Confidential Personal Information

Full Name _________ (Last) _________ (First) _____ (Middle) Age ____ Gender M/F ____

DOB ___/___/___ S.S.# ______________ Referred by ____________________________

Address: __________________________________/__________/__________/_____________
Street name city state zip code

Telephone # (____)________________ (_____) _____________ (____) ___________________
Home work cell phone

Email address: ____

Occupation: _________________________Full time _____ Part time____Student_____Retired_____

Employer/School : ____

Address:____

Emergency Contact: _______________________________________ Relationship_______________

Contact Phone ______________________

What is the best way to communicate with you between the office visits? Email___ Home ___ Work___ Cell___

May we send you educational/ promotional materials such as newsletters via email? YES____ NO_____
May we discuss your private medical information with you via email? YES____ NO____

Insurance Information

Insurance Company ____
Insurance Phone: (for providers) ____
Claim Address: ____

Insured Full Legal Name: ______________________DOB: __/___/___ Male__Female___
Insured Address: ____

Patient/ Subscriber ID# ___________________________ Group#________________ PPO____
Relationship to Insured: Self ___ Spouse ___ Child____ Other_____
Marital Status: Single____ Married____ Other_____

____

For Office Use Only
No coverage___ Coverage____ Deductible $_____ Amount met$ _____
Visits per year____ Allowable % _____ Other______________________________
Acupuncture Yes/No______ Units /Visits _______
Office Visit Yes/No______
PT Yes/No_______ Units/ Visits______

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of the Patient___________________________________ **Today's Date** ___________

Health Intake Form

Name_____________________ Today's Date _________________
Chief Complaint: ____
Date of onset ____
Secondary Complaints: _________________________________ Date of onset ___________
_________________________________ Date of onset __________
__________________________________ Date of onset ___________
For what concern did you last receive health or medical care? _________________________
Do you have any medical diagnose for this condition_________________________________
Your primary care physician __________________________ Tel: ____________________
Lab results ____
MRI/X-Ray/ Sonogram____
Surgeries/ Hospitalizations (please indicate dates) _____________________________________
Surgical removal of ☐tonsil ☐appendix ☐gall bladder ☐ Other _______________________
☐oral surgery ☐gastric bypass ☐sleeve gastrectomy ☐cosmetic surgery ☐ C-section
Have you ever had ☐chemotherapy ☐radiation therapy

Medications and Supplements (using now or used in the past year)

☐Laxatives ☐Anti-inflammatories ☐Antacids ☐Thyroid medications
☐Antibiotics ☐Allergy medication/shots ☐Asthma medication ☐Sleeping pills
☐Anti-depressants ☐Birth control pills ☐Cortisone ☐Blood pressure meds
☐Blood thinners ☐Fertility drugs ☐Blood sugar meds ☐Hormone replacement
☐Others ____

List any vitamin and nutritional supplements and herbs you are currently taking.
____
____
Alternative therapies (received currently or in the past year)
☐acupuncture ☐chiropractic ☐massage ☐cranial-sacral therapy
☐clinical nutrition ☐homeopathy ☐chelation therapy ☐functional medicine

Do you have any known contagious diseases at this time? ◻YES ◻NO
Are you pregnant at this time? ◻YES ◻NO
Do you have pacemaker? ◻ YES ◻NO
List any allergies (medications, food sensitivities, chemicals/ environmental)
____
____
Have you ever been alcohol or drug dependent? When? _________________________________
Do you smoke cigarette / cigar ? How much per day________ Marijuana? _____
Have you had any traumatic emotional stress in your ☐childhood or ☐ adult life?
Have you been diagnosed for ☐PTSD Post Traumatic Stress Disorder

Family Medical History (please indicate which family member)

☐Cancer _____ ☐Heart disease_____ ☐Diabetes ______ ☐Stroke ______ ☐Alcoholism______
☐Hypertension____ ☐Asthma____ ☐Arthritis______ ☐Hypothyroidism _____ ☐Depression_____

**System Review (**Check any symptoms you currently have or have had in the past 6 months.)

General
- ☐ Chills
- ☐ Feverish
- ☐ Fatigue
- ☐ Allergies
- ☐ Insomnia
- ☐ Poor concentration
- ☐ Frequent colds
- ☐ Frequent infections
- ☐ Weight loss
- ☐ Weight gain
- ☐ Emotional eating
- ☐ Stressed

Skin and Hair
- ☐ Rashes
- ☐ Eczema, Hives
- ☐ Acne, Boils
- ☐ Itching
- ☐ Dry skin/scalp
- ☐ Discoloration
- ☐ Bruise easily
- ☐ Fungal infections
- ☐ Slow wound healing
- ☐ Psoriasis
- ☐ Dry brittle hair and nail
- ☐ Premature gray hair
- ☐ Hair loss

Digestion
- ☐ Abdominal pain or cramps
- ☐ Gas/ Bloating
- ☐ Belching
- ☐ Nausea/ vomiting
- ☐ Heartburn/ acid reflux
- ☐ Diarrhea / loose stools
- ☐ Constipation
- ☐ Mucous in stools
- ☐ Bloody/ Black stools
- ☐ Gastric ulcers
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Gall stones
- ☐ Jaundice

