Kingston Crossing
WELLNESS CLINIC

Acupuncture Health Intake

I'm also interested in (check all that apply):
❑ Chiropractic ❑ Massage ❑ Regenerative Medicine

CONFIDENTIAL CONTACT FORM

First Name _____ Last Name _____ MI _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

___ / ___ /____ Date of Birth _____/_____/_____ Social Security No. Preferred Pronouns (please circle): She/Her They/Them He/Him

Gender: _____ Sex at Birth: _____

(_____) _____ - _____ Home Phone (_____)_____ - _____ Cell Phone (_____)_____ - _____ Work Phone

Email _____ Circle the best contact: → (Home) (Cell) (Work) (Email)

Occupation _____ _____ / _____ Hours / Week

Emergency Contact _____ Relationship to Patient _____ (_____)_____ - _____ Phone Number

Responsible Party (If Patient is Under 18) _____ Relationship to Patient _____ Signature _____

Whom my we thank for referring you? _____

Seeking treatment for an injury? Y / N ❑ Work ❑Auto ❑Other _____ Date of Injury _____ / _____ /_____

INSURANCE INFORMATION

Primary Insurance ❑ Health / Medical ❑ Automobile ❑ L&I / Workers Compensation

Name of Insurance Company _____ Prefix _____ ID# _____ Group # _____

Name of Insured _____ Relationship to Patient _____

Secondary Insurance

Name of Secondary Insurance _____ Prefix _____ ID# _____ Group # _____

Name of Insured _____ Relationship to Patient _____

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understanding that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (Print) _____ Patient Signature _____ Date _____

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PRIMARY HEALTH CONCERNS (List in order of concern to you)

Health Concern	Onset (June '78)	Frequency (2x/wk)	Severity 1 (mild) – 10 (severe)
1)			
2)			
3)			
4)			
5)			
6)			
7)			

LIST OF INJURIES (falls, sports injuries, repetitive stress injuries, major physical traumas)

Injury	Date
1)	
2)	
3)	
4)	
5)	

Have you been in any motor vehicle accidents? (please note type/year even if it doesn't pertain to current health concern)

_____

_____

_____

Surgeries/Operations (please note year)

_____

_____

_____

Disease/Diagnosis

_____

_____

_____

Primary Care Physician _____ **Phone** _____

Specialist Physician _____ **Phone** _____

Have you ever received:

Chiropractic Care: Y/N If Yes, Dr. _____ When _____ Location _____

Acupuncture Care: Y/N If Yes, _____, LAc When _____ Location _____

Naturopath Care: Y/N If Yes, Dr. _____ When _____ Location _____

Massage Care: Y/N If Yes, Dr. _____ When _____ Location _____

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List Current Medications and Supplements

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL MEDICAL HISTORY

Please check the following conditions that apply to you. If a choice is given circle the appropriate one.

_____ Alcoholism/Substance Abuse
_____ Anemia
_____ Anxiety
_____ Arthritis/Joint Disease
_____ Asthma
_____ Bipolar disorder
_____ Blood Clots/Phlebitis
_____ Cancer (type_____)
_____ Depression
_____ Diabetes (type_____)
_____ Digestive Disorders (UC, Crohn's, IBS, etc)
_____ Easy Bleeding
_____ Frequent Sinusitis
_____ Gall Bladder Trouble
_____ Hay Fever / Allergy / Eczema
_____ Headaches (Migraines, Tension, etc)
_____ Hearing Loss
_____ Heart Attack/ Disease/ Failure
_____ Heart Murmur
_____ High Blood Pressure
_____ High Cholesterol
_____ History of Infertility
_____ Kidney Disease/Stones
_____ Liver Disease (Hepatitis, etc)
_____ Lung Disease (COPD, etc)
_____ Pneumonia
_____ Radiation Treatments
_____ Rheumatic Fever
_____ Seizures, Epilepsy
_____ Skin Disease
_____ Sexually Transmitted Disease (type_____)
_____ Stroke / TIA
_____ Tuberculosis
_____ Urinary Difficulties (Incontinence, UTI, etc)
_____ Vision/Eye Problems
_____ Other:_____

BLOOD RELATIVES MEDICAL HISTORY

P = Parent S=Sibling G=Grandparent

Place the appropriate letter(s) in the blank if your blood relatives have/had any of the following:

_____ Alcoholism or Substance Abuse
_____ Anemia
_____ Arthritis/Joint Disease
_____ Cancer (type_____)
_____ Diabetes (type_____)
_____ Digestive Disorder
_____ Easy Bleeding
_____ Glaucoma
_____ Hay Fever, Allergy, Eczema
_____ Headaches (Migraines, etc)
_____ Heart Attack/Disease/Failure
_____ High Cholesterol
_____ Kidney Disease/Stones
_____ Liver Disease
_____ Lung Disease (COPD, CHF, Asthma, etc)
_____ Mental Illness, Depression, Anxiety
_____ Seizures, Epilepsy
_____ Stroke
_____ Suicide
_____ Thyroid Disease
_____ Tuberculosis
_____ Ulcers
_____ Osteoporosis
_____ Other_____

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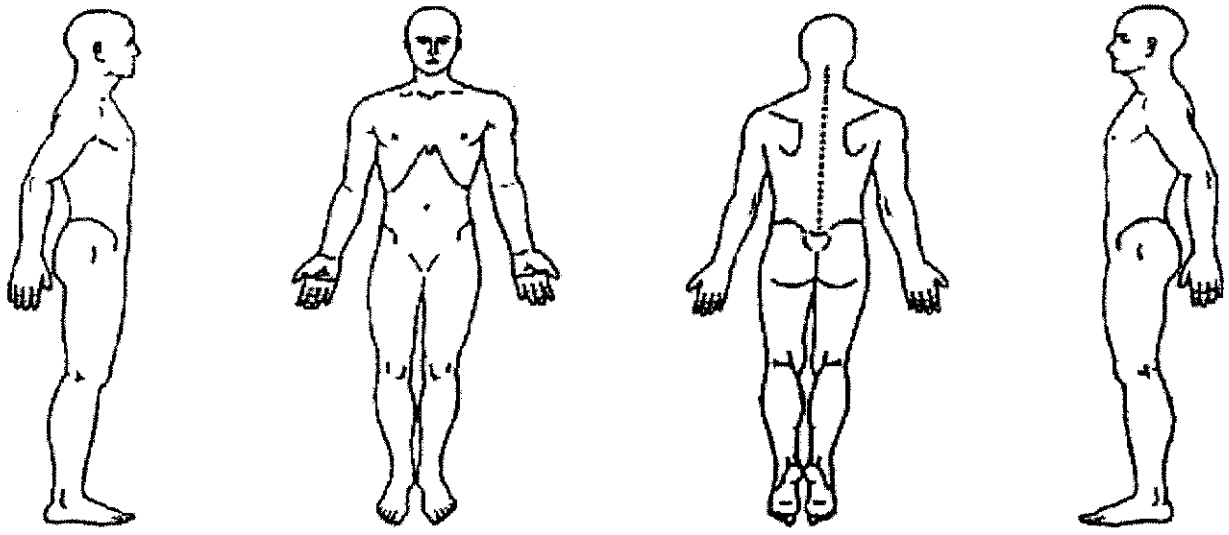

Indicate the location of pain/discomfort on the illustration. Use the symbol that best describes the feeling:

XXX Sharp/Stabbing **PPP** Pins/Needles **DDD** Dull/Aching **NNN** Numbness

LIFESTYLE

Type of Work/Occupation _____ Hours/Day _____

How is work/life affected by your pain/health concerns? _____

_____

Average hours of sleep per night? _____ Hrs Sleep quality (circle) **POOR** **FAIR** **GOOD**

Physical Activities/Exercise _____ Hours/Week _____

NUTRITION

Do you have any dietary restrictions/special diet (i.e. vegan, vegetarian, low-carb, ketogenic, etc.)?

