

PATIENT INFORMATION

(Please Print and complete in full)

Name: _____ Today's Date _____
What name would you like to be called (if different than above)? _____
Address: _____ Day Phone _____
_____ Evening Phone _____
_____ Cell Phone _____

Would you like to subscribe to my Wellness Newsletter? The newsletter is sent once a month. We never spam, and your email is protected. You can easily unsubscribe at any time.

If yes, list email address: _____

Date of Birth: _____ Age: _____ Sex: _____

Patient Status: Married Domestic Partnered Single Divorced Widowed Other _____

Referred By: _____

Emergency Contact: _____
name phone number relationship

EMPLOYMENT STATUS

Full Time Part Time Retired Unemployed Student Other _____

Occupation: _____

Employer's Name: _____ Telephone#: _____

Employer's Address: _____

PRIMARY HEALTH CARE

Physician's Name: _____ Telephone #: _____

Physician's Address: _____ Date of last visit: _____

Is your current health condition due to (please check): Illness Accident/unrelated to work Work-related Injury

HEALTH CARE: List the health care practitioners that you are currently working with.

Practitioner Name	Modality	Date of Last Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____

CANCELLATION POLICY Please Initial that you have read this policy: _____

I kindly ask twenty-four hours notice for cancellations or schedule changes. You will be charged the full service fee if you cancel within less than twenty-four hours. Insurance does not cover missed appointments, so insurance patients will be charged in full. Please call as soon as possible if you will be unable to keep your appointment or arrive to your appointment on time. Thank you for this consideration.

HEALTH INFORMATION

If there are any questions that you don't feel comfortable answering, please leave the section blank and we can discuss this in person.

What health complaint or issue brings you here today?

Are there any other health issues you would like addressed?

Are you currently being treated for a medical condition? (Please describe)

Have you ever had an acupuncture treatment? When and for what reason?

FAMILY HISTORY: Has anyone in your immediate family ever had (please circle): Allergies, Arthritis, Blood Disorder/Anemia, Diabetes, Cancer or tumors, Celiac, Glaucoma, Seizures, Heart Disease, High Blood Pressure, Kidney disease, Stomach or Intestinal Disorder, Drug/Alcohol Abuse, Thyroid Disorder, Tuberculosis, Heart Disease, Stroke, Psychological Diagnosis

Other: _____

PERSONAL HISTORY: Do you currently have or have you ever had (please circle): Allergies, Asthma, Attention Deficit Disorder, Arthritis, Bleeding Disorder, Blood Disorder/Anemia, Cancer or tumors, Celiac, Diabetes, Drug/Alcohol Abuse, Heart Disease, High Blood Pressure, Acute Hepatitis, Chronic Hepatitis, Kidney or Bladder Disorder, Liver Disease, Lyme, Meningitis, Seizures, Sexually Transmitted Infection, Stomach or Intestinal Disorder, Stroke, Thyroid Disorder, Tuberculosis, Ulcers, Depression, Anxiety, Psychological diagnosis

Other _____

If you circled any condition(s) above, please describe specific diagnosis and list the dates:

HOSPITALIZATIONS/Surgeries/Operations (list dates):

Any major scars on your body? Please describe location(s) and general date(s) of occurrence.

FOR FEMALES: Are you pregnant? ___ Currently trying to conceive? ___ Breast-feeding? ___

Total Pregnancies: ___ Living ___ Ectopic ___ Miscarriages ___ Abortions

MEDICINES: Please check any that you are currently taking:

Please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> acetaminophen (Tylenol) | <input type="checkbox"/> aspirin | <input type="checkbox"/> ibuprofen |
| <input type="checkbox"/> allergy medication | <input type="checkbox"/> blood pressure pills | <input type="checkbox"/> insulin |
| <input type="checkbox"/> antacids | <input type="checkbox"/> blood thinners | <input type="checkbox"/> oral contraceptives |
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> diet pills | <input type="checkbox"/> sleeping pills |
| <input type="checkbox"/> antidepressants | <input type="checkbox"/> fiber/laxatives | <input type="checkbox"/> tranquilizers |

Other Medications (list dates started):

Current Vitamins/Supplements/Herbs/Other (list dates started):

MEDICATION ALLERGIES: _____

ALLERGIES (food, substances (ex. latex), environmental, etc.):

FOOD INTOLERANCES: List any foods that cause negative symptoms for you.

HABITS:

Do you use (please circle): coffee, soda, sugar, artificial sweeteners, cigarettes, tobacco products, marijuana, alcohol, marijuana, crack, cocaine, heroin, methamphetamines, other

Describe usage: _____

Other: _____

DIET:

Please describe your typical daily diet

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Evening Snack _____

Other Snacks _____

Please describe any restricted dietary practices you currently follow or have followed in the past:

EXERCISE:

Please describe any regular exercise program: _____

Do you regularly stretch? Please describe: _____

SLEEP:

How many hours do you sleep per night? _____

STRESS LEVEL:

Please describe your general stress level on a scale of 0-10 (0= no stress, 10= very stressed) _____

DENTAL WORK: Please describe any major dental work that you have had.