Head and Neck
- ☐ Faintness/ Dizziness
- ☐ Heaviness
- ☐ Headache
- ☐ Migraine
- ☐ Jaw pain
- ☐ Swollen glands
- ☐ Goiter
- ☐ Neck stiffness or pain
- ☐ Vertigo
- ☐ TMJ
- ☐ Whiplash injury

Eyes, Ears and Nose
- ☐ Itchy eyes
- ☐ Watery eyes
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Blurry vision
- ☐ Floaters
- ☐ Double vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Tinnitus
- ☐ Earaches
- ☐ Sinus congestion
- ☐ Postnasal drip

Genitourinary
- ☐ Burning urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Urgent urine
- ☐ Frequent urine
- ☐ Incontinence
- ☐ Poor bladder control
- ☐ Urinary retention
- ☐ Bladder stone
- ☐ Kidney stone
- ☐ Enlarged prostate
- ☐ Prostate cancer

Respiratory
- ☐ Asthma
- ☐ Hay Fever
- ☐ Wheezing
- ☐ Chest congestion
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficult breathing
- ☐ Phlegm production
- ☐ Cough ☐Wet or ☐Dry
- ☐ Cough blood

Mouth and Throat
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Gum diseases
- ☐ Teeth grinding
- ☐ Cold sores
- ☐ Sore tongue, sore lips
- ☐ Excessive salivation
- ☐ Difficult swallowing
- ☐ Feeling lump in the throat
- ☐ Loss of taste

Cardiovascular
- ☐ Heart disease
- ☐ Angina/ chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Murmurs
- ☐ Irregular heart beat
- ☐ Palpitations/ fluttering
- ☐ Swelling ankles
- ☐ Pacemaker

Circulation
- ☐ Cold hands/feet
- ☐ Varicose veins
- ☐ Deep leg pain
- ☐ Bruising easily
- ☐ Raynaud's disease

Neurological

- ☐ Seizures
- ☐ Tremor
- ☐ Paralysis
- ☐ Convulsions
- ☐ Loss of balance
- ☐ Stroke
- ☐ Muscle weakness
- ☐ Numbness or tingling

Endocrine

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Heat or cold intolerance

Autoimmune

- ☐ Rheumatoid arthritis
- ☐ Hashimoto's
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Crohn's disease
- ☐ Leaky gut
- ☐ Ulcerative colitis
- ☐ IBS
- ☐ Multiple sclerosis

Women Only

- ☐ Abnormal pap smear
- ☐ Fibrocystic breast
- ☐ PMS
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Uterine fibroids/ polyps
- ☐ Endometriosis
- ☐ Polycystic Ovary Syndrome
- ☐ Infertility
- ☐ Miscarriages
- ☐ Vaginal thrush
- ☐ Abnormal vaginal discharge
- ☐ Pelvic Inflammatory Diseases
- ☐ Menopause /Perimenopause
- ☐ Low libido
- ☐ Osteoporosis
- ☐ Breast cancer
- ☐ Cervical cancer

Emotional

- ☐ Insomnia
- ☐ Irritability
- ☐ Anger
- ☐ Disturbed dreams
- ☐ Guilt
- ☐ Sadness/Grief
- ☐ Anxiety
- ☐ Fear/ phobia
- ☐ Panic attack
- ☐ Depression
- ☐ Mood swings
- ☐ Resentment
- ☐ Obsessive-compulsive
- ☐ Worry
- ☐ Restlessness
- ☐ Frequent crying
- ☐ Undecisiveness
- ☐ Emotional sensitivity

Musculoskeletal

- ☐ Osteo arthritis
- ☐ Degenerative discs
- ☐ Spinal stenosis
- ☐ Cervical spondylosis
- ☐ Muscle spasm
- ☐ Muscle weakness
- ☐ Bursitis
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Poor posture

Men Only

- ☐ Impotence
- ☐ Early ejaculation
- ☐ Swelling testicles
- ☐ Genital sores
- ☐ Low libido
- ☐ Varicocele
- ☐ Low sperm count
- ☐ Low motility
- ☐ Poor morphology
- ☐ Low testosterone
- ☐ Infertility
- ☐ Enlarged prostate
- ☐ Prostate cancer