If yes, explain _____

How many meals do you eat on average per day? (circle) 0 1 2 3 4 5 6+

Does your average meal include (circle all that apply): Grains Vegetables Fruit Dairy Meat Beans

How many glasses of water (8oz) do you drink on average per day? (circle) 0 1 2 3 4 5 6 7 8+

Do you drink coffee/caffeine? Y/N If yes, how many cups per day? (circle) 1 2 3 4 5 6 7 8+

Do you smoke cigarettes? Y/N If yes, how many cigarettes per day? (circle) 1 2 3 4 5 6 7 8 9 10+

Do you use recreational drugs? Y/N If yes, which ones and how often? _____

Do you drink alcohol? Y/N If yes, how many drinks per week? _____

RELATIONSHIP HISTORY

Do you identify as: (circle all that apply) Gay Lesbian Bisexual Straight Questioning Other: _____

Please describe your sexual activity during the last year (circle all that apply):

One partner Multiple partners (single gender) Multiple partners (multiple genders) Not sexually active Other: _____

Please describe your current relationship status (circle all that apply):

Single Married Civil Union Domestic partnership Divorced/Separated Widowed Committed Relationship Other: _____

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Please check all that apply:

Gastrointestinal

- ❑ Belching or Gas
- ❑ Nausea or vomiting
- ❑ Heart Burn or Acid Reflux (GERD)
- ❑ Bloating or abdominal discomfort
- ❑ Food sensitivities/allergies
- ❑ Diarrhea (chronic/recurrent)
- ❑ Stools are soft/loose and unformed
- ❑ Constipation
- ❑ Hemorrhoids or varicose veins

Skin

- ❑ Hives and/or rashes
- ❑ Cold Sores
- ❑ Dry flakey skin and/or dandruff
- ❑ Acne
- ❑ Itchy skin
- ❑ Skin infection history (MRSA, staph, etc.)
- ❑ Cysts or lipomas

Nails

- ❑ Ridged nails
- ❑ White spots on nails

Nose

- ❑ Post-nasal drip
- ❑ Runny nose
- ❑ Sinus congestion

Head, Mouth, & Throat

- ❑ Tension headaches (at the base of the skull)
- ❑ Migraines
- ❑ Dizziness
- ❑ Difficulty swallowing

Liver

- ❑ Sensitive to chemicals & fragrances
- ❑ Sensitive to tobacco smoke
- ❑ Chronic fatigue or Fibromyalgia
- ❑ Over stimulated from caffeine
- ❑ Feet have a strong odor
- ❑ Sweat has a strong odor

Eyes

- ❑ Dark circles around the eyes
- ❑ Puffy eyelids
- ❑ Bags under the eyes
- ❑ Dry eyes
- ❑ Inflamed/infected eyelids
- ❑ Watery or itchy eyes
- ❑ Blurred or tunnel vision

Ears

- ❑ Ear infections
- ❑ Ear drainage or discharge
- ❑ Itchy ears
- ❑ Ringing in the ears

Kidney

- ❑ Urine has a strong odor
- ❑ Pain in low-mid back region
- ❑ Urine is frothy
- ❑ Urinate frequently or with urgency

Immune System

- ❑ Frequent colds or flu
- ❑ Chronic stress
- ❑ Frequent infections (bladder, skin, ear, chest, sinus)

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Mental and Emotional

- ❑ Feelings of depression
- ❑ Worry, apprehensive, anxious
- ❑ Frustrated or agitated
- ❑ Difficulty concentrating
- ❑ Mood swings

Metabolism

- ❑ Thyroid or Adrenal issues
- ❑ Mood swings associated with periods/PMS
- ❑ Breast tenderness associated with cycle
- ❑ Overweight or obese

Heart and Lungs

- ❑ Flush or blush easily
- ❑ Heart palpations
- ❑ Cold hands/feet
- ❑ Asthma
- ❑ Wheezing or difficulty breathing
- ❑ Shortness of breath

Life Events (in last 12 months)

- ❑ Death of a spouse/partner
- ❑ Death of a close family member
- ❑ Death of a close friend
- ❑ Personal injury or illness
- ❑ Marriage
- ❑ Retirement
- ❑ Pregnancy
- ❑ Divorce/Partner Separation
- ❑ Sexual difficulties
- ❑ Addition to the family
- ❑ Change in work
- ❑ Change in number of partner arguments
- ❑ High financial debt
- ❑ Foreclosure / Bankruptcy
- ❑ Child leaving home
- ❑ Trouble with in-laws
- ❑ Spouse/partner begins or stops work
- ❑ Starting or finishing school

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KINGSTON CROSSING WELLNESS CLINIC POLICIES (please read, initial, & sign below)

I, _____, understand and agree to the following:

