This is an extensive intake form with many questions to answer that may or may not pertain to your health and what you may be experiencing. These questions help put together a picture of your current health and may help in finding undiagnosed conditions as well as connections between ailments. Please only answer what you feel comfortable answering and mark off questions you'd rather talk about in person. If there is something you'd like to address but don't yet feel comfortable addressing, let me know when you are comfortable doing so. Please take your time filling out this form.

Today's Date: _____/_____/_____

Name:_____ Preferred to be called:_____

Preferred Pronouns:_____ Sex: born as M F identify as:_____

Birth Date:_____/_____/_____ Address:_____

Email:_____ Phone: (H)_____ (C) _____

May I contact you regarding scheduling via (check all that apply) ( ) phone ( ) voicemail ( ) text message ( ) email

Would you like to receive emails regarding upcoming events and promotions? ( ) Yes ( ) No

Emergency contact name:_____ Relation:_____

Phone:_____ Address:_____

Are you (circle one): Married Single Partnered Divorced Other:_____

Do you feel safe in your current living situation? ( ) Yes ( ) No

Do you have a primary care physician? ( ) Yes ( ) No Physician Name:_____

Are you receiving care from other healthcare providers regarding your health for any reason? If yes, please provide your provider's name and reason for receiving care with them:_____

_____

_____

Please list past major surgeries, illnesses, injuries, and hospitalizations and the dates as best you can remember them:

_____

_____

_____

Have you experienced any of the following in the past or are you experiencing any now (please check all that apply):

□ Cancer	□ Diabetes	□ Hepatitis	□ High blood pressure	□ Heart disease
□ Seizures	□ Rheumatic fever	□ Venereal disease	□ Thyroid disease	□ Birth trauma
□ Asthma	□ Stroke	□ HIV/AIDS	□ Vein condition	□ Migraines
□ Bleeding tendency	□ Nervous disorder	□ Mononucleosis	□ Low immunity	

□ History of significant antibiotic use:_____

Are you currently taking any prescriptions or over the counter supplements/medications? Please list type and dosage:

_____

_____

_____

Significant family health history (cancer, diabetes, stroke, heart conditions, etc.) or anything you want me to know regarding your family that may be relevant to your health:_____

_____

_____

Please check the following that pertain to you:

Heart Energy:

- □ Palpitations
- □ "Anxiety"
- □ Sores on tongue
- □ Restlessness
- □ Mental confusion
- □ Chest pain
- □ Frequent dreams
- □ Wake unrefreshed

Spleen Energy:

- □ Low appetite
- □ Abdominal bloating
- □ Gas
- □ Crave sweets/carbohydrates
- □ Fatigue after eating
- □ Easily bruised
- □ Hemorrhoids
- □ Pensive
- □ Over-thinking
- □ Worry
- □ Gurgling noise in stomach
- □ Prolapsed organs (Previously diagnosed; which organ?_____)
- □ Abrupt weight gain/loss (Which?_____)

Stomach Energy:

- □ Burning sensation after eating
- □ Large appetite
- □ Bad breath
- □ Mouth sores
- □ Bleeding, swollen or painful gums
- □ Heartburn
- □ Acid regurgitation
- □ Ulcer (diagnosed)
- □ Belching
- □ Hiccoughs
- □ Stomach pain
- □ Vomiting

Dampness:

- □ Heavy sensation in body
- □ Mental sluggishness
- □ Mental fogginess
- □ Swollen hands
- □ Swollen feet
- □ Puffiness in face
- □ Other edema
- □ Chest congestion
- □ Nausea
- □ Snoring

Lung Energy:

- □ Nasal discharge
- □ Cough
- □ Nose bleeds
- □ Sinus congestion
- □ Allergies (To what?_____)
- □ Dry mouth
- □ Dry throat
- □ Dry nose
- □ Dry skin
- □ Alternating chills and fever
- □ Sneezing
- □ Sore throat
- □ Sadness
- □ Smoke cigarettes (# of cigs per day_____)
- □ Melancholy

