HEALTH INTAKE FORM

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All answers are confidential.

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Is it ok to contact you via email? Yes: _____ No:_____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Gender: _____ Marital Status: _____ Occupation: _____

Referred By: _____ Emergency contact & phone#_____

Primary Care Physician: _____ Phone #: _____

Are you currently/within the last year been under the care of your Primary Care Dr.?_____

What conditions? _____

Describe your main concerns (Symptoms, onset, diagnoses, duration, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What makes your condition better? (rest, movement, heat, cold, fresh air, eating, crying, etc.)_____

_____

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.) _____

_____

Any other related symptoms or other areas of tension? (headache, insomnia, nausea, etc.) _____

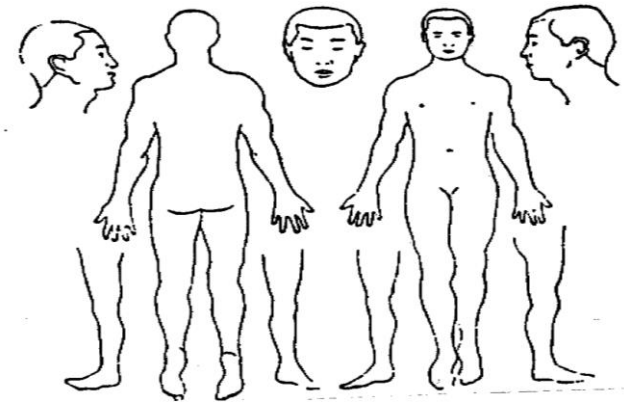
_____

Trauma (emotional, physical), Surgeries, accidents, injuries, chronic illness: (please include date).

_____

Union Center For Healing Integral PLLC Confidential

Please indicate where your symptoms are occurring & indicate any pain, tenderness, burning, numbness, tingling, stiffness, swelling, bruising, open wounds, scars, etc.



Allergies/Intolerances: (Nuts, oils, food, chemical, environmental, drugs, etc.)_____

_____

Medications: (names & dosages) Please attach an additional page if necessary._____

_____

Vitamins/Supplements/Herbs: _____

_____

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks Caffeinated Drinks Alcohol/week

	A lot	Some	A little	None
Veggies/fruit	☐	☐	☐	☐
Meat/seafood	☐	☐	☐	☐
Eggs/nuts/beans	☐	☐	☐	☐
Dairy	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐
White flour carbs	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Fried foods	☐	☐	☐	☐

Personal History Please check any conditions you have now or have had in the past.

☐ **Arthritis**	☐ **Liver/Gall Bladder Disease**	☐ **Stroke**	☐ **Heart Disease**
☐ **High/Low Blood Pressure**	☐ **Hypo/Hyperglycemia**	☐ **Kidney Disease**	☐ **Bleeding Disorder**
☐ **Cancer**	☐ **Diabetes**	☐ **Allergies**	☐ **Diverticulitis/IBS**
☐ **Ulcer**	☐ **Seizures/Epilepsy**	☐ **Hepatitis**	☐ **Raynaud's Disease**
☐ **Chronic Fatigue**	☐ **Anemia**	☐ **Thyroid Disorder**	☐ **Multiple Sclerosis**
☐ **Alcoholism**	☐ **Pregnancy**	☐ **Chronic Pain Condition**	☐ **Whooping Cough/TB**
☐ **Gastritis/Pancreatitis**	☐ **Asthma**	☐ **Infertility**	☐ **Emphysema**

Family Medical History F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather)

☐ **Diabetes ___**	☐ **Seizures ___**	☐ **Heart Disease ___**	☐ **Stroke ___**
☐ **High Blood Pressure __**	☐ **Allergies ___**	☐ **Cancer ___**	☐ **Asthma ___**

Please take your time and **check** if you have had any of these items listed below in the last **year** or you feel they are a significant part of your medical history.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Prefer Hot or Cold drink
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems
- ☐ Cold hands and feet

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing
- ☐ Weak or ridged nails

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Dry mouth
- ☐ Migraines
- ☐ Poor night vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks/TMJ
- ☐ Excess saliva
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches
- ☐ Head other_____

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Bronchitis
- ☐ Difficult inhale/exhale
- ☐ Difficulty breathing when lying down
- ☐ Excess Production of phlegm…Color_____

Gastrointestinal

Frequency of Bowel Movements_____

- ☐ Loose stools (>2 per day) ☐ Dry ☐ Soft ☐ Mucous ☐ Incomplete ☐ Undigested Food
- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating
- ☐ Changes in appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite ☐ Excessive

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Night urination… What time?_____ How often?_____
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections
- ☐ Excessive libido

Gynecological/Reproductive

- ☐ Difficult/Painful intercourse
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Age of first menses_____
- ☐ Date of last menses_____
- ☐ Date of last PAP/Pelvic_____

☐**Vaginal discharge** ☐**Fibrocystic breast tissue** ☐**Number of pregnancies____**
☐**Infertility** ☐**Polycystic Ovarian Disease** ☐**Number of ectopic pregnancies_____**
☐**Irregular menstruation** ☐**PMS** ☐**Number of live births_____**
☐**Painful menstruation** ☐**Number of miscarriages_____**
Do you practice birth control?_____ ☐**Number of abortions_____**
What type?_____ How long?_____

Musculoskeletal

☐**Neck pain** ☐**Shoulder pain** ☐**Hand/wrist pain** ☐**Carpal Tunnel**
☐**Knee pain** ☐**Sprains/Strains** ☐**Sciatica** ☐**Foot/ankle pain**
☐**Hip pain** ☐**Muscle pain** ☐**Muscle weakness** ☐**Tendonitis**
☐**Back pain Low___ Middle___ Upper___** ☐**Bursitis** ☐**Rotator Cuff**

Neuropsychological

☐**Seizures** ☐**Loss of balance** ☐**Vertigo/Dizziness** ☐**Areas of numbness**
☐**Anxiety/Panic attacks** ☐**Bad temper** ☐**Easily susceptible to stress** ☐**Seasonal Affective Disorder**
☐**Nervousness** ☐**ADD/ADHD** ☐**Manic Depression** ☐**Irritable**
☐**Numbness** ☐**Tics**
Have you ever been treated for emotional problems? _____, Substance Abuse? _____, Suicide? _____

Patient Notification of Qualifications, Scope of Practice & Treatment Consent Form

WA state law requires the East Asian medicine practitioners to inform the public of the practitioners' scope of practice and qualifications. (18.06.130 RCW) The practitioner must give it to each patient in writing prior to or at the time of the initial patient visit. (246-803-300 WAC).

Our **qualifications** include the following education and license information:
Roxane Geller: 2001, EAMP, Bastyr University. License: AC 1869
Victoria Summerquist: 2001, EAMP, Bastyr University. License: AC 0798
Kate Chilson: 2003, EAMP Northwest Institute of Oriental Medicine. License: AC 2310
Samara White, EAMP, Seattle Institute of Oriental Medicine License AC 60503724

The **scope of practice** for an East Asian medicine practitioner in the state of Washington includes the following: (a) Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; (b) of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; (c) Moxibustion; (d) Acupressure; (e) Cupping; (f) Dermal friction technique; (g) Infra-red; (h) Sonopuncture; i) Laserpuncture; j) Point injection therapy (aquapuncture); and (k) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; (l) Breathing, relaxation, and East Asian exercise techniques; (m) Qi gong; (n) East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and (o) Superficial heat and cold therapies.

The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder, is pregnant, or has a pace maker prior to any treatment.

Potential risks include, but not limited to, temporary pain, bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include broken needle, dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising, redness, or blistering, lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully

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

I will notify the acupuncturist should I become **pregnant** or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. _____**(initial)**

Printed Name_____Signature _____ Date_____
(Of patient, parent or representative)

HIPAA Privacy Practices Acknowledgement Form

Due to new HIPAA compliance statutes, we as a healthcare provider are required to provide you with a Notice of Privacy Practices that describes your rights as a patient and must document that every patient or client has read and received it. The form is found on our website and is available at our center for you to read and take home with you.

By Signing below, I acknowledge the receipt of the Notice of Privacy Practices at Union Center For Healing Integral, PLLC.

Printed Name_____Signature _____ Date_____
(Of patient, parent or representative)

Communication Consent

We are required (UCFH and the individual provider) to have your consent to communicate via Email, Fullslate (online scheduling) and Text. At this time the emails, text and Fullslate are not encrypted. We are able to communicate with you by each of these forms but need your consent to do so. If you have sensitive health care information you wish to share through email, contact your provider first so we can send an encrypted message.

I consent to communicate by email, text, and Fullslate: Yes _____ No _____

Late Cancellation & Missed Appointment Agreement

Please provide 24 hours advance notice of any changes or cancellations.
Appointments that are missed/rescheduled/cancelled with less than 24 hours notice will be billed $40.

Signature: _____ Date:_____

Insurance Information

Coverage is not guaranteed and needs to be verified with your health plan. Although acupuncture is generally a covered service, it is only covered for certain conditions. Most plans require a prescription for massage.

Name _____ Date of birth _____
Employer _____ Single ____ Married ____

PRIMARY INSURANCE: Insurance Name: _____
Subscriber ID #(**include letters**) _____ Group # _____
Relationship to insured: Self _____ Spouse/DP _____ Child _____ Other_____

PLEASE FILL OUT INFORMATION BELOW IF YOU DID NOT CHECK SELF:
Name on plan if not self _____ Date of Birth _____
Address (if other than yours) _____
Employer _____ Phone # _____

If your primary insurance does not cover acupuncture or massage but you have secondary insurance that does. We will be glad to provide you with a superbill for you to submit for reimbursement from your insurance company.

MOTOR VEHICLE (PIP) OR L & I:
Claim #_____ Company Name _____
Billing Address: _____
Contact Name _____ Phone number_____
Date of Injury _____ Name of insured _____
Attorney Name, Address and Phone _____
_____

PLEASE READ AND SIGN:
In the event that my insurance coverage expires or denies payment, I understand that I am personally, fully responsible for all fees incurred. I agree to release any medical information my insurance company, adjustor, or the attorney involved in my case may need in order to process payment. I assign some benefits to be paid to the above named provider.

Signature _____ Date _____

Insurance and Payment Information - FOR YOU TO KEEP, PLEASE READ

We want you to experience your time here with minimal effort. The following information will help you become familiar with the insurance process, including billing, copays, contracted rates and statements from Union Center for Healing and Nightingale Billing Service.

If you have any questions about your statements please contact Nightingale Billing at alan@nightingalebilling.com or call 206-508-0330.

YOUR PART:

- Confirm that your insurance covers Acupuncture or Massage, and if you need to obtain any physician referral or prescription prior to your first appointment. An insurance benefit verification form is provided on our website for your convenience.
- Confirm that your insurance plan covers the condition(s) or diagnosis for which you would like to be seen; most plans only cover certain conditions.
- Confirm the number of appointments your insurance plan allows. Keep track of this number.
- Please know the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay. Our office does not guarantee that your insurance will pay.

MASSAGE: Prescriptions are needed for massage prior to the first date of service. Insurance will not cover visits without a prescription. **The following information is required on the prescription:** Start and end dates, diagnoses, number of visits, provider or clinic name, and your provider's name. Please note that most plans only cover specific pain related conditions. Find out what is covered under your plan to be sure the condition you want treated is covered.

CO-PAYS: If you have a co-pay (indicated on your card) you can pay it at the time of your appointment or every 2-4 appointments. We accept Cash, Check and Credit Cards. Any co-pays not collected at the time of service will be billed to the address you provide.

BILLING: We use a third party biller, **Nightingale Billing**, to process claims and payments. Claims are sent to your insurance company every week and are usually processed by the insurance company within 9-30 days. Since we are contracted with your plan, we agree to be paid the contracted rate, which is a set amount. Your financial obligation is the copay, or co-insurance (a percentage), or deductible. If you are paying towards your deductible, you are only responsible for the contracted rate. **Codes billed:** There are only a few codes that we use for acupuncture. On your first visit you will see a first office visit code (99201-99203) and the standard two codes used for a typical acupuncture treatment, 97810/97811 or 97813/97814. On some return visits you may see 99212 which indicates a new condition or further evaluation. Massage is coded 97124 or 97140.

STATEMENTS: Statements are mailed monthly every 4 weeks for balances due. These balances include deductibles, copays, co-insurances, or any balances unpaid by the insurance. The statements will only include balances due once the insurance has been processed.

PAYMENTS: You may pay your balance with cash, check or credit card. You can mail it, bring it in with you to your next appointment, or pay through Paypal on our website. Nightingale can provide you with a receipt summary of your visits for you FSA plan.

Patient Handout to Keep-Your First Visit

Your first visit will last approximately 90-120 minutes. We will discuss, in detail, your concerns and goals great and small. Since Chinese medicine is a holistic practice, we will ask about the well-being of the different parts of you. After we discuss your concerns, we will feel your pulse, look at your tongue, and perhaps palpate on your abdomen. The pulse, in Chinese medicine, helps tell us about the energy flow in your body. If you are coming in for a pain condition, we may do a little massage, cupping, or moxibustion, in addition to the acupuncture.

Please be sure that you are not hungry when you come in. Try to eat 1-2 hours before receiving acupuncture. If you can, wear loose, comfortable clothing.

All return visits last 50-60 minutes. We will check in to see how you are doing and then you will receive a treatment.

If you have any questions or concerns please just let us know. Acupuncture is generally very relaxing and gives you a feeling a calm. Enjoy!

What Is Acupuncture?

Chinese medicine is an ancient healing art that has been practiced in China for over 2,500 years. Chinese medicine includes acupuncture, moxibustion, Chinese herbal therapy, dietary recommendations, tui-na (massage), cupping, and lifestyle counseling. Acupuncture is the insertion of fine needles into an acupuncture point along an energetic pathway on the body. The function of acupuncture is to regulate and balance the flow of vital energy (Qi) and blood in the body to harmonize the physical, emotional, mental and spiritual health of an individual.

A practitioner of Chinese medicine diagnoses by examining the relative harmony within the body, mind and spirit. Diagnosis is made by examining how the organs are working on its own and relative to one another. Chinese medicine has evolved from its inception thousands of years ago prior to the modern invention of microscopes and the discovery of cells or the understanding of anatomical structure and physiological processes. Its theories are based on observations in nature and the cycles of life. The practitioner discusses signs and symptoms with the patient, areas of excess and deficiency in the organ system, looks for areas of heat and cold, and evaluates the body fluids.

In modern terms, acupuncture has been shown to stimulate our body's own healing system. Many modern health concerns such as chronic pain, chronic immune dysfunction, endocrine dysfunction and pain may be caused by the breakdown of the body's ability to function. This may happen through poor lifestyle choices, environmental factors, stress, and infection. Acupuncture has been shown to stimulate the body's own healing system to help fight the imbalance. For example, acupuncture stimulates the nervous system which in turn stimulates areas of the brain, spinal cord and muscles to mitigate the pain pathway, the release of hormones or other chemicals in the body to promote healing and balance.

The World Health Organization recognizes over 40 conditions where acupuncture is considered an appropriate treatment. Chinese medicine can strengthen the immune system, increase circulation, regulate hormones, increase energy and reduce stress.

<u>Components of Chinese medicine</u>

-Treating the body, mind and spirit as one, treating the whole individual.
-Treating the root cause of the disease to stimulate the body's own natural healing systems.
-Promoting the maximum potential for health and well-being of the individual through lifestyle counseling and planning.

<u>Training and Licensure</u>

Acupuncturists in California have been licensed since 1976. Standards of practice are governed by the NCCAOM. In Washington State, practitioners earn a Master's degree with over 3,000 hours of training.