Anything else that you think would be important for me to know?

Do you have any feedback about this intake form?

Please check:

GENERAL

past current

- ___ ___ Low Energy
- ___ ___ Fatigue
- ___ ___ Weakness
- ___ ___ Change in Appetite
- ___ ___ Low Appetite
- ___ ___ Excessive Appetite
- ___ ___ Fevers
- ___ ___ Chills
- ___ ___ Often feel warmer than others
- ___ ___ Often feel colder than others
- ___ ___ Night sweats
- ___ ___ Sweat easily
- ___ ___ Aversion to wind
- ___ ___ Difficulty falling asleep
- ___ ___ Difficulty waking
- ___ ___ Excessive dreams
- ___ ___ Poor memory
- ___ ___ Lack of thirst
- ___ ___ Strong Thirst
- ___ ___ Crave sour foods
- ___ ___ Crave bitter foods
- ___ ___ Crave sweet foods
- ___ ___ Crave salty foods

GENITO-URINARY

past current

- ___ ___ Kidney stones
- ___ ___ Painful urination
- ___ ___ Frequent urination
- ___ ___ Blood in the urine
- ___ ___ Cloudy urine
- ___ ___ Difficulty in urination
- ___ ___ Urgency to urinate
- ___ ___ Urinary Incontinence
- ___ ___ Other: _____

HEAD AND NECK

past current

- ___ ___ Dizziness
- ___ ___ Neck Stiffness
- ___ ___ Enlarged Lymph glands
- ___ ___ Headaches
- ___ ___ Jaw tightness/Pain
- ___ ___ Concussion/trauma to head
- ___ ___ Other: _____

EARS

past current

- ___ ___ Recurring ear infections
- ___ ___ Ear ringing
- ___ ___ Itching
- ___ ___ Decreased Hearing
- ___ ___ Other: _____

NOSE, THROAT & MOUTH

past current

- ___ ___ Nose bleeds
- ___ ___ Frequent sinus infections
- ___ ___ Recurring Sore throats
- ___ ___ Seasonal allergies
- ___ ___ Grinding teeth
- ___ ___ Difficulty swallowing
- ___ ___ Goiter
- ___ ___ Other: _____

CARDIOVASCULAR

past current

- ___ ___ High blood pressure
- ___ ___ Low blood pressure
- ___ ___ Blood clots
- ___ ___ Palpitations/Heart fluttering
- ___ ___ Chest Pain/Pressure
- ___ ___ Irregular heart beat
- ___ ___ Phlebitis/Vein Inflammation
- ___ ___ Fainting
- ___ ___ Cold Hands/Feet
- ___ ___ Swelling of Hands/Feet
- ___ ___ Heart Murmur
- ___ ___ Other: _____

RESPIRATORY

past current

- ___ ___ Asthma
- ___ ___ Bronchitis
- ___ ___ Chronic Obstructive Pulmonary Disease
- ___ ___ Cough
- ___ ___ Cough with blood
- ___ ___ Cough with phlegm
- ___ ___ Pneumonia
- ___ ___ Chest Congestion
- ___ ___ Frequently catching colds
- ___ ___ Other: _____

NEUROLOGICAL

past current

- ___ ___ Seizures
- ___ ___ Tremors
- ___ ___ Numbness/tingling in limbs
- ___ ___ Pain _____
- ___ ___ Paralysis
- ___ ___ Fainting
- ___ ___ Migraine
- ___ ___ Concussion
- ___ ___ Other: _____

GASTRO-INTESTINAL

past current

- ___ ___ Nausea
- ___ ___ Vomiting
- ___ ___ Diarrhea
- ___ ___ Constipation
- ___ ___ Incomplete bowel movements
- ___ ___ Irritable Bowel Syndrome
- ___ ___ Blood/Black stools
- ___ ___ Belching
- ___ ___ Abdominal Pain/Cramps
- ___ ___ Abdominal bloating
- ___ ___ Indigestion
- ___ ___ Rectal Pain
- ___ ___ Anal Fissure
- ___ ___ Gas/Flatulence
- ___ ___ Gallbladder or Liver disease
- ___ ___ Gallstones
- ___ ___ Heart Burn/Acid Reflux
- ___ ___ Ulcer
- ___ ___ Bad breath
- ___ ___ Other: _____

EYES

past current

- ___ ___ Blurred vision
- ___ ___ Visual Changes
- ___ ___ Tearing
- ___ ___ Red eyes
- ___ ___ Dry Eyes
- ___ ___ Eye pain
- ___ ___ Poor night vision
- ___ ___ Floaters, spots
- ___ ___ Cataracts
- ___ ___ Eyeglasses/contact lenses
- ___ ___ Other: _____

