Persimmon Health Center of Eastern Medicine

Acupuncture and Chinese Herbal Medicine
Yonie Young, L. Ac.

Initial Patient Intake Form

Thank you for coming here for treatment. The questions below have been chosen carefully to help make a complete holistic evaluation. Please take the time to answer as completely as possible.

Patient Full Name:_____ Date:_____

Date of Birth:_____ Age:_____ Occupation:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Preferred way of contacting you or leaving messages:_____

Emergency Contact:_____

Physician:_____

□ Single □ Married □ Divorced □ Significant Other □ Widowed

□ Caregiver for dependent Number of children:_____

Main reason for seeking treatment:_____

_____

_____

Current medical treatment and western medical diagnosis: _____

_____

_____

Current Medications and dosages, including prescribed and over the counter: _____

_____

_____

Current vitamins, herbs, and other supplements: _____

_____

_____

Significant illnesses (please check all that apply):

□ Asthma	□ Cancer	□ Chronic Fatigue	□ Depression
□ Diabetes	□ Eating Disorder	□ Heart Disease	□ Hepatitis
□ HIV/AIDS	□ Obesity	□ Multiple Sclerosis	□ High Blood Pressure
□ Seizures	□ Shingles	□ Hypo/Hyperthyroid	□ Stomach ulcers
□ Stroke	□ STD	□ Rheumatic fever	□ Pneumonia

□ Other _____

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Please check if any of the following are true:

□ I have a pacemaker

□ I am taking Coumadin/warfarin

□ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please list any surgeries you've had, including dates: _____

_____

_____

Please list any significant physical or emotional trauma (car accidents, sports injuries, death of family members, etc.) _____

_____

Please list any allergies or food sensitivities: _____

_____

Family Medical History (please specify family member):

□ Asthma
□ Cancer
□ Depression
□ Diabetes
□ Eating Disorder
□ Heart Disease
□ High Blood Pressure
□ Hypo/Hyperthyroid
□ Multiple Sclerosis
□ Obesity
□ Stomach ulcers
□ Stroke
□ Other _____

Lifestyle (please check all that apply and note frequency of use):

□ Tobacco
□ Alcohol
□ Recreational Drugs
□ Caffeinated beverages

Please list types of exercise/physical activity and frequency: _____

_____

_____

Please list your dietary preferences and frequency of meals and snacks: _____

_____

_____

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Please check all that apply:

Head
□ Concussion
□ Headaches
□ Dizziness
□ Memory Loss
□ Migraines
□ Hair loss
□ Other _____

Eyes
□ Blurred Vision
□ Pain
□ Dryness
□ Redness
□ Glasses/Contacts
□ Eyestrain
□ Color blindness
□ Night blindness
□ Cataracts
□ Floaters
□ Other _____

Ears
□ Poor hearing
□ Ringing in the ears
□ Frequent ear infections
□ Other _____

Nose
□ Frequent colds
□ Sinus infections
□ Allergies
□ Nosebleeds
□ Runny nose
□ Other _____

Mouth
□ Gum inflammation
□ Canker sores
□ TMJ syndrome
□ Cold sores
□ Unusual tastes
□ Other _____

Throat
□ Sore throat
□ Difficulty swallowing
□ Scratchy throat
□ Other _____

Respiratory
□ Asthma
□ Bronchitis
□ Chest Pain
□ Cough
□ Coughing Blood
□ Difficulty breathing
□ Phlegm
□ Pneumonia
□ Wheezing
□ History of smoking
□ Other _____

Heart and Thorax
□ Palpitations
□ Rapid heart beat
□ High Blood Pressure
□ Low Blood Pressure
□ Tightness in chest
□ Arteriosclerosis
□ Heart attack
□ Other _____

Circulation
□ Bruise easily
□ Cold hands/feet
□ Fainting
□ Phlebitis
□ Varicose Veins
□ Anemia
□ Other _____

Skin
□ Rashes
□ Hives
□ Dryness
□ Dandruff
□ Eczema
□ Hair loss
□ Acne
□ Purpura
□ Recent moles
□ Excessive sweating
□ Brittle nails
□ Fungal infections
□ Other _____

Gastrointestinal
□ Poor Appetite
□ Bad breath
□ Excessive Hunger
□ Excessive Thirst
□ Heartburn/Belching
□ Gas
□ Abdominal Pain
□ Parasites
□ Nausea
□ Vomiting
□ Constipation
□ Chronic Laxative use
□ Loose stools/diarrhea
□ Blood in stools
□ Hemorrhoids
□ Rectal Pain
□ Stomach Pain
□ Colitis or IBS
□ Gallstones
□ Other _____

Urogenital
□ Frequent urination
□ Difficult urination
□ Burning urination
□ Retention of urine
□ Waking to urinate
□ Dribbling of urine
□ Bedwetting
□ Bladder weakness
□ Itching of genitals
□ Decreased libido
□ Impotency/Infertility
□ Kidney stones
□ Other_____

Sleep
□ Insomnia
□ Night sweats
□ Drowsiness
□ Sleepwalking
□ Nightmares
□ Poor quantity
□ Poor quality
□ Other _____

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Neuropsychological
□ Anxiety
□ Irritability
□ PMS
□ Depression
□ Easily Stressed
□ Poor memory
□ Worry
□ Fear
□ Seasonal Mood Disorder
□ Social Anxiety
□ Tics/Tremors
□ Other _____

Musculoskeletal
□ Spinal Pain
□ Low back pain
□ Joint Pain
□ Arthritis
□ Limited range of Motion
□ Disc degeneration
□ Osteoporosis
□ Numbness
□ Tingling
□ Other _____

Please rate how you feel about the following areas of your life (1=bad; 10=great):

	Great	Good	Fair	Poor	Bad	Comments:
Work	□	□	□	□	□	_____
Health	□	□	□	□	□	_____
Love	□	□	□	□	□	_____
Family	□	□	□	□	□	_____
Money	□	□	□	□	□	_____
Spirituality	□	□	□	□	□	_____
Self	□	□	□	□	□	_____
Diet	□	□	□	□	□	_____
Exercise	□	□	□	□	□	_____

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Women only

Age of first period:_____

Age of menopause (if applicable): _____

How many days does your period last? _____

How many days between periods? _____

Date of last ob/gyn exam: _____

□ Abortion	□ Miscarriage	□ Live birth
□ Birth Control Pills	□ Pain at ovulation	□ Cramps/Low back pain
□ Breast cancer	□ Fibrocystic breast	□ Ovarian cysts
□ Fibroids	□ Candida yeast	□ Vaginal Discharge
□ Vaginal odor	□ Spotting between periods	□ Amenorrhea
□ Dysmenorrhea	□ Irregular cycle	□ HPV
□ Other _____		

Menstrual Flow:

□ Clots	□ Start and stop flow	□ Red
□ Brownish	□ Bright red	□ Flooding
□ Small amounts	□ Other _____	

Please list any symptoms related to your period (pains, cravings, emotions, etc): _____

_____

_____

_____

Men only

Date of last prostate check-up: _____

PSA results: _____

Manual prostate exam results: _____

Lab results: _____

□ Prostate Problems	□ Delayed stream	□ Dribbling
□ Incontinence	□ Retention of urine	□ Rectal dysfunction
□ Increased libido	□ Decreased libido	□ Premature ejaculation
□ Impotence	□ Back pain	□ Groin pain
□ Testicular pain	□ Other _____	

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Notice of Privacy Practices for HIPAA Regulations

This note describes general office practices regarding confidentiality of your medical information.

Office Practices:

All information regarding patients, their treatments, diagnosis, and appointments is kept strictly confidential within the confines of the practitioner. Patient charts and financial data will be seen only by the practitioner.

There is no electronic transfer of your medical data from this office.

For treatment purposes, information will be provided to another practitioner only after your written consent is given.

Discussion of treatment is confined to the consultation room or treatment room, not in the presence of other patients.

Communication:

I routinely communicate with patients over the phone to schedule and confirm appointments. While the name "Persimmon Health Center of Eastern Medicine-Yonie Young" is given in the messages, no reference to medical service is made.

If you have a preferred number that I can reach you, please provide that phone number below.

_____

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in this office and have been informed on how I can gain access to and control this medical information.

_____

Signature of Patient or Personal Representative

_____

Print name of Patient or Personal Representative

_____

Date

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Financial Agreement

Assignment of Benefits for Insurance
I authorize payment of benefits be made directly to Persimmon Health Center of Eastern Medicine and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Cancellation Policy
Please be respectful of the time set aside for your treatment. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week so that the effects from the treatment will not be interrupted.

All scheduled appointment require a 24 hour cancellation notice or the patient will be charged for a full office visit fee.

Returned Check Policy
All returned checks will be subject to an additional charge of $25.

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

_____
Signature of Patient or Personal Representative

_____
Print name of Patient or Personal Representative

_____
Date

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Patient Advisory to Consult a Physician and Informed Consent

Patient Advisory to Consult a Physician:
While Eastern medicine has a great deal to offer as a health care system, it cannot replace the resources available through traditional Western Medical practices. Consequently, we recommend that you consult a physician regarding condition (s) for which you are seeking acupuncture and Eastern medicine.

Informed Consent to Acupuncture Treatment:
I understand that methods of treatment may include but are not limited to: acupuncture, acupressure, therapeutic massage, bioelectrical stimulation, moxibustion, cupping therapy, and reiki. Acupuncture is a safe method of treatment with a history of over 2, 500 years. However, acupuncture may have side effects such as dizziness, fainting, bruising, numbness or tingling near the needling sites that may last a few days on rare occasions. Slight bruising is a possible side effect of acupuncture and cupping therapy. Mild burns and/or scarring are a possible risk of moxibustion. Highly unusual risks of acupuncture may include infections, spontaneous miscarriage, minor nerve damage, and organ puncture. We comply with strict protocols for needle usage and associated healing modalities. I understand while this document describes the possible risks of treatments, other side effects may occur.

Informed Consent to Herbal Medicine:
Eastern Medicine uses and recommends herbs and nutritional supplements from plant, animal, and mineral sources which are traditionally considered safe in oriental medicinal practices. However, taking large doses may be toxic. Herbs may have an unpleasant smell or taste. Possible side effects from taking herbs are nausea, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. Some herbs may be inappropriate during pregnancy. I will notify my treating acupuncturist if I am pregnant or suspect that I am pregnant before each treatment begins. I understand that the recommended herbs need to be prepared and consumed according to the instructions provided orally and in writing by the attending acupuncturist. I will immediately notify my acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal recommendations.

I understand that it is my responsibility to inform my treating acupuncturist if I become pregnant or suspect that I am pregnant before each treatment begins.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely of the acupuncturist to exercise judgment in my best interest during the course of treatments which are determined based upon the facts clearly presented to the treating acupuncturist prior to treatment. All of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the entire contents of this Patient Advisory to Consult a Physician and Informed Consent Form. I understand the risks and benefits of acupuncture and other associated procedures. I have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment at Persimmon Health Center of Eastern Medicine.

Signature of Patient or Personal Representative	Signature of Acupuncturist
Print name of Patient or Personal Representative	Print name of Acupuncturist
Date of consent	