OFFICE POLICIES

At Kingston Crossing we understand that life happens. If you need to reschedule an appointment please call or email us 24 hours in advance of the scheduled appointment time. Currently we do not charge a cancellation fee but please understand that the practitioners do get paid per appointment slot and rescheduling last minute makes it extremely difficult for us to fill your appointment time. As a courtesy to your practitioner, please give advanced notice for rescheduling, as it is greatly appreciated. _____Initial

PATIENT NON-DISCRIMINATION POLICY

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identify, or gender expression. Our office supports tolerance and inclusivity. _____Initial

CONSENT FOR RELEASE OF INFORMATION

Kingston Crossing Wellness Clinic respects your privacy. We understand that your personal health information (PHI) is very sensitive. We will not disclose your information to others unless you allow us to do so, or unless the law authorizes us to do so. _____Initial

Federal and state laws allow us to disclose your PHI for purposes of treatment and health care operations. State law requires us to get your written authorization to disclose this information for payment purposes.

I, authorize Kingston Crossing Wellness Clinic:

1. The release, use and disclosure of my PHI under HIPAA's Privacy Rule to any and all of my health care providers to facilitate my health care and any and all of my insurance companies to facilitate the processing of my claims. _____Initial
2. To release any and all of my insurance/medical information to my spouse, significant other and/or family member(s). _____Initial
3. To call me at any phone number I have provided to Kingston Crossing Wellness Clinic and leave a message at any of these phone numbers as necessary. _____Initial

FINANCIAL POLICIES & AGREEMENTS

I am solely responsible for the expenses of my care and/or the care of my dependents. While I may assign payment of benefits to Kingston Crossing Wellness Clinic, any uncovered services, deductibles, and co-payments are my financial obligation, to the extent allowed by terms of the Kingston Crossing Wellness Clinic's provider contracts with insurance plans. _____Initial

INSURANCE NON-COVERED SERVICE DISCLOSURE & AGREEMENT

1. Potential non-covered status include: the service is or may be deemed (a) investigational or experimental under the carrier's internal guidelines; (b) not medically necessary under the carrier's internal care or cost management guidelines; (c) not covered under the plan to which you are subscribed; (d) not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines. _____Initial
2. The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided. _____Initial
3. I acknowledge that the Non-Covered status of the proposed service(s) has been explained and that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. If any portion of the care provided is not, or may not be covered by insurance, then I shall be responsible for payment and shall make the necessary financial agreement with the healthcare provider to pay for these services. _____Initial

AUTHORIZATION FOR TAKING AND RETAINING X-RAY FILMS

I hearby authorize the taking of analytical x-ray films by the doctors, clinic, and/or staff of Kingston Crossing Wellness Clinic, of such areas as may be of anatomical interest and which may be recommended from time to time by the doctor(s). Further I agree that the doctor(s)/clinic shall be the sole owner of such analytical films and shall remain in custody and in control of said films, until such time as I shall sign a Release Form stating otherwise that will be provided by Kingston Crossing Wellness Clinic upon request. _____Initial

By signing below I, the patient, acknowledge that I have read the above statements regarding my care and treatment at Kingston Crossing Wellness Clinic. This consent will remain in effect until revoked by me, the patient, in writing.

_____ _____ _____

Patient/Responsible Party Signature **Printed Name** **Date**

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Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needing sites that may last a few days, and dizziness or fainting. 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. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff 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, 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 Signature	*(Date)*

(Or Patient Representative) ***(Indicate relationship if signing for patient)***

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Kingston Crossing Wellness for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kingston Crossing Wellness.
I understand that diagnosis or treatment of me by the treating provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Kingston Crossing Wellness is not required to agree to the restrictions that I may request. However, if Kingston Crossing Wellness agrees to a restriction that I request, the restriction is binding on Kingston Crossing Wellness.
I have the right to revoke this consent, in writing, at any time, except to the extent that Kingston Crossing Wellness has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identities me, or there is a reasonable basis to believe the information may identify me.
I understand I have the right to review Kingston Crossing Wellness's Notice of Privacy Practices prior to signing this document.

Kingston Crossing Wellness's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kingston Crossing Wellness.

The Notice of Privacy Practices for all treating providers is also provided at the front desk of Kingston Crossing Wellness.

This Notice of Privacy Practices also describes my rights and the duties of Kingston Crossing Wellness with respect to my protected health information.

Kingston Crossing Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority