NEW PATIENT INTAKE FORM

Today's Date:

Name_____ Cell Phone_____

Address_____e-mail:_____

City, State, Zip_____

Home Phone_____ Work Phone _____Occupation_____

Marital Status_____ Birthdate _____ Age_____ M____F____Ht_____Wt_____

Emergency Contact: Name & Phone_____

Referred by_____

Have you had acupuncture before? Yes_____No_____ Chinese herbal medicine? Yes_____No_____

Reason for visit today_____

How long have you had this condition?_____

Is it getting worse?_____ Does it bother your: Sleep_____ Work_____Other (what)?_____

What seemed to be the initial cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Are you under the care of a physician now? Yes_____No_____ If yes, for what?_____

Who is your physician?_____Physician's Phone_____

Other Concurrent therapies_____

FAMILY MEDICAL HISTORY

☐ Allergies:	☐ Arteriosclerosis	☐ Cancer	☐ Chemical Dependency	☐ High Blood Pressure
_____	☐ Asthma	What kind? _____	☐ Diabetes	☐ Seizures
_____	☐ Alcoholism	_____	☐ Heart Disease	☐ Stroke

YOUR PAST MEDICAL HISTORY

(Check any of the following conditions you currently have, or have had in the past. Please also check if any of the following are a significant part of your medical history.)

☐ Addiction_____	☐ Chronic Fatigue Syndrome	☐ Liver Disease	☐ Psychiatric Care	☐ Tuberculosis
☐ AIDs/HIV	☐ Diabetes	☐ Measles	☐ Rheumatic Fever	☐ Typhoid Fever
☐ Alcoholism	☐ Emphysema	☐ Migraine Headaches	☐ Seizures	☐ Ulcers
☐ Allergies	☐ Epilepsy	☐ Mononucleosis	☐ Stroke	☐ Venereal Disease
☐ Aneurysm	☐ Epstein Barr Virus	☐ Multiple Sclerosis	☐ Surgery (list)	☐ Vaginal Infections
☐ Appendicitis	☐ Fibromyalgia	☐ Mumps	_____	☐ Whooping Cough
☐ Arteriosclerosis	☐ Gout	☐ Pacemaker	_____	☐ Other (specify)
☐ Arthritis	☐ Heart Disease	☐ Pleurisy	_____	_____
☐ Asthma	☐ Hepatitis	☐ Pneumonia	☐ Thyroid Disorders	_____
☐ Birth Trauma	☐ Herpes	☐ Polio	☐ Major Trauma	_____
(Your own birth)	☐ High Blood Pressure	☐ Prostate Problem	(Car, fall, etc—list)	
☐ Cancer	☐ High Cholesterol	☐ Scarlet fever	_____	
☐ Chicken Pox	☐ Kidney Disease		_____	
			_____	

YOUR DIET

☐ Appetite ☐ Low	☐ Soft Drinks	☐ Artificial Sweetener	☐ Sugar	Thirst for water:
☐ High	☐ Prefer hot food/drinks	☐ Cravings:	☐ Salty Food	# Glasses per day:_____
☐ Coffee	☐ Prefer cold food/drinks	_____		

AVERAGE DAILY MENU

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATIONS TAKEN IN LAST 2 MONTHS_____

_____

VITAMINS/SUPPLEMENTS TAKEN IN LAST 2 MONTHS_____

_____

YOUR LIFESTYLE

☐ Alcohol	☐ Drugs	☐ Occupational hazards	☐ Regular exercise	
☐ Tobacco	☐ Stress at home	☐ Hobbies/Recreation?_____	Type _____	Frequency_____
☐ Marijuana	☐ Stress at work	_____	Type_____	Frequency_____

GENERAL SYMPTOMS

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands or feet	☐ Night sweats	☐ Peculiar taste (describe)
☐ Strongly like cold drinks	☐ Dream-disturbed sleep	☐ Poor circulation	☐ Sweat easily	_____
☐ Strongly like hot drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps	_____
☐ Recent weight loss/gain	☐ Lack of strength	☐ Fever	☐ Vertigo or dizziness	

HEAD, EYES, EARS, NOSE, THROAT

☐ Glasses	☐ Night blindness	☐ Sores on lips or tongue	☐ Recurrent sore throat	☐ Headaches
☐ Eye strain	☐ Glaucoma	☐ Dry mouth	☐ Swollen glands	☐ Migraines
☐ Eye pain	☐ Cataracts	☐ Excessive saliva	☐ Lumps in throat	☐ Concussions
☐ Red eyes	☐ Teeth problems	☐ Sinus problems	☐ Enlarged thyroid	☐ Other head or neck problems
☐ Itchy eyes	☐ Grinding teeth	☐ Excessive phlegm	☐ Nose bleeds	_____
☐ Spots in eyes	☐ TMJ	Color of phlegm	☐ Ringing in ears	_____
☐ Poor vision	☐ Facial pain	_____	☐ Poor hearing	_____
☐ Blurred vision	☐ Gum problems		☐ Earaches	

RESPIRATORY

☐ Difficulty breathing when lying down	☐ Tight chest	☐ Cough:	☐ Color of phlegm	☐ Coughing blood
	☐ Asthma/wheezing	☐ Wet ☐ dry	_____	☐ Pneumonia
☐ Shortness of breath	☐ Bronchitis		☐ Thick ☐ thin?	