MALE

past current

- ___ ___ Genital pain
- ___ ___ Genital itching
- ___ ___ Genital lesions
- ___ ___ Genital discharge
- ___ ___ Impotence
- ___ ___ Erectile difficulty
- ___ ___ Premature ejaculation
- ___ ___ Lumps on testicles
- ___ ___ Low libido
- ___ ___ Prostatitis
- ___ ___ Weak urine stream
- ___ ___ Other: _____

FEMALE

past current

- ___ ___ Frequent urinary tract infections
- ___ ___ Genital Pain
- ___ ___ Genital itching
- ___ ___ Genital lesions
- ___ ___ Genital discharge
- ___ ___ Pelvic Inflammatory Disease
- ___ ___ Endometriosis
- ___ ___ Ovarian Cyst
- ___ ___ Uterine Fibroid
- ___ ___ Abnormal Pap smear
- ___ ___ Irregular Periods
- ___ ___ Abnormal Bleeding
- ___ ___ Painful menstrual periods
- ___ ___ Pre-menstrual symptoms
- ___ ___ Menopause symptoms
- ___ ___ Breast lumps
- ___ ___ Infertility
- ___ ___ Low libido
- ___ ___ Other: _____

INFECTION SCREENINGS

past current status

HIV _____ positive negative

Hepatitis _____ positive negative

Type _____

Gonorrhea _____ positive negative

Chlamydia _____ positive negative

Syphilis _____ positive negative

Genital warts _____ positive negative

HPV _____ positive negative

Herpes _____ positive negative

Type: oral/ genital

Other: _____

Informed Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Daniela Freda, L.Ac. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal medicine, supplements, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects. These side effects could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, numbness or tingling near the needle site, and the possible aggravation of symptoms existing prior to acupuncture treatment. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

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 I am not required to take these substances but must follow the directions for administration and dosage (provided both orally and in writing) if I do decide to take them. The herbs may have an unpleasant taste or smell. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: nausea, gas, changes in bowel movement, abdominal pain or discomfort, vomiting, headache, rashes, hives, tingling of the tongue, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any unanticipated or unpleasant effects which I associate with these substances, I should suspend taking them and call Daniela Freda, L.Ac. as soon as possible.

I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that some acupuncture or massage procedures may be inappropriate during pregnancy. I understand that some herbs may be inappropriate during pregnancy and breast-feeding. **I will notify Daniela Freda, L.Ac. if I am or become pregnant or am or will begin breast-feeding.**

I understand that while this document describes major risks of treatment, other side effects and risks may occur. I do not expect Daniela Freda, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my practitioner to exercise judgment during the course of the treatment which she thinks at the time, based upon the facts then known, is in my best interest.

I understand Daniela Freda, L.Ac. may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment. I 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.

Print name of patient

Signature

Date

Print name of practitioner

Signature

Date

Daniela Freda, L.Ac., 543 Castro Street, San Francisco, CA 94114, (415) 335-0238

Notice of HIPAA Privacy Practice

I consent to the use or disclosure of my identifiable health information by Daniela Freda, L.Ac. for the purpose of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Daniela Freda, L.Ac. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request restrictions as to how my identifiable health information is used or disclosed. My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan or my employer. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand that I have the following rights:

- Ask to see, read and/or obtain a copy of my health records
- Ask to correct information that I believe is wrong in my health records
- Ask that my health information not be shared with certain individuals
- Ask that my health information not be used for certain purposes (for example, research)
- Ask Daniela Freda, L.Ac. to send copies of my health records to whomever I wish
- Be informed as to who has read my records (for reasons other than treatment or payment)
- Specify how and where Daniela Freda, L.Ac. may contact me
- Receive a paper copy of the full Notice of Privacy Practices

I understand that to use or disclose my confidential patient health information I will need to sign a written authorization prior to access or disclosure. I also understand that under HIPAA there are certain exceptions to this rule. Disclosures can be made without patient authorization subject to professional judgement, for public health and safety purposes, for government functions, for law enforcement and based on a judicial request or subpoena. Please refer to the "Notice of Privacy Practices" for a list of all covered exemptions.

I understand that my signature below does not authorize disclosure but only acknowledges that I have read and understand this notice. I also understand that at times I may receive a phone call or email from Daniela Freda, L.Ac. and I agree to receive these phone calls or emails.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

(or Patient Representative; indicate relationship if signing for patient)

Office Signature: _____ Date: _____

Notice of Privacy Practices (Patient copy)

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members or other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health

information that we maintain. You may request a written copy of a revised Notice of Privacy Practices.

If you feel that your privacy protections have been violated you have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

For more information about HIPAA, or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775