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: City, Zip Code:	

Day Phone:	Cell Phone:	Preferred Language:

Email:	Do you give my office permission to communicate via email? ☐Yes ☐ No

Date of Birth:	Gender Identity:	Sex assigned at birth:
Emergency Contact Name:	Phone:	Relationship:
Referred By:		

Would you like to subscribe to my Wellness Newsletter? (please check) ☐Yes ☐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 Newsletter (if different than above):____

EMPLOYMENT STATUS

Please Check: ☐Full Time ☐Part Time ☐Retired ☐Unemployed ☐Disability ☐SAHM ☐Student ☐Other____________

Occupation:	
Employer's Name:	Telephone:
Employer's Address:	

PRIMARY HEALTH CARE

Physician's Name:	Date of last visit:

Is your current health condition due to (please check): ☐Illness ☐Accident/unrelated to work ☐Work-related Injury ☐ None of these

Gynecologist Name:	Date of Last Visit:
OB/GYN or Midwife Name:	Date of Last Visit:

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 of $100 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): Alcoholism, Allergies, Asthma, Attention Deficit Disorder, Arthritis, Bleeding Disorder, Blood Disorder/Anemia, Cancer or tumors, Celiac, Diabetes, Drug Abuse, Eating Disorder, Heart Disease, High Blood Pressure, Acute Hepatitis, Chronic Hepatitis, Kidney or Bladder Disorder, Liver Disease, Lyme, Meningitis, Migraine, Seizures, Sexually Transmitted Infection, Stomach or Intestinal Disorder, Stroke, Thyroid Disorder, Tuberculosis, Ulcers, Depression, Anxiety, Mental Health Diagnosis.

Other:
If you circled any condition(s) above, please describe your diagnosis and list the dates of diagnosis:
HOSPITALIZATIONS/Surgeries/Operations (list dates):

Do you menstruate? Yes, No, Not Applicable (please circle) If not applicable, skip to next page.
If so, date of last menses:_______________; If you don’t menstruate, age of last period:_________
Are you pregnant?____ If so, how many weeks pregnant (as of today)? _______Expected Due Date?________
Total Pregnancies: Living:_____ Ages:_______Stillbirth:____ Ectopic:____ Miscarriages:____ Abortions:___

Are you currently trying to conceive? ____ If so, for how long? _____________________________________
Have you had a diagnosis related to fertility?____ If so, please describe:______________________________
Have you had or are currently undergoing fertility treatments? _____ If yes, when and where:____________
(Please use the back of this page to list a history of treatments, dates, and outcomes)

MEDICINES: Please check any that you are currently taking:

Please check: __acetaminophen (Tylenol); ___allergy medication; ___antacids; ___antibiotics; ___antidepressant; ___ aspirin;___birth control;___ Botox ;___ blood pressure medication;___blood thinners; ___ fiber/laxatives; ___ hormone therapy;____ibuprofen; ___insulin; ____medicinal cannabis;___naproxen (Aleve);___sleeping pills; ____thyroid medication; _____other (describe below)

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 food intolerance and the symptoms they cause:

INFECTION SCREENINGS: Have you been screened for the following?

___ HIV, __ Hepatitis (Type____), __Gonorrhea, __Chlamydia, __Syphilis, __HPV, __Herpes (Type: oral/ genital)

Please Describe Positive Diagnosis and Treatment:

HABITS: (Please note that you can disclose additional information during your appointment if you choose not to complete this section)

Do you currently use: ___ caffeine;___ cigarettes/tobacco products;___ alcohol; ____ recreational marijuana /cannabis

Do you currently use: ___cocaine ;___ methamphetamines ; ___ heroin; ___ crack ; ___ ecstasy; _____ other

Describe Usage:
Other Habits:

DIET:

Please describe your **typical** daily diet or foods that you **generally** eat (amounts are not necessary):

Breakfast:
Lunch:
Dinner:
Snacks:
Beverages/Fluids:

Please describe any dietary practices you currently follow:

EXERCISE:

Please describe any regular exercise program:

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) ____________

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

Do you have any feedback about this intake form? (P.S. I know it's long! Thanks for your patience 😊)

Please Check:

GENERAL

past current

___ ___ Low Energy
___ ___ Fatigue
___ ___ Weakness
___ ___ Bleed/Bruise easily
___ ___ Change in Appetite
___ ___ Low Appetite
___ ___ Increased Appetite
___ ___ Fevers
___ ___ Chills
___ ___ Often feel warmer
___ ___ Often feel colder
___ ___ Night sweats
___ ___ Sweat easily
___ ___ Difficulty falling asleep
___ ___ Difficulty staying 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 AND HAIR

___ ___ Rashes
___ ___ Eczema
___ ___ Acne
___ ___ Dry Skin
___ ___ Hair Loss
Other: ____________________

URINARY

past current

___ ___ Kidney stones
___ ___ Painful urination
___ ___ Frequent urination
___ ___ Frequent UTIs
___ ___ Cystits
___ ___ Blood in the urine
___ ___ Cloudy urine
___ ___ Difficulty in urination
___ ___ Urgency to urinate
___ ___ Urinary Incontinence
Other:__________________

HEAD AND NECK

___ ___ Dizziness
___ ___ Neck Stiffness
___ ___ Headaches
___ ___ Jaw tightness/Pain
Other:__________________

EARS

past current

___ ___ Recurring ear infections
___ ___ Ear ringing
___ ___ Decreased Hearing
Other:__________________

NOSE, THROAT & MOUTH

___ ___ Nose bleeds
___ ___ Frequent sinus infections
___ ___ Recurring sore throats
___ ___ Seasonal allergies
___ ___ Grinding teeth
___ ___ Goiter
Other:___________________

CARDIOVASCULAR

past current

___ ___ High blood pressure
___ ___ Low blood pressure
___ ___ Blood clots
___ ___ Palpitations
___ ___ Chest Pain/Pressure
___ ___ Irregular heart beat
___ ___ Fainting
___ ___ Cold Hands/Feet
___ ___ Swelling of Hands/Feet
Other:__________________

RESPIRATORY

___ ___ Asthma
___ ___ Bronchitis
___ ___ Cough
___ ___ Pneumonia
___ ___ Frequently catch colds
Other:____________________

NEUROLOGICAL

past current

___ ___ Seizures
___ ___ Tics
___ ___ Numbness/tingling
___ ___ Nerve Pain __________
___ ___ Paralysis
___ ___ Fainting
___ ___ Migraine
___ ___ Concussion
Other:___________________

GASTRO-INTESTINAL

___ ___ Nausea
___ ___ Vomiting
___ ___ Diarrhea
___ ___ Constipation
___ ___ Incomplete bowels
___ ___ Irritable Bowel Syndrome
___ ___ Blood/Black stools
___ ___ Hemorrhoids
___ ___ 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:_________________

MUSCULOSKELETAL

___ ___ Joint Pain, Describe:______
___ ___ Muscle Pain, Describe:____
___ ___ Limited range, Describe:___
Other:_________________

PELVIC & HORMONAL HEALTH

past current

___ ___ Genital pain
___ ___ Genital itching
___ ___ Genital lesions
___ ___ Genital discharge
___ ___ Pelvic pain
___ ___ Pelvic floor dysfunction
___ ___ Low libido
___ ___ Diagnosis of infertility
Please Describe:______________

past current

___ ___ Impotence
___ ___ Erectile difficulty
___ ___ Prostatitis
___ ___ Weak urine stream
Other:_________________

past current

___ ___ Endometriosis
___ ___ Ovarian Cyst
___ ___ PCOS
___ ___ Uterine Fibroid
___ ___ Polyp
___ ___ Abnormal Pap; Date:______
Please describe:__________________
___ ___ Irregular Periods
___ ___ Abnormal Bleeding
___ ___ Painful menses
___ ___ PMS symptoms:
___digestive ___headaches
__acne ___tender breasts __bloating
___mood swings; other:__________
___ _____ Peri-menopause
_____ Menopause
___ ____ Breast lumps
Other:_________________

Informed Consent to Treatment

By signing below, I do voluntarily consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me by Daniela Freda, L.Ac.

I understand that the methods of treatment may include acupuncture, moxibustion, cupping, electro-stimulation, massage, herbal medicine, supplements, and nutritional counseling. I have had the opportunity to discuss the nature and purpose of the treatments and procedures.

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, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Infection is a very low risk since the office uses sterile disposable needles and maintains a clean and safe environment. Unusual risks of acupuncture include nerve damage, organ puncture, including lung puncture (pneumothorax).

Cupping therapy and moxibustion may be a recommended treatment. Bruising is a common effect of cupping therapy. Small burns are a potential risk of moxibustion. Acupressure or light massage may be a recommended part of my treatment. Bruising and soreness are a potential side effect of acupressure or massage.

I understand that I may ask Daniela Freda, L.Ac. to stop these treatments at any time if there is pain or discomfort associated with the treatments.

Herbs and nutritional supplements may be recommended and are considered safe in the practice of Chinese Medicine. The herbs (which are from plant, animal and mineral sources) are traditionally safe in in the doses prescribed. I understand that I must follow the directions for administration and dosage. 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, rash, 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 contact Daniela Freda, L.Ac. as soon as possible.

I understand that certain acupuncture points 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 pregnant, possibly pregnant, or planning for pregnancy. I will notify Daniela Freda, L.Ac. if I am 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.

____

Patient Name (print) Signature Date

____

Practitioner (print) Signature Date

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