

_____

Any household pets or other animals you or family members are in close contact with:

_____

What could we do to make you happier? _____

_____

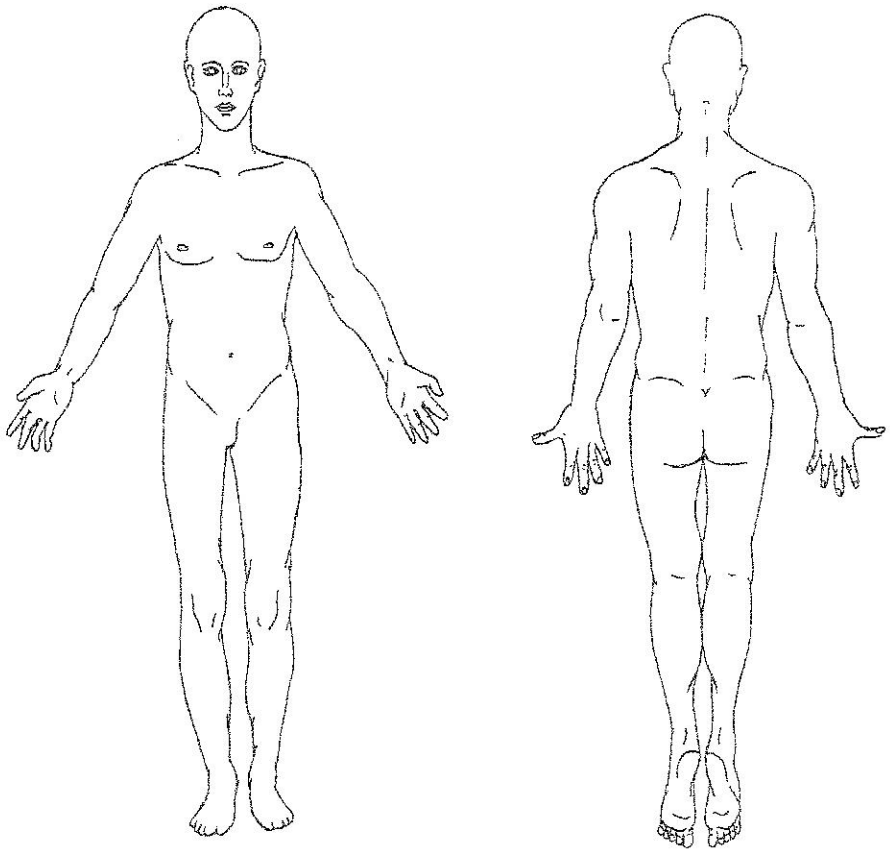
_____

Signed:_____ Date _____

Patient or guardian if patient is a minor)

Natural Health Improvement Center
NEW PATIENT INFORMATION FORM

Please Mark All Scars Below, Including Surgeries, Injuries, Piercings, Tattoos, and Childbirth (Episiotomy, Caesarian) Scars



Notes:

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.

● ○ ○ MILD symptoms (occurred once or twice last 6 months).

○ ● ○ MODERATE symptoms (occurred once or twice last month).

○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).

○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets

	1	2	3	
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

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
Certificate of Advanced Clinical Training in Nutrition Response Testing® 2023

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