Acupuncture & Herbal Consultation Intake Form

Lydia Warren, LAc, MAcOM ::: Healing Roots

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Cell Phone Number: _____ Email Address: _____

Do you prefer text or email reminders? _____ If text preferred, who is cell phone provider? _____

Would you like to receive the Healing Roots newsletter? Y / N Referred By: _____

Date of Birth: _____ Age: _____ Sex: M / F

Height: _____ Weight: _____ Maximum weight: _____ When? _____

Emergency Contact (name and phone number): _____

Prim Care Physician: _____ OBGYN: _____

Chiropractor: _____ Pediatrician: _____

MAJOR HEALTH COMPLAINTS: (Please note when symptoms began).

1) _____

What makes this better: _____

What makes this worse: _____

2) _____

What makes this better: _____

What makes this worse: _____

ADDITIONAL HEALTH CONCERNS: _____

_____

_____

Is there any chance you may be pregnant? Y / N Do you have any infectious diseases? Y / N

If Yes, Please identify: _____

Childhood Illness: _____

Hospitalizations and Surgeries (Include date): _____

_____

Allergies/ Sensitivities (including food): _____

_____

Current medications and supplements. Please include dosage: _____

_____

What are the 3 healthiest things you do for yourself? _____

What are the 3 healthiest foods you eat? _____

What are the 3 unhealthiest foods you eat? _____

FAMILY HISTORY:

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Anemia			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Celiac disease		
Seizures			Alcoholism			Breathing difficulty		
Chronic fatigue			Multiple sclerosis			HIV/AIDS		
Arthritis			Depression			Anxiety		
Other:								

Please circle the following if you are currently experiencing symptoms, and <u>underline</u> if you have experienced symptoms in the past:

Cold hands/feet	Prefers warm drinks	Hot flashes	Weak/sore knees
Cold knees	Sore throats	Nighttime urination	Hair loss
Cold body temperature	Hot hands/feet	Prefers cold drinks	Premature graying
Incontinence	Strong thirst	Frequent cavities	Loose teeth
Low back pain	Hot body temperature	Weak bones	Root canals/cavities
Low libido	Night sweats	Tinnitus/hearing loss	Developmental disorders
Prone to illness	Easily fatigued	Persistent cough	Sweats easily
Shortness of breath	Sinus congestion/allergies	Asthma/wheezing	Dry skin
Anxiety	Insomnia	Manic moods	Mental restlessness
Palpitations	Tongue ulcers	Restless/vivid dreams	Nosebleeds
Low/weak appetite	IBS/Colitis	Incomplete Stools	Indigestion
Weight fluctuation	Loose stools/diarrhea	Gas/Bloating	Stomach aches
Fatigue after meals	Mucous in stool	Ravenous appetite	Bad breath
Gurgling in intestines	Constipation	Bleeding gums	Heartburn
Hypoglycemia	Blood in stool	Nausea/vomiting	Mouth ulcers
Bruises easily	Less than 1 BM/day	Hiccups	Eating disorder
Mental fogginess	Symptoms worse with rain	Excessive sweating (volume)	Swollen hands
Heaviness of head or limbs	Joint stiffness/aches	Poor mental focus	Swollen feet/legs
Chest pain/tightness	Irritability	Depression	Acne
Blurry vision	Headaches	Eye pain/dryness	Floaters in vision
All over body tension	Pain in ribcage	Convulsions/seizures	Lump in throat
Muscle spasms/cramps	Numbness/tingling	Tendency toward sighing	Hives
Dizziness/light-headedness	Chronic infections	Migraines	Fainting
Weak/brittle nails	Itchy skin	Poor memory/concentration	Dandruff
Varicose veins	Muscle pain	Poor balance	Low energy

EMOTIONAL HEALTH:

Tendency toward the following emotions/expressions:

Worry	Over pensiveness	Negativity	Joyfulness
Anger	Unresolved grief/sorrow	Fear	Withdrawal
Tearfulness	Nervousness	Anxiety	Depression

FEMALE HEALTH:

No. of Pregnancies _____	Cesarean births _____	Abortions _____	Vaginal births _____
Miscarriages _____	Ectopic _____	Age of First Menses _____	Length of cycle _____
Vaginal discharge	Menopausal symptoms	PMS symptoms	Painful periods
Heavy flow	Clots	Difficulty conceiving	Breast lumps
Irregular cycle	Vaginal dryness	Birth control method(s): _____	

If not currently, have you take oral/hormonal contraceptives in the past? Y / N For how long? _____

MALE HEALTH:

Testicular pain/swelling	Premature ejaculation	Penile discharge	Prostate swelling
Impotence	Nocturnal emission		

LIFESTYLE:

A) What does your typical daily diet consist of?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do you drink daily? _____

B) Exercise routine: _____

C) Spiritual practice: _____

D) Occupation: _____ Employer: _____

Hours/Week: _____ Do you enjoy work? Y / N Why/Why not? _____

E) Please include how much of the following substances you consume weekly:
Nicotine _____ Caffeine _____ Recreational drugs _____
Alcohol _____ Marijuana _____

F) Which season do you most prefer? _____ Which season do you least prefer? _____

G) Any energy bursts throughout the day? Y / N Time: _____ Any energy dips? Y / N Time: _____

H) Have you experienced any major traumas? Y / N Explain:_____

I) What frustrates you? _____

J) What makes you happy? _____

I acknowledge that all disclosed information is confidential between patient and practitioner. I also agree to inform Lydia Warren, LAc, of any changes in medical conditions or medications/dosages.

Name (printed): _____ Signature: _____ Date: _____

Guardian (printed) if under 18: _____ Signature: _____ Date: _____

Healing Roots
Lydia Warren, LAc, MAcOM

Authorization to Contact

Appointment Reminders and Health Care Information Authorization

Lydia Warren or affiliated staff members may use your name, address, phone number, email and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone, a message will be left on your voicemail. Thank you cards, appointment reminders, holiday cards, and other correspondence may be sent to your mailing or e-mail address.

Please be aware that you have a right to refuse or limit this contact. You may restrict the individuals or organizations to which your health care information is released. You may also revoke this authorization with us at any time as long as your revocation is in writing and is delivered to Lydia Warren, LAc. You should also know that if you were required to give your authorization to release health care information as a condition of obtaining insurance, the insurance company may have a right to your health information should they decide to contest any of your claims.

I, _____, authorize you to use or disclose my health information in the manner described above and I am giving authorization for Lydia Warren, LAc, and affiliated staff members to contact me with the types of information described above.

Name (printed): _____ Date: _____

Signature: _____

Cancellation Policy

Thank you for your consideration.

I understand that Lydia Warren, LAc, relies on slotted appointment times to maintain a viable business, and that these appointments are often impossible to fill if cancelled last minute. I agree to pay a missed appointment fee in full if I do not show up or cancel with less than 24 hours notice.

Signed: _____ Date: _____

Healing Roots
Lydia Warren, LAc, MAcOM

Informed Consent to Treatment

I, _____, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, gua sha, herbal therapy, bodywork, Reiki and medical Qigong. I am hereby informed that the aforementioned treatment methods are all generally safe but that there may be some side effects or risks, as follows:

- Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection.

- Potential risks of moxibustion include blistering, burns, and scarring.

- Common side effects of cupping and gua sha are temporary bruising and redness lasting up to 10 days.

- The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

- I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

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

- I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

- I understand that my practitioner will keep all of my records confidential.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, healthcare operations received, incurred, or carried out by my practitioner.

Name (printed): _____ Date: _____

Signature: _____

Healing Roots
Lydia Warren, LAc, MAcOM

NOTICE OF HIPAA PRIVACY POLICIES

This notice summarizes how health data about you may be used and shared and how you may access this data. We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if you would like to read the complete details.

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.

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 read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from Lydia Warren, LAc, of Healing Roots at any time.

Name (printed): _____ Date: _____

Signature: _____