Liver/Gallbladder Energy:

- □ Alternating diarrhea & constipation
- □ Tight sensation in chest
- □ Bitter taste in mouth
- □ Anger easily
- □ Frustration/Irritability
- □ Depression
- □ Skin rashes
- □ Temple/eye headache
- □ Tingling sensation
- □ Numbness
- □ Muscle spasms
- □ Seizures: type_____
- □ Convulsions
- □ Lump in throat
- □ Neck/shoulder tension
- □ Recreational drugs
- □ High-pitched ringing in ears
- □ Gallstones (history or current)
- □ Muscle twitching or cramps (which?_____)
- □ Drink alcohol (how much?_____)
- □ Sexually transmitted disease (Which?_____)
- □ Trouble adapting to stress (causes of stress? _____)

Kidney/Bladder Energy:

- □ Easily broken bones
- □ Sore knees
- □ Weak knees
- □ Low back pain
- □ Tooth problems (what kind?_____)
- □ Memory problems
- □ Excessive hair loss
- □ Low-pitched ringing in ears
- □ Kidney stones
- □ Fear
- □ Easily startled
- □ Osteoporosis/osteopenia (diagnosed)

Other symptoms:

Anatomically Female:
Age of 1st menstruation:_____
Age of menopause:_____
□Hysterectomy: □ Full □ Partial

Do you experience any of the following before, during or after your period?:

Nausea	□ Before	□ During	□ After
Vomiting	□ Before	□ During	□ After
Light-headedness	□ Before	□ During	□ After
Headaches	□ Before	□ During	□ After
Migraines	□ Before	□ During	□ After
"Anxiety"	□ Before	□ During	□ After
"Depression"	□ Before	□ During	□ After
Irritability	□ Before	□ During	□ After
Weepiness	□ Before	□ During	□ After
Food cravings	□ Before	□ During	□ After

For what:_____
Breast swelling/tender □ Before □ During □ After
Water retention □ Before □ During □ After
Pain □ Before □ During □ After
What type: (dull, sharp)_____
Other:

Anatomically Male:
□ Swollen testes
□ Testicular pain
□ Impotence
□ Premature ejaculation
□ Feeling of coldness or numbness in external genitalia
Other:

Please indicate the healthcare concerns you would like to address today and how long they have been of concern (choose the two most pressing):_____

_____

_____

_____

Have you received a diagnosis for these concerns by your primary care physician? ( ) Yes ( ) No. If yes, please explain:_____

_____

What other treatments have you previously received to address these concerns?_____

_____

How do these concerns impact your life? Do they prevent you from doing the things you need and want to do?_____

_____

_____

What is your goal regarding these concerns?_____

_____

_____

How willing are you to make changes to meet these goals? Very willing, I will do whatever it takes ( ). Willing, I have already tried so many things ( ). Somewhat willing, I don't know what I can do ( ). I don't think there is anything I can do ( ). Other:_____

_____

_____

What role do you see your other healthcare providers playing in helping you reach your goals?_____

_____

_____

Are you interested in me collaborating with your other healthcare providers to integrate your care? ( ) Yes ( ) No

Provider Contact Info:_____

_____

What are some things you do to relax and take time for yourself: _____

_____

_____

Thank you for your time and thorough intake form.

Kind regards,
Laura Parkinson

Signed:_____

Printed:_____

Date:_____/_____/_____

Informed Consent to Treat

By signing this form, you agree that you have the right to have your questions answered regarding treatment and you understand the potential risks of these treatments. By signing this you also give consent for Laura Parkinson LAc to treat you as an acupuncturist and not as a primary care provider. I will outline a few of the risks below:

Acupuncture: Acupuncture involves the insertion of small, stainless steel single use needles. Side effects and risks are few and rare: pain or bruising at the site of needling, initial worsening of symptoms, fatigue, needle shock and pneumothorax. All licensed acupuncturists are trained to avoid these side effects. Please let me know if you have any concerns.

