344 40th St, Oakland, CA 94609 • 510-923-0178
www.paeoniaintegrativemedicine.com

New Patient Intake Form

Date:_________

Name____ Date of Birth___/___/___ Age______

Address____ Gender_______________

Contact Phone______________________________________ Email _______________________

Emergency Contact________________________________ Phone________________________

Occupation_______________________ Hrs Per Week______

How or from whom did you hear about Paeonia Integrative Medicine?___________________

Primary Care Physician or other practitioner_________________________ Phone #__________

Please us about the top 2 health concerns for which you are seeking treatment.:

1. ____

When did this start?___________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp Weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

How is this affecting your daily life?____

2. ____

When did this start?___________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp Weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

How is this affecting your daily life?____

Physical Activity:

How many days per week do you exercise?_________ What types of exercise do you do?______

____

Please list all medications, including herbs and vitamins you are presently taking including dosage, or therapies you are presently undergoing:

____

____

Please list all past serious illnesses, injuries, and operations w/date of occurrence:

____

____

Circle conditions you have now or have had in the past:

(Mark "N" for Now, or "P" for Past " or F" for Family)

Anemia	Pacemaker	Cancer
Arthritis	Stroke	Hepatitis B or C
Cancer	High Cholesterol	High Blood Pressure
Diabetes I or II	Thyroid Disorder	Low Blood Pressure
Autoimmune Disorder	Enlarged Liver	Mononucleosis
Seizures	Enlarged Lymph Nodes	HIV / AIDS
Bleeding Disorder	Epilepsy	

Check if you have experienced any of the following conditions:

(Please note the organ systems listed pertain to Chinese Medical Diagnosis and **NOT** organ Western Pathology)

TCM Liver/Gall Bladder

- ☐ Chronic Pain (where?)
- ☐ Headaches
- ☐ Red, Dry or Itchy Eyes
- ☐ Blurred Vision
- ☐ Dizziness
- ☐ "Lump in Throat" Feeling
- ☐ Teeth Clenching
- ☐ Muscle Cramping
- ☐ Tendonitis
- ☐ Neck/Shoulder Tightness
- ☐ Frustration
- ☐ Pain/Tightness Below Ribcage
- ☐ Seizures/Tremors
- ☐ Gallstones
- ☐ Brittle Nails
- ☐ Dry Skin
- ☐ Bitter Taste in Mouth
- ☐ Frequently Indecisive
- ☐ Mood Swings
- ☐ Depression

TCM Spleen/Stomach

- ☐ Hard to get up in AM
- ☐ Edema
- ☐ Sleepy/Bloated After Meals
- ☐ Gain Weight Easily
- ☐ Bruise Easily
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Light Headedness/Dizzy Spells
- ☐ Abdominal Pain
- ☐ Chronic Loose Stools
- ☐ Foggy Thinking
- ☐ Anemia
- ☐ Worry
- ☐ Always Thirsty/Never Thirsty

TCM Heart/Small Intestine

- ☐ Heart Palpitations
- ☐ "Tight Chest" Feeling
- ☐ Chest Pain
- ☐ Cold Hands
- ☐ Easily Startled
- ☐ HBP / LBP (circle one)
- ☐ Anxiety
- ☐ Restlessness
- ☐ Vivid Dreams/Nightmares
- ☐ Dark Urine
- ☐ Chronic Flushed Cheeks
- ☐ Mouth Ulcers

TCM Lung/Large Intestine

- ☐ Dermatitis/Rash
- ☐ Eczema/Psoriasis
- ☐ Seasonal Allergies
- ☐ Asthma
- ☐ Cold/Flu Often
- ☐ Chronic Sinus Infections
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Bronchitis
- ☐ Grief
- ☐ Chest Congestion
- ☐ Chronic Cough
- ☐ Dry Cough
- ☐ Dry Throat/Nose/Eyes
- ☐ Itchy or Sore Throat
- ☐ Shortness of Breath
- ☐ Sweat Easily/Excessively

TCM Urinary Bladder/Kidney

- ☐ Frequent Urinary Tract Infections
- ☐ Lower Back Pain
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ Osteoporosis
- ☐ Hypo or Hyper Thyroid (circle)
- ☐ Cold Feet
- ☐ Poor Memory
- ☐ Hair/Teeth Loss
- ☐ Hearing Issues/Tinnitus
- ☐ Incontinence
- ☐ Fear
- ☐ Sore/Achy Knees

Energy: High Low Up/Down **Sex Drive**: High Low Up/Down

Body Temperature

☐Cold Hands/Feet ☐Hot ☐Sweat Day/Night ☐Other____________________

Bowel Movements: _____x/day ☐ Formed ☐Hard ☐Constipation ☐Loose ☐Diarrhea ☐ Mucus or Blood Other Descriptor__________

Urination: _____x/day _____x/night Odor__________ Color__________

Sleep

How would you describe your sleep?_____________________________

☐ Difficulty Falling Sleep ☐Wake at night ____x/per night?

Please describe your general diet:

Breakfast: ____

Lunch: ____

Dinner:____

Snacks: ____

Drinks: ____

Women's Health:

Are you pregnant / could you potentially be pregnant? ☐ No ☐ Yes
How far along are you? ____________________
Are you past menopause? ☐ No ☐ Yes Since what age?______
Are you currently experiencing any troubling menopausal symptoms? ____________________
____

Date of your last period: _____________________
Length of your menstrual cycle? ____days Length of your menses itself?______days
☐ Irregular Periods ☐No Periods, how long? __________

Do you ever experience any of the following before/during/after your period:
☐ Irritability ☐ Clotting ☐ Low Back Pain ☐ Breast tenderness ☐ Constipation
☐ Diarrhea ☐ Cramping If so circle when in your cycle: Before / During / After
☐ Other Symptoms ____

Quality of menses: ☐ bright ☐ dark ☐pink ☐watery ☐ brown
☐ Heavy Flow ☐ Light Flow ☐Other Descriptor ____________________

Men's Health

Hernias	☐Y	☐N	☐Past
Testicular Pain	☐Y	☐N	☐Past
Lumps or testicular swelling	☐Y	☐N	☐Past
Difficulty or loss of erection	☐Y	☐N	☐Past
Nocturnal emissions	☐Y	☐N	☐Past
Prostate Disease	☐Y	☐N	☐Past
Infertility	☐Y	☐N	☐Past

Other____

Financial Agreement

Fees for Services:

Semi Private Treatment
First Visit: $25 Initial Paperwork Fee + $45 Treatment = $70
Return Visit: $45

Private Treatment
First Visit: $125
Return Visit: $85

Herbal Consult
$25, 15 minutes

All Herbal Medicines are charged separately.

Payment Method:

Payment is due at time of service.
We accept cash, check, and credit/debit card.

Cancellation and Lateness Policy:

Your appointment is reserved exclusively for you. If you are unable to keep your appointment for any reason, we ask that you call the clinic at least **24 hours in advance** to cancel or reschedule the appointment. Otherwise you will be charged full price for the missed appointment. If you are **10 or more minutes late**, your appointment will be cancelled and you will be charged full price for the reserved appointment time.

Patient Acknowledgement:

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I understand the contents of this disclosure and agree to abide by these policies.

Patient Signature: ___________________________Date: _________

Informed Consent

I hereby request and consent to the performance of acupuncture treatments 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 Amanda Seaman, who is a Licensed Acupuncturist in the state of California, and/or other licensed acupuncturists who now or in the future treat me while employed by, working for, associated with, or serving as back-up for Amanda Seaman, L.Ac, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. 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 Amanda Seaman, L.Ac. uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 immediately notify Amanda Seaman, L.Ac. of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify Amanda Seaman, L.Ac. who is caring for me if I am or become pregnant.

Amanda Seaman, L.Ac. does not provide Western medical care, and asks that you see your medical doctor for routine check-ups. If you are pregnant, have a pacemaker, high blood pressure, have a bleeding disorder, local infection, or if you have been prescribed anticoagulant medications such as Coumadin, she can still treat you but needs to be informed of your condition. I have informed Amanda Seaman, L.Ac. of such conditions above and voluntarily consent to the above procedures.

I do not expect Amanda Seaman, L.Ac. to anticipate and explain all risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment which she 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 office's medical and administrative staff may review my medical 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, this 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's Name (PLEASE PRINT)____________________________________

Patient's Signature______________________________ Date Signed__________

Name of Legal Guardian (PLEASE PRINT) ____________________________________

Signature ____

Notice of HIPAA Privacy Policy

This Notice describes how health information about you may be used, and your rights regarding the use of that information. Please read this summary and the full Notice carefully.

Paeonia Integrative Medicine understands that information about you and your health is personal. We are committed to protecting your health information.

You have the right to:

- Ask to see, read, and/or obtain a copy of your health record (charges may be necessary)
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared wtih certain individuals.
- Ask that your health information not be used for certain purposes: for example, research.
- Ask that Paeonia Integrative Medicine send copies of your health records to whomever you wish (charges may be necessary).
- Be informed about who has read your record.
- Specify where and how Paeonia Integrative Medicine employees may contact you.
- Receive a paper copy of the full Notice of Privacy Practices.

Who is authorized to see confidential Patient Health Information (PHI) at Paeonia Integrative Medicine?
The Acupuncturist may access the entire medical record. The "Notice of Privacy Practices" describes the ways in which we may use patient health informtaion without obtaining patient's specific authorization. Certain uses such as for Treatment, Payment, and health care operations are permitted:
1. Treatment of patient, including appointment reminders.
2. Payment of health care bills.
3. Healthcare operations and business operations, including teaching and medical staff quality activities, research (when approved by the IRB and with the patient's written permission); health care communications between patient and their health care practitioner.

Written Authorization
To use or disclose patient health information for almost any other reason, you will need to sign a written authorization prior to access of disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization required related to public policy, certain health disease reporting requirements and lay enforcement activities. (Available as of April 14, 2003 at http://www.ucsf.edu/hipaa .)

Exceptions to the Rules
Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement and based on judicial request or subpoena.

If you believe your privacy rights have NOT been maintained you may file a complaint with: US Dept. of Health and Human Services, Office of Civil Rights, ATTN: Regional Manager, 50

United Nations Plaza, Rm322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

- I acknowledge receipt of the "Notice of Practices and Patient's Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full notice.
- I understand and acknowledge that it is the practice of Paeonia Integrative Medicine to send reminder emails the day before treatment, and I agree to receive these emails.

Please Print Name: ________________________________

Signature: ______________________________________ Date: ________

Patient declined to sign receipt (staff signature): _______________________________