

PATIENT INFORMATION

(Please Print or Type. If there are any questions you choose not to answer, we can discuss this during the appointment.)

Name:		Today's Date:	
What name would you like to be called (if different than above)?			
Address:			
Day Phone:	Evening Phone:	Cell Phone:	
Email:		Do you give my office permission to communicate via email (Yes/No)	
Would you like to subscribe to my Wellness Newsletter? (please check) <input type="checkbox"/> Yes <input type="checkbox"/> No			
The newsletter is sent monthly. We never spam, and your email is protected. You can easily unsubscribe at any time.			
If yes, list the email address to receive my Wellness Newsletter (if different than above):			
Date of Birth:	Age:	Sex:	
Emergency Contact	Name:	Phone:	Relationship:
Referred By:			

EMPLOYMENT STATUS

Please Check: 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 responsible for the full charge of the appointments. 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

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 what 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 your diagnosis and list the dates of diagnosis:

HOSPITALIZATIONS/Surgeries/Operations (list dates):

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

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 acetaminophen (Tylenol) allergy medication antacids antibiotics antidepressant
 aspirin blood pressure pills blood thinners diet pills fiber/laxatives ibuprofen insulin
 oral contraceptives sleeping pills 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 and the symptoms they cause:

INFECTION SCREENINGS:

HIV, Hepatitis (Type _____), Gonorrhea, Chlamydia, Syphilis, Genital Warts, HPV, Herpes (Type: oral/ genital)

Please Describe:

HABITS:

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

Describe Usage:
Other Habits:

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
- Often feel colder
- 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
- Skin Issues

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

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
- Chest Pain/Pressure
- Irregular heart beat
- 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 catch colds

Other: _____

NEUROLOGICAL

past current

- Seizures
- Tremors
- Numbness/tingling
- Pain _____
- Paralysis
- Fainting
- Migraine
- Concussion

Other: _____

GASTRO-INTESTINAL

past current

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Incomplete bowels
- Irritable Bowel Syndrome
- Blood/Black stools
- Belching
- Abdominal Pain/Cramps
- Abdominal bloating
- Indigestion
- Rectal Pain

- Anal Fissure
- Gas/Flatulence
- Gallbladder disease
- 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/contacts

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
- Endometriosis
- Ovarian Cyst
- Uterine Fibroid
- Abnormal Pap smear
- Irregular Periods
- Abnormal Bleeding
- Painful menses
- Pre-menstrual symptoms
- Menopause symptoms
- Breast lumps
- Infertility
- Low libido

Other: _____

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

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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