TRACY ANDERSEN DAOM, LAc

Doctor of Acupuncture & Oriental Medicine
Acupuncture ✦ Shiatsu ✦ Chinese Herbs

PATIENT INFORMATION

Name_____ Prefer to be Called_____ Date _____
Home Address _____ Apt # _____
City _____ State_____ Zip _____
Phone (h) _____ (w)_____ (c) _____
Email_____ What is the best way to contact you?_____
May we send you our e-newsletters? Y ○ N ○ (Your information will not be sold and you may be removed at any time)
Age _____ Date of Birth_____ Gender _____
Employer Name_____ Occupation _____
Relationship status: Married ○ Separated ○ Divorced ○ Widowed ○ Partner ○ Single ○
Live with: Spouse ○ Partner ○ Parents ○ Children ○ Friends ○ Alone ○ Other ○
How did you hear about our clinic?_____

Successful health care and preventative medicine work best when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

MEDICAL HISTORY

1. When and where did you last receive health care? _____
For what reason? _____

2. **CONDITIONS** Please identify the health concerns that have brought you to the seek Acupuncture in order of importance below:
Condition A _____ Past Treatment _____
How does condition A affect you? _____
Condition B _____ Past Treatment _____
How does condition B affect you? _____
Condition C _____ Past Treatment _____
How does condition C affect you? _____
Condition D _____ Past Treatment _____
How does condition D affect you? _____

3. **FAMILY MEDICAL HISTORY** (if known) Please specify; M = mother; F = father; S = sister; B = brother; A = aunt; U = uncle; PGM = paternal grandmother; PGF = paternal grandfather; MGM = maternal grandmother; MGF = maternal grandfather
arthritis_____ allergies _____ eczema_____ hay fever _____ hypertension_____ diabetes____
mental illness_____ cancer _____ osteoporosis_____ birth defects_____ tuberculosis _____
heart disease _____ other _____

4. **DO YOU HAVE ANY INFECTIOUS DISEASES** Y ○ N ○ If yes, please identify: _____

5. **ALLEGIES** (if applicable) List any foods, drugs, or medications you are hypersensitive or allergic to (include reaction)

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6. **MEDICATIONS** List any prescribed or over-the-counter medicine, vitamins, and supplements you are currently taking _____

_____

Please check any that you currently use: Laxatives ○ Pain relievers ○ Antacids ○ Cortisone ○ Antibiotics ○ Sleeping pills ○ Heart/Blood medication ○ Allergy medication ○ Thyroid medication ○ Anti-depressants ○ Birth Control Pills ○ Hormones ○

7. **HEIGHT** _____ **WEIGHT** Currently _____ Past Maximum _____ When? _____

8. **BLOOD PRESSURE**
What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

9. **CHILDHOOD ILLNESS** (please check any that you have had)
Scarlet Fever ○ Diphtheria ○ Rheumatic Fever ○ Mumps ○ Measles ○ German Measles ○ Chicken Pox ○

10. **IMMUNIZATIONS** (please check any that you have had)
Polio ○ Tetanus ○ Measles/Mumps/Rubella ○ Pertussis ○ Diphtheria ○ Hib ○ Hepatitis B ○
Others _____

11. **HOSPITALIZATIONS AND SURGERIES** (reason & when)
1. _____ 3. _____
2. _____ 4. _____

12. **X-RAYS/CAT SCANS/MRI'S/NMR'S/SPECIAL STUDIES** (reason & when)
1. _____ 3. _____
2. _____ 4. _____

13. **EMOTIONAL** (check any that you experience now and underline any that you have experienced in the past)
Mood Swings ○ Nervousness ○ Mental Tension ○ Depression ○ Eating Disorder ○ History of counseling ○
Anxiety or nervousness ○ Considered or attempted suicide ○ Tension ○

14. **ENERGY & IMMUNITY** (check any that you experience now and underline any that you have experienced in the past)
Fatigue ○ Slow wound healing ○ Chronic infections ○ Chronic fatigue syndrome ○ Frequent colds ○
History of counseling ○ Autoimmune disease ○ Allergies or hay fever ○ Chronically swollen glands ○

15. **HEAD, EYE, EAR, NOSE, AND THROAT** (check any that you experience now and underline any that you have experienced in the past)
Impaired Vision ○ Eye Pain/Strain ○ Glaucoma ○ Glasses/Contacts ○ Tearing/Dryness ○
Impaired Hearing ○ Ear Ringing ○ Earaches ○ Headaches ○ Sinus Problems ○ Nose Bleeds ○
Frequent Sore Throats ○ Teeth Grinding ○ TMJ/Jaw Problems ○ Hay Fever ○

16. **RESPIRATORY** (check any that you experience now and underline any that you have experienced in the past)
Pneumonia ○ Frequent Common Colds ○ Difficulty Breathing ○ Emphysema ○ Persistent Cough ○
Pleurisy ○ Asthma ○ Tuberculosis ○ Shortness of Breath ○
Other Respiratory Problems _____

