HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the TCM Health Clinic "Notice of Privacy Practices" upon request. I understand that I have the right to review this "Notice of Privacy Practices" prior to signing this document.

I understand that staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone and only regarding appointment

I acknowledge that all information discussed during the assessment and treatment at the TCM Health Clinic will be held confidential except in the instance where my safety or the safety of others may be at risk

____ _________________________

Patient Name (print) **Date**

____ _________________________

Patient Signature **Date**

The TCM Health Clinic is not responsible for untrue statements made by patients.

INFORMED CONSENT TO ORIENTAL MEDICAL HEALTH CARE

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the acupuncturists at TCM Health Clinic: including acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my practitioners the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of biomedicine medicine, in the practice of Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I expect the practitioner to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic effect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient who is under the influence of illegal drugs, alcohol, or appears to be overly medicated, then a treatment may not be performed at that time. The patient will be informed that they may not be treated at that time and will be requested to reschedule their appointment

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to procedures and conditions of treatment. 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 at TCM Health Clinic.

______________________________	______________________________
Patient's name (please print)	Patient's signature
______________________________	______________________________
Print Name of Patient's Representative (if applicable)	Relationship or Authority of Patient's Rep.
______________________________	______________________________
Signature of Patient's Representative (if applicable)	Date Signed

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Preferred title: Mr. Mrs. Ms./Miss	Today's Date	
First name	Last name	Middle initial
Sex/Gender	Date of birth	Age
Occupation	Main Phone #	
E-mail address	Allow email contact? Yes / No	
Address: Street	City	State
Relationship status Family Physician or Chiropractor	# of children	
Emergency contact name	Phone	
Phone How did you find out about our clinic? *Friends/Relatives(name)____________________ Direct mail Location / Walk by Website* *Referred by___________________________ Health Fair/ Public Event Periodicals_______________*		

<u>Main problem(s)</u>:____

What diagnosis, if any, have you received for this problem? ____________________________________

When did this problem begin?____

What kind of treatment have you tried? ____

What makes this problem worse? ____

What makes this problem better? ____

<u>Medical History</u> **Surgeries:** ____

Hospitalization or **Significant trauma**:(auto accidents, sports injuries, etc)________________________

Allergies: (drugs, chemicals, foods, environmental):____

<u>Medicines</u> taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages): ____

Occupation: ________________________________Do you usually work indoors outdoors?

Occupational stress (chemical, physical, psychological, etc.): ____________________________________

Personal Height___________ Weight now_____________ Weight one year ago_______

Weight maximum ______________@Year _____________

Habits Do you smoke ? Yes No What? ___________How many per day? _______ Since when? ____

Please describe any use of drugs for non-medical Purposes:___________________________________

Do you exercise regularly? Yes No Please describe your exercise program: ___________________

How many hours do you sleep in general? ______ What time do you usually go to bed? _____________

Diet How much coffee do you drink? ____cups/day Colas ______number/day Tea _____cups/day

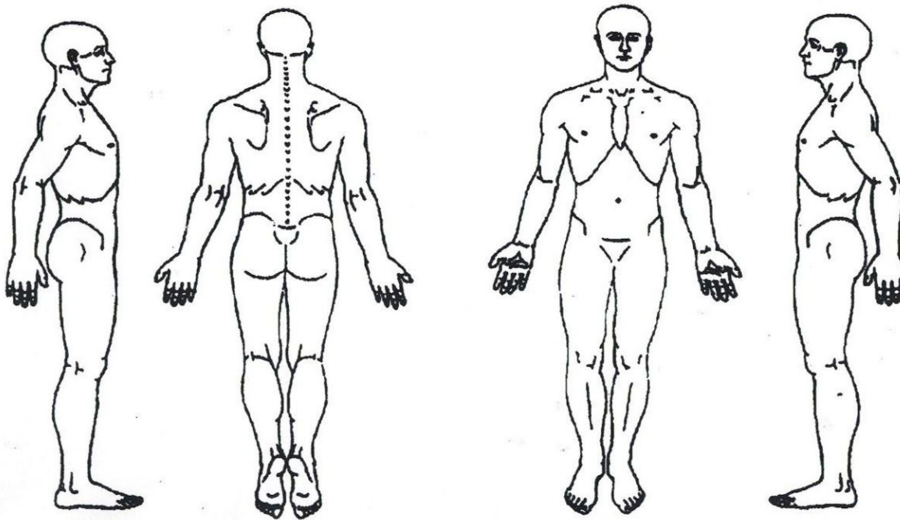
What kind of alcoholic beverages do you usually drink, if any? ______________ Average number of

drinks/week? _______ How much water do you drink per day? _______

Are you a vegetarian? Yes No Yes, but not so strict

Do you eat a lot of spicy food? Yes No

Remarks and additional information (e.g. diet) _______________________________________



Indicate pain level and/or painful or distress

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (type)			Breathing problems			Tuberculosis		
Diabetes			Heart			High Cholesterol		
Hepatitis			Digestive Disorder			High Blood Pressure		
Thyroid			Venereal disease			Emotional Disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression/Anxiety			Other		

Please circle if you have or have had (in the last three months) any of the following diseases or conditions.

General Poor appetite Poor sleep Fatigue Fevers Chills Night sweats Sweat easily Tremors

Cravings Change in appetite Poor balance Bleed or bruise easily Localized weakness Weight loss

Weight gain Peculiar tastes Desire hot food Desire cold food Strong thirst (cold or hot drinks)

Sudden energy drop (What time of day) _________ Favorite time of year ___________ Worst time of year _______

Skin & hair Rashes Ulcerations Hives Itching Eczema Pimples Acne Dandruff Dry skin

Recent moles Loss of hair Purpura Change in hair or skin texture Other? ___________

Musculoskeletal Joint disorders Muscle weakness Pain/soreness in the muscles Tremors

Cold hands/feet Difficulty walking Swelling of hands/feet Spinal curvature Back pain Hernia

Numbness Tingling Paralysis Neck Tightness Neck pain Shoulder pain

Hand/wrist pain Hip pain Knee pain Joint Sprain Other?

Head, eyes, ears, nose, and throat Dizziness Concussions Migraines Glasses/lens

Eye strain Eye pain Color blindness Night blindness Poor vision Cataracts

Blurry vision Earaches Ringing in ears Poor hearing Spots in front of eyes Sinus problems

Nose bleeding Sore throat Grinding teeth Facial pain Jaw clicks Sores on lips/tongue

Difficulty swallowing Other?

Cardiovascular High blood pressure Low blood pressure Chest pain Palpitation Fainting

Phlebitis Irregular heartbeat Rapid heartbeat Varicose veins Other?

Respiratory Cough Coughing blood Wheezing Difficulty breathing Bronchitis

Pneumonia Chest pain Production of phlegm – What color? ______

Neuro-psychological Loss of balance Lack of coordination Concussion

Depression Anxiety Stress Bad temper Bi-polar

Gastrointestinal Nausea Vomiting Diarrhea Constipation Gas Belching Black stools

Blood in stools Indigestion Bad breath Rectal pain Hemorrhoids Abdominal pain/cramps

Gallbladder problems Parasites

Genito-urinary Painful urination Frequent urination Blood in urine Urgency to urinate

Kidney stones Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection

Genital pain Genital itching Genital rashes STD Other?

Reproductive Sex assigned at birth: Male Female Gender reassignment operation(s) _____________

Frequent vaginal infections Pelvic infection Endometriosis Vaginal/genital discharge Fibroids

Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods Breast tenderness

Breast Lumps Fertility Problems Hot Flashes Moodiness related to periods

______ Number of pregnancies ______ Number of births ______ Miscarriages ______ Abortions ______

Premature births ______ C-sections ______ Difficult deliveries Date of last menstrual period ______________

Are you currently, or could you possibly be, pregnant? Yes No Age of first menstrual period ________

Duration of periods ________days Duration of cycle ______ days Do you practice birth control? Yes No

If yes, what type and for how long? _________________________________ If you're taking oral contraceptives,

what are you taking and for how long? ______________________________________

Prostate problems Discharge Erectile dysfunction Ejaculation problems

Frequent seminal emission Fertility problems Painful/swollen testicles Other

I have completed this form correctly to the best of my knowledge.

Signature____

patient guardian or parent spouse
(circle one)