East-West Integrative Medicine

CONFIDENTIAL

PATIENT INTAKE

Name ______________________________ Date ____________

Street Address ______________________________

City ______________________ State ________ Zip Code ____________

Day Phone ____________________ Alternate/Cell Phone ____________________

E-Mail Address ______________________________

Emergency Contact ______________________________

Primary Care Physician ____________________ Specialty Care Physician ____________________

Age ________ Height ________ Weight ________ Date of Birth ____________

What condition brings you in for treatment? ______________________________

Have you received acupuncture treatment before? ☐ Yes ☐ No

If yes, for what condition(?) ______________________________

____

MEDICAL HISTORY

MEDICAL DIAGNOSES

(**Please list all medical conditions you may currently have.)

Signature ______________________________

East-West Integrative Medicine

PATIENT INTAKE

Name ____ **Date** ____________

OPERATIONS **(**Please include dates and reasons for each operation)**

INJURIES OR TRAUMAS **(**Please include dates)**

CURRENT MEDICATIONS AND SUPPLEMENTS

(Please include the reason, dose and schedule of each medication and supplement)**

Do you have any allergies? ☐ **Yes** **List:** ____ ☐ **No**

Signature ____________________________________

East-West Integrative Medicine

PATIENT INTAKE

Name ______________________________ **Date** ______________

SOCIAL HISTORY

Do you use/consume any of the following? If so, please indicate how much/how often?

- ☐ Caffeine (_______ cups or sources/day)
- ☐ Alcohol (________drinks/week)
- ☐ Tobacco (________packs/day)
  - If a former smoker, when did you quit? ____________
- ☐ Recreational Drugs
  - If yes, which drug? ___________________________
  - How much? _________________ How often? __________________

Do you exercise regularly? ☐ Yes ☐ No

- If yes, what activity? ______________________
- How many hours/session? __________
- How often? ____________

Employment:

☐ Full-Time ☐ Part-Time **Profession/Vocation:**______________________________

Signature ______________________________

East-West Integrative Medicine

TCM SYSTEM REVIEW

Name ______________________________ Date ______________

**Do you have or experience any of the following symptoms?

KD YIN XU

- [ ] Lower back pain
- [ ] Ringing in the ears
- [ ] Dizziness
- [ ] Prematurely gray hair
- [ ] Dark under eye circles
- [ ] Night sweats
- [ ] Hot flashes

KD YANG XU

- [ ] Sore/weak lower back/knees
- [ ] Cold feet (esp. at night)
- [ ] Usually colder than others
- [ ] Low libido
- [ ] Often fearful
- [ ] Wake up to urinate
- [ ] Frequent/profuse urination
- [ ] Early morning diarrhea

SP QI XU

- [ ] Frequently fatigued
- [ ] Poor appetite
- [ ] Tired after eating
- [ ] Bloated after eating
- [ ] Crave sweets
- [ ] Loose stools/digestive problems

SP QI XU

- [ ] Abdominal pain
- [ ] Cold hands and feet
- [ ] Feel heavy/sluggish
- [ ] Head feels heavy, fuzzy or clouded
- [ ] Bruise easily
- [ ] Frequent muscle cramps
- [ ] Varicose veins
- [ ] Arms/legs feel weak
- [ ] Unable to exercise consistently
- [ ] Prone to worry
- [ ] Sweat without exertion
- [ ] Dizziness/vision changes when standing quickly
- [ ] Frequently sick/have allergies
- [ ] Hypothyroid
- [ ] Anemic
- [ ] Hemorrhoids/polyps

BLD X

- [ ] Numb hands/feet (esp. at night
- [ ] Varicose/spider veins
- [ ] Red hemangiomata on skin
- [ ] Dark, sooty complexion
- [ ] Abdominal masses

BLD X

- [ ] Blood clotting/vascular abnormality
- [ ] Clots in menstrual blood
- [ ] Endometriosis
- [ ] Uterine fibroids

BLD XU

- [ ] Dry, flaky skin
- [ ] Chapped lips
- [ ] Brittle, dry hair/nails
- [ ] Generalized hair loss
- [ ] Poor night vision
- [ ] Scanty/late menses
- [ ] Lightheadedness during

HT XU

- [ ] Wake up early and cannot return to sleep
- [ ] Heart palpitations (esp. when anxious
- [ ] Have nightmares
- [ ] Low spirits/lack vitality
- [ ] Agitated/restless
- [ ] Fidgety
- [ ] Sweat excessively, esp. on the chest

(Check all that apply)

Signature ______________________________

East-West Integrative Medicine

TCM SYSTEM REVIEW

Name ______________________________ Date ____________

**Do you have or experience any of the following symptoms?

LV QI X

- [ ] Emotional depression
- [ ] Easily angered/enraged
- [ ] Easily irritated/frustrated
- [ ] Nipple pain/discharge
- [ ] Bloating after eating
- [ ] Difficulty falling asleep at night
- [ ] Heartburn/wake up with bitter taste in the mouth
- [ ] Premenstrual breast distension/pain
- [ ] Painful menses

DMP/DH

- [ ] Feel tired/sluggish after eating
- [ ] Brain fog/difficulty focusing
- [ ] Cystic/pustular acne
- [ ] Joints ache more with movement
- [ ] Overweight/obesity
- [ ] Foul-smelling urine
- [ ] Urgent, foul-smelling stools
- [ ] Vaginal/rectal itching
- [ ] Foul-smelling green/yellow vaginal discharge

XS HEAT

- [ ] Pulse usually rapid (> 80 bpm)
- [ ] Mouth/throat usually dry
- [ ] Thirsty for cold drinks
- [ ] Usually warmer than others
- [ ] Wake up sweating/hot flashes
- [ ] Red acne
- [ ] Short menses (under 4 days)

(Check all that apply)

With my signature here and on all other pages, I confirm that my medical history as I have entered it is true, accurate and correct.

Signature ______________________________

East-West Integrative Medicine

PATIENT INFORMED CONSENT

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 named below and/or other licensed acupuncturists who now, or in the future, treat me while employed by, working with or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to the form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Oriental massage), Gua Sha (channel scraping), Reiki healing, kundalini healing, vitamin or homeopathic injection therapy Oriental herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and/or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. **I will not exceed the dosage and schedule advised by my acupuncturist.**

I have been informed that acupuncture is a generally safe method 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. Bruising that may last several days or weeks is a common occurrence with cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinician uses sterile, disposable needles and maintains a clean, safe environment. Burns and/or scarring are potential risks of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that Reiki therapy and kundalini healing are generally safe and have few side effects, however given that both Reiki and kundalini healing act as forms of energetic detoxification, dizziness, dysphoria and recall of symptoms of recent illness may temporarily occur following treatment. 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 Oriental 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 inform my acupuncturist if I am or become pregnant.**

I do not expect the clinician to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinician to exercise judgement during the course of treatment which the clinician thinks at the time, based upon the facts then known is in my best interest. I acknowledge, understand and accept that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient records and lab reports, but all of my records will be kept confidential and will not be released without my written consent.

I understand that any services, consultation, advice, products or treatments that I receive from the acupuncturist are not a substitute or replacement for conventional Western medical services, medications or treatments.

By voluntarily signing below, I indicate 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.

Acupuncturist: **Cheryl L. Yelverton, AP, MD**
Facility: **East-West Integrative Medicine**

Print Name ____

Patient Signature ____ **Date** ____________________

OR
Patient Representative ____
(indicate relationship to patient)

East-West Integrative Medicine

PATIENT QUESTIONNAIRE

Name ____ Date ____________

1. Please list the family members or other persons, if any, with whom we may communicate about your general medical condition and your diagnosis (including treatment, payment and general health care):

Name ______________________________ Contact Number________________

Name ______________________________ Contact Number________________

2. Please list the family members or other persons, if any, whom we may and should inform about your medical condition ONLY IN AN EMERGENCY:

Name ______________________________ Contact Number________________

Name ______________________________ Contact Number________________

3. Do you have a special address to which anything mailed to you should be sent?

☐ **Yes** List here: ____ ☐ **No**

4. If anything is mailed to you, do you need it specifically marked CONFIDENTIAL?

☐ **Yes** ☐ **No**

5. Do you have a special phone number that must be used to call you?

☐ **Yes** List here: ___________________ ☐ **No**

6. May confidential messages be left on your contact voicemail?

☐ **Yes** ☐ **No**

Signature ______________________________

East-West Integrative Medicine

PATIENT PRIVACY CONSENT

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 so, 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

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Print Name ____

Patient Signature ____ **Date** ________________

OR
Patient Representative ____
(indicate relationship to patient)

East-West Integrative Medicine

BRIEF SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a CONDENSED version of our 'Notice of Privacy Practices". The full-length Notice is available upon request.

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

We understand thay your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the "Notice of Privacy Practices", that is available):

- For medical treatment
- To obtain payment for services
- In emergency situations
- For appointment and patient recall reminders
- To run our practice more efficiently and ensure all of our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and/or tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Practitioner. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an account of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed "Notice of Privacy Practices".