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17. **CARDIOVASCULAR** (check any that you experience now and underline any that you have experienced in the past)
Heart Disease ○ Chest Pain ○ Swelling of Ankles ○ High Blood Pressure ○ Poor Circulation ○
Palpitations/Fluttering ○ Stroke ○ Heart Murmurs ○ Rheumatic Fever ○ Varicose Veins ○

18. **GASTROINTESTINAL** (check any that you experience now and underline any that you have experienced in the past)
Ulcers ○ Changes in Appetite ○ Nausea/Vomiting ○ Epigastric Pain ○ Passing Gas ○ Heartburn ○
Belching ○ Gall Bladder Disease ○ Liver Disease ○ Hepatitis B or C ○ Hemorrhoids ○ Abdominal Pain ○

19. **GENITO-URINARY TRACT** (check any that you experience now and underline any that you have experienced in the past)
Kidney Disease ○ Painful Urination ○ Frequent UTI ○ Frequent Urination ○ Heavy Flow ○
Kidney Stones ○ Impaired Urination ○ Blood in Urine ○ Frequent Urination at Night ○

20. **FEMALE REPRODUCTIVE/BREASTS** (check any that you experience now and underline any that you have experienced in the past)
Irregular Cycles ○ Breast Lumps/Tenderness ○ Nipple Discharge ○ Heavy Flow ○ Vaginal Discharge ○
Premenstrual Problems ○ Clotting ○ Bleeding Between Cycles ○ Menopausal Symptoms ○
Difficulty Conceiving ○ Painful Periods ○ Low Libido ○

21. **MENSTRUAL/BIRTHING HISTORY** (Y = Yes; N = No; P = Past)
Age of First Menses _____ ; Are cycles regular? _____; How many days of bleeding per cycle_____
Length of cycle (days)_____ ; Discharge _____; Endometriosis _____; Ovarian cysts _____;
Abnormal paps _____ ; Birth Control Type _____ ; Do you do self breast exams?_____;
Breast lumps or pain _____; Nipple discharge _____; Number of Pregnancies _____ ;
Number of abortions _____ ; Number of miscarriages _____ ; Number of live births _____ ;
Pronouns _____; Are you sexually active?_____ ;

22. **MALE REPRODUCTIVE** (check any that you experience now and underline any that you have experienced in the past)
Sexual Difficulties ○ Prostrate Problems ○ Testicular Pain/Swelling ○ Penile Discharge ○ Low Libido ○
Hernias ○ Impotence ○ Pronouns _____; Are you sexually active? _____

23. **MUSCULOSKELETAL** (check any that you experience now and underline any that you have experienced in the past)
Neck/Shoulder Pain ○ Muscle Spasms/Cramps ○ Arm Pain ○ Upper Back Pain ○ Mid-Back Pain ○
Low Back Pain ○ Leg Pain ○ Joint Pain (if so, where?) _____

24. **NEUROLOGIC** (check any that you experience now and underline any that you have experienced in the past)
Vertigo/Dizziness ○ Paralysis ○ Numbness/Tingling ○ Loss of Balance ○ Seizures/Epilepsy ○
Loss of Memory ○

25. **ENDOCRINE** (check any that you experience now and underline any that you have experienced in the past)
Hypothyroid ○ Hypoglycemia ○ Hyperthyroid ○ Diabetes ○ Mellitus ○ Night Sweats ○
Feeling Hot or Cold ○

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26. **OTHER** (check any that you experience now and underline any that you have experienced in the past)

Anemia ○ Cancer ○ Rashes ○ Eczema/Hives ○ Cold Hands/Feet ○

Is there anything else we should know? _____

27. **LIFESTYLE**

a. How many hours per night do you sleep? _____ Do you wake rested? Y○ N○

b. Do you typically eat at least three meals per day? Y○ N○ If no, how many? _____

c. Exercise routine _____ Spiritual practice _____

d. Have you experienced any major traumas? _____

e. Do you enjoy work? Y○ N○ Why/Why not? _____

f. Nicotine / Alcohol / Caffeine Use _____

g. How many glasses of water do you drink per day? ____ Television hours/week ____ Reading hours/week ____

h. Interests and Hobbies _____

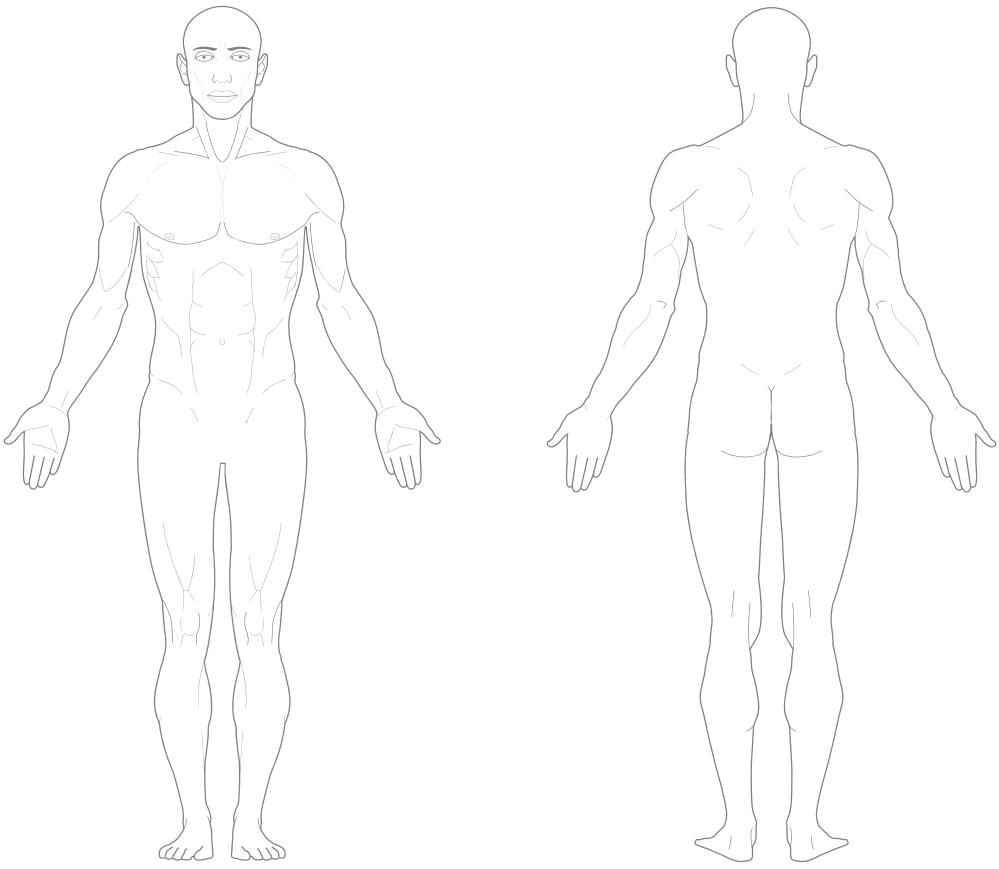
i. How does your health affect your everyday life? _____

j. How would your life be different if you didn't have this condition(s)? _____

k. On a scale of 1-10 (with 10 being the best), how committed are you to improving your health? _____

l. On a scale of 1-10, how much change are you willing to make at this time for improving your health? _____

28. **PLEASE SHADE IN AREAS WHERE YOU ARE EXPERIENCING PAIN ON FIGURES.**



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INSURANCE & FINANCIAL POLICIES

EMERGENCY CONTACT: (Name and address of nearest relative or friend)

Last Name_____ First Name _____ Middle Initial _____

Phone (home) _____ (work) _____ (Cell) _____

Relationship to Patient _____

INSURANCE: (Please present your insurance card(s) to the receptionist.)

Insured's Name _____Insured's date of birth _____

Insurance Name & ID#_____ Group or Plan # _____

RESPONSIBLE PARTY: Fill out if you are not the patient but are responsible for the bill.

Responsible Party _____ Relationship to the patient _____

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Legal Name _____ Date _____

Please Read and Sign. If you have questions about any of our financial policies please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

INSURANCE: In many cases we will be able to call to verify your coverage during your first visit. **If benefits cannot be determined at the time of service and/or if there is any doubt regarding your coverage, payment in full is expected.** If your insurance company remits payment you will be reimbursed when we receive payment. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment. **We recommend reviewing your policy to confirm that the information we received is correct.** Please check with your insurance company to find out if there are any exclusions in your policy. Please note that it is the patient's responsibility to pay for visits and procedures not paid by insurance within a usual and customary time frame (60-90 days).

LATE CANCELLATION/MISSED APPOINTMENTS: There will be a $50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice. After two missed appointments, you will be charged for the entire time reserved for you on the schedule.

METHODS OF PAYMENT: We accept cash, checks, debit, Visa, and MasterCard. There is a $25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made.

AUTHORIZATIONS: I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the copay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage. I authorize the release of any medical or other information necessary to process any claims. I authorize payment of medical benefits to Tracy Andersen DAOM, LAc for all services rendered.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

_____ _____

Patient Name Patient Signature Date

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NOTICE OF PRIVATE PRACTICES

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. **Important Note:** This does not include all of the details about our privacy policy. For more details, please request and read the **Notice of Privacy Practices.**

I. How we may use and share health data about you:
- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the **Notice of Privacy Practices** of this practice.

Patient Name _____ Patient Signature _____ Date _____

If patient is a minor, or if patient is being represented by another party, your representative signs below:

Personal Representative _____ Personal Representative _____ Date _____

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CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions. In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient Name _____ Patient Signature _____ Date _____

If patient is a minor, or if patient is being represented by another party, your representative signs below:

Personal Representative _____ Personal Representative _____ Date _____

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