HOLISTIC PRIMARY CARE

PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name

Address City State Zip

Home Phone Cell Work

Email

Age Date of Birth Male_____ Female _____

Employer Occupation

Emergency Contact Telephone ( )

How did you find us? Referred by:_____ Google/ internet? _____

24-Hour Cancellation Policy

At Holistic Primary Care, we take pride in the quality of care we offer patients. To maintain fairness to all, we enforce this cancellation policy:

- **We require at least a 24-hour notice prior to your appointment time, and you must let us know during business hours if you need to reschedule or cancel an appointment. You may be charged an automatic cancellation fee of up to the full price of the missed appointment for a late cancellation or no-show.**

Thank you for your understanding. We have reserved a time slot just for you, and we want to give each patient that same attention. Please sign below that you have read and understand our cancellation policy.

Patient Name (print) _____

Patient Signature X_____ Date _____

HOLISTIC PRIMARY CARE

Informed Consent to Treat

I hereby request and consent to receive treatments including herbal consultations, acupuncture treatments, acupuncture injection therapy (AIT) and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by any licensed acupuncture physician and/or herbal practitioners, massage therapists, and any other practitioner associated with Holistic Primary Care, including those working at 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, acupuncture injection therapy (AIT), injection of vitamins, nutritional or homeopathic supplements, moxibustion, cupping, electrical stimulation, 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 and in writing. The herbs may be unpleasant in 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 needling 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 effect and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are generally 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 the 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, herbal medicine, 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 X_____
(or patient representative; indicate relationship if signing for patient)

Printed name: _____ Date: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

DATE OF BIRTH _____

I understand that as part of my healthcare, or my legal dependent's healthcare, this organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning care and treatment.
- A means of communication among the many healthcare professionals who contribute to care.
- A source of information for applying diagnostic and medical information to a bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of health information for directory purposes.
- To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Signed:
X_____

HOLISTIC PRIMARY CARE

Health Questionnaire

Name_____ **Date**_____

Age_____ **Date of Birth**_____

Major Symptoms (Please list in order of importance to you.)

_____For how long?_____

_____For how long? _____

_____ For how long? _____

Medications/Supplements--please list those you are currently taking, as well as over-the-counter medicines and supplements you take on a regular basis.

_____

Allergies:_____

Medical History--Please list significant conditions and when diagnosed. (Examples: diabetes, heart disease, cancer, thyroid disease, high blood pressure, high cholesterol, seizures, hepatitis, HIV)

_____

Surgeries/Accidents (Please include the dates):

_____

For women: Are you pregnant now? Yes_____ No_____ Unsure _____

Social history/Health habits: (Please check any that you take.)

Coffee, tea, sodas?_____ Alcohol?_____ Cigarettes/cigars?_____ Other drugs?_____

Have you been treated for emotional issues?_____ Considered or attempted suicide?_____

Who is your source of primary social support (relationship to you):

_____

Current exercise activities:_____

Do you follow a special diet? (Vegan, low-carb, etc.)_____

Any other information that you think is relevant for us to know: _____

CHECK ALL THAT APPLY:

GENERAL:
____Poor appetite
____Excessive appetite
____Insomnia
____Fatigue
____Fevers
____Night sweats
____Sweat easily
____Chills
____Poor coordination
____Bleed or bruise easily
____Catch cold easily
____Strong thirst
____Other:_____

SKIN AND HAIR:
____Rashes
____Hives
____Itching
____Eczema
____Pimples
____Rosacea
____Dryness
____Tumors, lumps
____Other:_____

HEAD AND NECK:
____Dizziness
____Enlarged lymph glands
____Headaches
____Other:_____

EARS:
____Infection
____Ringing
____Decreased hearing
____Other:_____

EYES:
____Blurred vision
____Visual changes
____Poor night vision
____Floaters
____Cataracts
____Glasses/contacts
____Eye inflammation
____Other:_____

NOSE, THROAT, MOUTH:
____Nose bleeds
____Sinus Infections
____Hay fever or allergies
____Recurring sore throats
____Grinding teeth/TMJ
____Difficulty swallowing
____Other:_____

CARDIOVASCULAR:
____High blood pressure
____Low blood pressure
____Heart palpitations
____Irregular heartbeat
____Blood clots
____Phlebitis
____Chest pain
____Cold hands/feet
____Swelling of hands/feet
____Fainting
____Other:_____

RESPIRATORY:
____Difficult breathing
____Asthma
____Bronchitis
____Frequent colds
____COPD
____Pulmonary disease
____Pneumonia
____Cough
____Coughing blood
____Production of phlegm
____Other:_____

GASTROINTESTINAL:
____Bad breath
____Nausea
____Vomiting
____Diarrhea
____Belching
____Blood in stools
____Black stools
____Rectal pain
____Hemorrhoids
____Constipation
____Pain or cramping
____Indigestion
____Gas
____Gall bladder disorder
____Other:_____

GENITO-URINARY:
____Kidney stones
____Painful urination
____Frequent urination
____Blood in urine
____Urgency to urinate
____Unable to hold urine
____Other:_____

MALE:
____Pain/itching genitalia
____Genital lesions/discharge
____Erectile dysfunction
____Weak urinary stream
____Lumps in testicles
____Other:_____

FEMALE:
____Frequent urinary tract infections
____Frequent vaginal infections
____Pain/itching of genitalia
____Genital lesions
____Vaginal discharge (abnormal)
____Pelvic inflammatory disease
____Abnormal pap smear
____Irregular menstrual periods
____Painful menstrual periods
____Premenstrual syndrome (PMS)
____Abnormal bleeding
____Menopausal syndrome
____Hot flashes
____Breast lumps
____Other:_____

NEUROLOGICAL:
____Seizures
____Tremors
____Numbness/tingling
____Paralysis
____Memory problems
____Other:_____

PSYCHOLOGICAL:
____Depression
____Anxiety
____Irritability
____Emotional or work-related stress
____Being treated for emotional or psychological problems
____Other:_____

INFECTION SCREENING:
____HIV
____TB
____Hepatitis
____Gonorrhea
____Chlamydia
____Syphilis
____Genital warts
____Herpes: oral
____Herpes: genital
____Other:_____

MUSCULAR-SKELETAL:
____Stiff neck/shoulders
____Shoulder pain
____Neck pain
____Back pain
____Hip pain
____Knee pain
____Joint pain
____Sciatica
____Muscle spasm or cramps
____Other:_____