Hello!

I have attached the initial intake form, notice of privacy practices, and a cancellation agreement form below for you to please print, fill out, and bring with you for our first appointment. We'll talk about what brings you in first, and then I'll ask additional health questions to gain more understanding of you as a whole.

Please wear loose fitting clothing where the knees and elbows can be reached. Depending on what style treatment is best for addressing your chief complaint, we may want to use some acupuncture points on the trunk of the body as well as distal points.

If you're coming for an orthopedic ailment, expect to receive acupuncture in that region. Please note that sometimes treatment addressing musculoskeletal ailments can cause soreness, stiffness, or feelings of muscle bruising for a few days after treatment. This is considered a normal part of healing, though it can be inconvenient or bothersome. Please be aware that while I try to moderate intensity of treatment to best suit your need and comfort without causing much soreness, sometimes it is hard to predict who or which part of the body will respond with soreness or a sense of temporary worsening post-treatment.

It is best to have eaten something before you come, especially if this is your first time receiving acupuncture.

If you have any questions, please contact me either by email, call, or text! If something comes up to where you need to reschedule your appointment, please let me know asap.

Thank you for choosing me to be one of your allies in health and wellness. I look forward to meeting soon!

Sincerely,

Jessica

New Patient Intake Form

Patient Information

Name:			
Date of Birth:		Gender:	
Address:		City, State, Zip:	
Email Address:			
Primary Phone:		Phone Type:	☐ Home ☐ Mobile ☐ Work
Occupation:		Employer:	
Marital Status:	☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed		

-Are your symptoms the result of an accident? ☐ Yes ☐ No

-Is this your first experience with Acupuncture? ☐ Yes ☐ No

-Have you been prescribed Chinese Herbal formulas before? ☐ Yes ☐ No

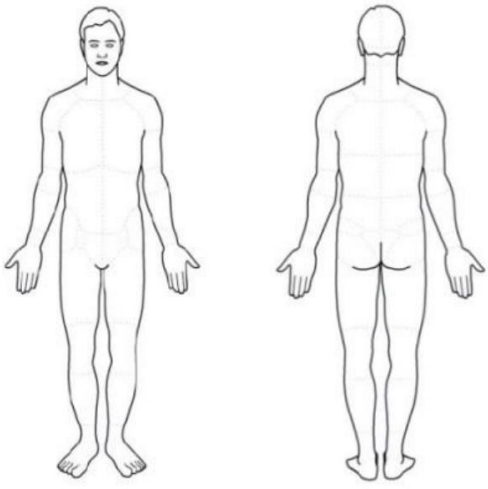
Whom may I thank for referring you? & may I thank them?

Current MD:	
Emergency Contact:	

Name *Relation* *Phone #*

Areas of Complaint

PLEASE DRAW ON THE DIGAGRAM to indicate any area(s) where you are currently experiencing pain or tension…



Please describe the reason for your visit:

1.	
2.	
3.	

SYMPTOM FREQUENCY

☐ Constant	75-100% of awake time
☐ Frequent	51-75% of awake time
☐ Intermittent	26-50% of awake time
☐ Occasional	0-25% of awake time

SYMPTOM CHANGES

- ☐ It is worse in the morning
- ☐ It is worse in the evening
- ☐ It is worse in after movement
- ☐ It changes with the weather
- ☐ It does not change

SYMPTOM RELIEF

- ☐ Ice
- ☐ Heat
- ☐ Medications
- ☐ Movement
- ☐ Nothing helps
- ☐ Rest

Rate the severity of your pain (circle a #):

0= No pain, 10= severe pain

0 1 2 3 4 5 6 7 8 9 10

Review of Systems

Please ☑ conditions you PRESENTLY HAVE (i.e. last few weeks). Write **"P"** for any PREVIOUS conditions.

Head & Neck
- ☐ Dizziness
- ☐ Fainting
- ☐ Neck stiffness
- ☐ Enlarged lymph glands
- ☐ Headaches
  - ☐ Vertex
  - ☐ Occipital
  - ☐ Temple
  - ☐ Frontal
  - ☐ Migraines
  - ☐ Orbital
- ☐ other

Skin
- ☐ Hives
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Itching
- ☐ Dermatitis
- ☐ Excess sweating
- ☐ Dryness
- ☐ Bruises easily
- ☐ Changes in moles or lumps
- ☐ Acne

Neurological
- ☐ Numbness or tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Pain
- ☐ Paralysis

Respiratory
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Wheezing or asthma
- ☐ Frequent colds
- ☐ Emphysema
- ☐ Other _____

Ears
- ☐ Frequent infections
- ☐ Tinnitus
- ☐ Decreased hearing

Eyes
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Poor night vision
- ☐ Spots or floaters
- ☐ Eye inflammation

Nose, Throat, & Mouth
- ☐ Bleeding
- ☐ Sinus infections
- ☐ Hay fever or allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Changes in taste
- ☐ Difficulty swallowing
- ☐ Oral ulcers/canker sores

Gastrointestinal
- ☐ Indigestion
- ☐ Nausea or vomiting
- ☐ Stomach pain
- ☐ Bloating
- ☐ Gas
- ☐ Irritable bowel disease
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Celic disease
- ☐ Ulcers
- ☐ Recent changes in bowels
- ☐ Diarrhea; #stools/day ____
- ☐ Constipation: #stools/wk__
- ☐ Dry, hard stools
- ☐ Soft, difficult, sticky stools
- ☐ Irregular or poorly formed stools
- ☐ Hemorrhoids
- ☐ -with pain or blood
- ☐ Gall Bladder disorder
- ☐ Food cravings
- ☐ Recent changes in weight
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Other_____

Muscles & Joints
- ☐ Joint disorder
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Backache
- ☐ Back pain
- ☐ Fibromyalgia

Urinary
- ☐ Frqt UT or bladder infections
- ☐ Weak urinary stream
- ☐ Frqt nigh urination, ___x
- ☐ Frqt day urination, ___x
- ☐ Recent change in bladder habits
- ☐ Kidney disease

Female
- ☐ Frqt vaginal infections
- ☐ Frqt yeast infections
- ☐ Infertility
- ☐ Pain or itching of genitalia
- ☐ Genital lesion or discharge
- ☐ Pelvic inflammatory disease
- ☐ Menopausal symptoms
- ☐ Breast lumps or cysts
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Abnormal bleeding
- ☐ Night sweats

Male
- ☐ Pain or itching of genitalia
- ☐ Genital lesions or discharge
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Prostate issues
- ☐ Infertility
- ☐ Other _____

Cardiovascular
- ☐ Palpitations
- ☐ Chest pain or tightness
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Heart disease
- ☐ Poor circulation
- ☐ Swelling of the ankles
- ☐ Cold hands/feet
- ☐ Cardiac pacemaker
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other _____

General
- ☐ Fatigue
- ☐ Strong thirst
- ☐ Aversion to cold
- ☐ Insomnia
- ☐ Frequent dreams/nightmares
- ☐ Depression
- ☐ Agitation
- ☐ Irritability
- ☐ Anxiety
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Sores that don't heal
- ☐ Congenital abnormalities
- ☐ Surgical implants
- ☐ Unusual bleeding/discharge
- ☐ Jaundice
- ☐ Hernia
- ☐ Epstein Barr Virus (EBV)
- ☐ Rheumatic Fever
- ☐ Diabetes mellitus
- ☐ Thyroid disorder
- ☐ Cancer
- ☐ Anemia or other blood disorder
- ☐ Lupus erythematosus

Other
- ☐ Mood swings
- ☐ Issues with libido
- ☐ Insomnia
- ☐ Sleep issues

Family Medical History

Please ☑ if a family member currently has, or has had, any of the following conditions listed below and indicate who.

	Condition Name	Who?		Condition Name	Who?
☐	Alcoholism	_____	☐	Diabetes	_____
☐	Allergies	_____	☐	Drug abuse	_____
☐	Asthma	_____	☐	Heart Disease	_____
☐	Arthritis	_____	☐	High Blood Pressure	_____
☐	Auto-immune disorders	_____	☐	Obesity	_____
☐	Cancer	_____	☐	Osteoporosis	_____
☐	Depression	_____	☐	Thyroid Disease	_____
☐	Other_____	_____	☐	Other _____	_____

Medical History (please list any…)

Surgeries, including date of surgery:

Serious iniuries, illnesses, accidents, or trauma:

Allergies (food, environmental, medical):

Sensitivities:

Current Medications & Supplements

Please List and include reason for using medication/supplement

Women's Health

Most recent menstrual cycle: ____/_____/_____

Length of cycle: _____ Days of flow: _____

Age at first menses: _____

Do you believe you are pregnant? ☐ **yes** ☐ **no**

Is your cycle regular? ☐ yes ☐ no ☐ menopause

Amount: ☐ heavy ☐ moderate ☐ light

Consistency: ☐ thin ☐ thick ☐ watery ☐ dilute

Do you experience any of the following conditions before or during menses?

☐ Premenstrual syndrome ☐ Irregular periods ☐ Migraine ☐ Pain or cramps ☐ Frustration ☐ Nightmares

☐ Fluid retention ☐ Depression ☐ Clots ☐ Loneliness ☐ Fatigue

_____# of pregnancies _____# of births _____# of miscarriages _____# of children

Do you use contraceptive pills or other forms of birth control? If yes, please list: _____

Men's Health

Please indicate which of the following areas are troublesome (if any).