CARDIOVASCULAR

☐ High blood pressure	☐ Chest pain	☐ Fainting	☐ Irregular heartbeat	☐ Swelling of ankles
☐ Low blood pressure	☐ Difficulty breathing	☐ Heart palpitations	☐ Phlebitis	☐ Varicose veins
☐ Blood clots	☐ Congestive heart failure	☐ Tachycardia		

GASTROINTESTINAL

☐ Nausea	☐ Bad breath	☐ Mucous in stools	☐ Rectal pain	
☐ Vomiting	☐ Diarrhea	☐ Excessive hunger	☐ Hemorrhoid	
☐ Acid regurgitation	☐ Constipation	☐ Excessive thirst	☐ Bowel movements:	
☐ Gas	☐ Laxative use	☐ Intestinal pain or cramping	Frequency_____	Texture/form_____
☐ Hiccup	☐ Black stools	☐ Burning anus		
☐ Bloating	☐ Bloody stools	☐ Itching anus	Color_____	Odor_____

MUSCULOSKELETAL

☐ Neck/shoulder pain	☐ Upper back pain	☐ Limited range of motion	☐ Pain moves around or is intermittent	☐ Other (describe)
☐ Muscle pain	☐ Low back pain	☐ Limited use		_____
☐ Joint pain	☐ Rib pain			

SKIN AND HAIR

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/skin texture	☐ Other hair or skin problems
☐ Hives	☐ Psoriasis	☐ Itching	☐ Fungal infections	_____
☐ Ulcerations	☐ Acne	☐ Hair loss		_____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Poor memory	☐ Irritability	☐ Considered/attempted Suicide	☐ Blackouts
☐ Numbness	☐ Depression	☐ Easily stressed		☐ Other (specify)
☐ Tics	☐ Anxiety	☐ Abused survivor	☐ Seeing a therapist	_____

GENITO-URINARY

☐ Pain on urination	☐ Blood in urine	☐ Venereal disease	☐ Increased libido	☐ Painful intercourse
☐ Frequent urination	☐ Unable to hold urine	☐ Bedwetting	☐ Decreased libido	☐ Impotence
☐ Urgent urination	☐ Incomplete urination	☐ Wake to urinate	☐ Kidney stone	☐ Premature ejaculation
				☐ Nocturnal emission

GYNECOLOGY

Are you pregnant now?_____	Color of flow_____	PMS SYMPTOMS:		☐ Infertility
Age menses began_____	Consistency:	☐ Cramps	☐ Fatigue	# Pregnancies_____
Age at menopause_____	☐ Heavy ☐ light ☐ clots	☐ Bloating	☐ Mood swings	# Live Births_____
Cycle length (day 1 to day 1)	☐ Vaginal discharge	☐ Gas	☐ Irritability	Date of last PAP_____
_____	(color)_____	☐ Breast tenderness	☐ Food cravings	Date of last mammogram_____
Duration of flow_____days	☐ Odor ☐ Itch	☐ Headache/migraine	☐ Other_____	_____
☐ Irregular periods	☐ Vaginal dryness			Date last period began_____
Amount of flow:	☐ Vaginal sores			_____
☐ Heavy ☐ moderate ☐ light	☐ Breast lumps			

Other _____

_____

_____

_____

_____

Nancy A. Barnett, L.Ac.
36 Malaga Cove Plaza, Suite 203
Palos Verdes Estates, CA 90274
Phone 310-791-2624 *Fax 310-791-2626*

Dear Patients,

I request two simple but very important things of you to help with the running of a smooth and efficient front office.

1. *Except in the case of an emergency, I ask that you give at least a 24 hours notice of cancellation to avoid being charged for a missed appointment. Late arrivals of 20 minutes or more will also be billed at the current clinic rate whether or not you receive a treatment.*

2. *I ask that you pay for your visit at the time services are rendered. I will gladly provide you with a super bill to bill your own insurance. I unfortunately am not set up or have the staff to provide insurance billing services.*

Thank you for your understanding and cooperation.
Please sign below in acknowledgement of the above requests.

_____ _____
Signature *Date*

Sincerely,
Nancy A. Barnett, L.Ac.

NANCY A. BARNETT, L.Ac.
36 Malaga Cove Plaza, Suite 203
Palos Verdes Estates, CA 90274

NOTICE OF PRIVACY PRACTICES

(We have always kept your health information confidential. A new law requires us to give you this notice)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer or from credit card companies. For example, your health plan may request and receive information on dates of services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of the office Nancy A. Barnett, L.Ac. For example, information on the services you received may be used to support billing and financial reporting and activities to evaluate and promote quality. Our business associates, such as a billing service, are also required to protect your privacy. We may send you newsletters or other information. We may call and remind you about appointments and if you are not at home, we may leave information on your answering machine or with the person who answers the telephone. In an emergency, we may also disclose your health information to a family member or another person responsible for your care.

Law enforcement. Your health information may be disclosed when required by law, without your permission, to facilitate law-enforcement investigations and to comply with government mandated reporting and audits.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Except as described as above, this practice will not use or disclose you health information without your specific prior written authorization.

You have the right to request an amendment or change. Your request must be in writing. However, your decision to revoke the authorization will not affect or undo any use or disclosure that occurred before you notified us of your decision. You have the right to receive confidential communications concerning your medical condition and treatment.

You have the right to see and copy your protected health information, with few exceptions. Give us a written request and reasonable time regarding the information you require. Files will be mailed or faxed for you if transferred to another practice.

You have the right to know of any uses or disclosures of your health information beyond the above normal uses.

You have the right to receive a copy of this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. You will be provided with a revised notice on your next office visit. If you have a comment or complaint, submit it in writing to Nancy A. Barnett, L.Ac. (at our office address above). You may also contact the Department of Health and Human Services, 200 Independence Ave, SE, Rm509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

This notice in effect as of April 14, 2003

Acknowledgement: I have received a copy of the Notice of Privacy Practices

Date_____Signed X_____Print Name_____

If signing as a parent or guardian, please note the name of the patient_____