Diet and Life style

- ☐ Vegetarian
- ☐ Vegan diet
- ☐ Weight Loss diet
- ☐ Organic foods
- ☐ Gluten free diet
- ☐ Non-GMO foods
- ☐ Hormonal free
- ☐ Whole foods diet
- ☐ Mediterranean diet
- ☐ Green leafy vegetables
- ☐ Fresh seasonal fruits
- ☐ Nuts and seeds
- ☐ Legumes
- ☐ Fish and sea food
- ☐ Soy product
- ☐ Eat much carbohydrates
- ☐ Eat much red meat
- ☐ Eat much dairy products
- ☐ Eat much fired foods
- ☐ Sugar cravings/ sweet tooth
- ☐ Salt cravings
- ☐ Microwave dinner
- ☐ Eat out all the time
- ☐ Fast food / Junk food
- ☐ Eat regular 3 meals
- ☐ Skip breakfast often
- ☐ Dinner later than 7:00 pm
- ☐ Desert every night
- ☐ Eat till 100% full
- ☐ Drink coffee / decaf
- ☐ Drink herbal tea/ green tea
- ☐ Use artificial sweetener
- ☐ Drink alcohol everyday
- ☐ Drink milk everyday
- ☐ Prefer iced water/ beverage
- ☐ Drink < 8 glasses of water
- ☐ Drink commercial juice
- ☐ Go to bed after 11:00pm
- ☐ Taking sleeping pills
- ☐ Travel often across time zones
- ☐ Arts / Music
- ☐ Spiritual practice
- ☐ Yoga/Meditation/Qigong practice
- ☐ Exercise regularly
- ☐ Exercise excessively
- ☐ No exercise

Musculoskeletal Pain

Locations of pain ____
How long you have had this pain____
Recent injuries _____________________ Is this due to an auto accident ____or work related_______

Describe the pain (check all that apply):
☐Sharp ☐ Dull Aching ☐Numbness ☐Tingling ☐Superficial Pain ☐Deep Pain
☐ Burning ☐Stiffness ☐ Shooting ☐ Cramping ☐Pressure ☐Spasm ☐Constant Pain
☐Pain worse/better with heat ☐Pain worse/better with cold ☐ Pain worse/better with pressure
☐ Pain worse in am/pm ☐ Pain worse/better with movement ☐Pain worse with humid weather
☐ Swollen joints ☐Tendonitis ☐Arthritis/joint pain ☐Bone pain ☐Muscle cramping
☐Pinched nerve ☐Repetitive Strain Injury ☐ Fractured Bone(s),Where____________
☐Other__________________

Pain Diagram (please mark "X" at all areas of pain on diagram below)
A= aching B= burning N=numbness P= pins and needles S= stabbing pain O= other type of sensation

Circle you pain level on the pain scale chart below.

No Pain | Moderate Pain | Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

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Consent Form

- **Financial Agreement** I understand that I am financially responsible for all services received regardless of insurance payment or denial. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I understand that I am solely responsible for payment of all charges. There is a $25 service charge on any returned checks.

- **Assignment of Benefits** I authorize LONGEVITY ACUPUNCTURE to release to insurance carrier listed above any information needed for this or related to claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to LONGEVITY ACUPUNCTURE.

- **Consent for Treatment** I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by acupuncturists and other members of my health care team. I agree to participate in the self care program we select. I promise to inform my practitioner any time I need clarification involving my care. I expect my acupuncturist to provide safe and effective treatment. I understand acupuncture and is a generally safe treatment procedure with the use of disposable acupuncture needles. However, in rare instances, side effects may occur, such as localized skin irritation, bruising, localized numbness, dizziness or fainting. Chinese Herbal Medicine is an integral part of Oriental Medicine. It is also considered safe and time tested in the practice of Traditional Chinese Medicine (TCM). Due to individual's unique constitution, possible side effects may occur, which include nausea, gas, headache, diarrhea or rashes.

- C**onsent for Care** It is my choice to receive acupuncture, and I give my consent to receive treatment. I have reported all the health conditions that I am aware of and will inform my practitioner of any changes in my health.

Name ______________________________ Date ____________________________

Signature ______________________________

HIPAA-Health Insurance Portability and Accountability Act

YOUR RIGHTS- Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have the right to request restrictions on how we use or disclose your personal information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your health care or the paying of your care.

ACCESS TO YOUR PERSONAL HEALTH INFORMATION - You have the right to inspect and or/obtain a copy of your personal health information we maintain in your designated medical records. You must sign a release of medical records consent form to obtain these records.

FAMILY, FRIENDS, AND PERSONAL REPRESENTATIVES - With your written consent we may disclose to family members, close personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best physical interest, we may disclose your personal health information without your written or verbal approval. We may also disclose your personal health information to the public or private entities to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES: We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

For public health activities (reporting of disease, injury, birth, death, or suspicion of child abuse, neglect, or domestic violence)

To government authority if we believe an individual is a victim of abuse, neglect or domestic violence.

For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions)

For judicial or administrative proceedings (for example pursuant to a court order, subpoena or discovery request)

For law enforcement purposes (i.e. reporting wounds or injuries or for identifying or locating suspects, witnesses or missing persons)

To avert a serious threat to health or safety under certain circumstances

For military activities if you are a member of the armed forces or an inmate or individual confined to a correctional institution.

For compliance with worker's compensation claims

We will adhere to all state and federal laws or regulations that provide protections to your privacy. We will only disclose AIDS/HIV related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by law.

Patient Signature Date

______________________________________ ___________________________

Witness Signature Date

______________________________________ ___________________________