☐ Hernias ☐ Prostate problems ☐ Urination issues ☐ Erection problems ☐ Libido ☐ Fertility

Diet & Lifestyle

What do you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

Which meal is your largest meal of the day? ☐ Breakfast ☐ Lunch ☐ Dinner

Do you have any food allergies, sensitivities, or restrictions? _____

Alcohol: # per week _____ ☐ Beer ☐ Liquor ☐ Wine

Caffeine: Coffee cups/day?_____ Tea cups/day? _____ Soda cans/day? _____

Cigarettes: packs/day? _____ **Recreational drugs:** ☐ yes ☐ no

Exercise: Type? _____ Frequency? _____

How much sleep do you get each night on average? ☐ 6 hrs or less ☐ 6-8 hrs ☐ 8+ hrs

What time do you go to sleep? _____ What time do you wake up? _____

Do you wake up feeling rested? ☐ yes ☐ no

How would you rate your mental concentrations? ☐ Strong ☐ Moderate ☐ Weak

How would you rate your energy level on a scale of 1-10 (10 highest, 1 lowest)? _____

Do you experience any of the following?

☐ Depression ☐ Anger ☐ Anxiety ☐ Lack of memory ☐ Panic ☐ High stress level

☐ Loneliness ☐ Lack of energy ☐ Worry ☐ fear ☐ Fatigue ☐ Irritation

Are you suicidal? ☐ yes ☐ no **If yes, do you have an active plan?** ☐ yes ☐ no

Have you ever attempted suicide? ☐ yes ☐ no

Rate the following emotions in the order that you experience the most often. 1 being most often, and 5 being least often:

___Joy ____Worry/obsession ___Sorrow ___Fear ___ Anger

Is there anything else you would like me to know about you? _____

NOTICE OF PRIVACY PRACTICES

The attached Notice describes how health information about you may be used, and your rights, regarding the use of that information. Please review this summary and the full Notice carefully.

Our Pledge: Staff and Employees of Old Growth Acupuncture & Chinese Medicine and its affiliates and contract providers understand that information about you and your health is personal. We are committed to protecting your health information.

Who will follow the rules in this notice: All our staff and contract provider employees, affiliates, as well as students, clinical assistants and volunteers, must follow these rules.

You have the right to:

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask us to send copies of your health record to whomever you wish (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
- Specify where and how our employees may contact you.
- Receive a paper copy of the full Notice of Privacy Practices.

Who is authorized to see confidential Patient Health Information (PHI)?

The Acupuncturists and other licensed providers in the health care team may access the entire medical record, based on their "need to know". All other members of our workforce have access only to the information needed to do their jobs. The "Notice of Privacy Practices" describes the ways in which we may use PHI without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted:

1. Treatment of the patient, including appointment reminders
2. Payment of health care bills (insurance claim submission, authorizations and payment posting)
3. Health care operations and business operations, including, teaching and medical staff quality activities, research (with a patient's written permission); healthcare communications between a patient and their health care practitioner.

Minimum Necessary Standard

We will apply the "minimum necessary" standard regarding PHI. For example, although Clinical Administration, Acupuncturists, Massage Therapists, Students and Clinical Assistants and other care providers may need to view the entire record, a billing/insurance clerk or data entry staff member might only need to see a specific report to determine the billing codes. An admissions staff member may not need to see the medical record at all, only an order form with the admitting diagnosis and identification of the admitting physician.

Written Authorizations

To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. (Available at http://www.ucsf.edu/hipaa.) If you do not know or understand what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement and based on a judicial request or subpoena.

Questions and Complaints

If you have any questions, complaints, or want more information, contact this office. If you believe that your privacy rights have been violated, you may file a complaint with us. Jessica Dodds, DACM, Lac. 3066 Venable Road, Kents Store, VA 23084. If you are not satisfied with the manner in which this office handles your complaint, you also have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services. US Dept. of Health and Human Services (DHHS), Office of Civil Rights, 200 Independence Ave SW, Room 509 F HHH Building, Washington, DC 20201. We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or the Department of Health and Human Services.

I acknowledge receipt of a copy of the Notice of Privacy Practices (HIPAA) and Patients' Rights of Jessica Dodds and Old Growth Acupuncture & Chinese Medicine.

Signature:_____ Date:_____

Cancellation Agreement

Please note that there is a 48 hour cancellation policy. Please understand that it can be difficult to fill your appointment with even 48 hours' notice as your appointment time slot has been saved just for you. I appreciate as much notice as possible.

Late Arrivals

Please understand that if you arrive 15 or more minutes after the start of your appointment I may not be able to see you that day. Often, the full length of the appointment is needed in order to best serve you. Late arrivals may be charged for a missed appointment.

Thank you for your consideration and understanding that our agreed-upon appointment time is a joint commitment to a time slot. I understand unforeseeable events happen. In order to manage a successful practice, I must charge for the missed appointment.

I _____ (please print name), have read the above policy and acknowledge that I will be charged the full amount and am responsible for payment of my scheduled appointment if I cancel or reschedule with less than 48 hours notice, or if I arrive 15 or more minutes late to my appointment.

Signed (patient signature): _____

Date: _____