Moxibustion: "Moxa" for short, is a heat therapy that involves burning materials on or over the skin. Risks include a potential for burn, or an allergy to the smoke.

Gua Sha and Cupping: These are vigorous massage methods that can intentionally cause bruising. Areas that have been treated should be covered after treatment for 24 hours, and bruises should heal within about a week.

Electro Acupuncture: A mild electrical current is applied to the needles in order to continuously stimulate the acupuncture needle to produce greater desired effect. Some patients may feel a mild tingling sensation. The risks include a mild electrical shock or irritation to the needle site which can be easily avoided by proper application as I am trained to do so.

Tuina: A form of Chinese bodywork that addresses musculoskeletal issues among other issues in the body through massage, acupuncture and is used to correct things like hip joint subluxation, acute lumbar sprain, and works great for pediatric care with the ability to treat without using needles.

Shiatsu: A form of massage where the application of finger pressure is used on the meridians of the body to produce harmony, balance and relieve pain while the patient is fully clothed. It involves hara diagnosis which is abdominal palpation used as a diagnostic technique.

Herbal medicine, supplements and dietary suggestions: Chinese herbal medicine and supplementation is a prescription service. As with any prescription, it should not be shared. Because the prescribing is highly specific to you and your health concern at the time of prescribing, it may not even help someone with seemingly the same condition. It is also important that you take your herbs and supplements as prescribed. Taking more, less, or at non-prescribed times can cause unwanted effects. Side effects may include nausea, the potential for vomiting, and other digestive upset. If this occurs, try taking your herbs or supplements with food. If it still occurs, please stop taking your prescription and contact me as soon as possible 515-868-1212.

I will also notify my practitioner if I become pregnant or if I am in the process of becoming pregnant so that my practitioner can avoid specific acupuncture points, herbs and other afore mentioned modalities that may induce miscarriage. Otherwise, Chinese medicine can be beneficial during pregnancy and even during the birthing process.

Signed:_____

Printed:_____

Date:_____/_____/_____

HIPAA (Health Insurance Portability and Accountability Act)

Notice of Privacy Policies

_ You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

_ You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

_ You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

_ You have a right to receive an accounting of disclosures of your protected health information made by Total Family Wellness

_ You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

_ Please note that this office submits insurance claims via electronic media and fax machine. If you are not comfortable with this, please notify us and we will use alternate methods.

Changes to this Notice of Privacy Practices

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints

Complaints about your privacy rights, or how Total Family Wellness has handled your health information should be directed to Laura Galligan by calling this office at 515-868-1212. If Laura Parkinson not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Avenue,

S.W. Room 509F HHH Building Washington, DC 20201

FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY, PLEASE VISIT:

www.hcfa.gov/medicaid/hipaa NOTICE OF PRIVACY

PRACTICES

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

Total Family Wellness is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Communication

We may communicate the following information through one or more of these methods:

- In person
- By phone
- By Fax
- By US mail
- By Email

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. “It is our policy to provide a substitute health care provider, authorized by Total Family Wellness to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment: If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Workers' Compensation: If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners

Organ Donation & Research: Though highly unlikely or probable we must inform you that there may a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing & Other Communication: We may contact you for marketing purposes or fundraising purposes, as described below:

We may contact you through our email marketing or by mail to provide you with information about upcoming events including classes, fundraisers, and parties as well as provide you with general health & wellness information.

If you have questions, complaints or want more information, please contact Laura Parkinson LAc at 515-868-1212

Signed:_____

Printed:_____

Date:_____/_____/_____

Financial and Cancellation Policy

All payments are due at the time of service, unless prior arrangements have been made.

At this time, I do not bill to insurance companies. However, I can print a superbill for you to submit to your insurance company for reimbursement but I cannot guarantee repayment. Not billing insurance allows me to offer group acupuncture as well as more financial options.

Cancellations: Please provide me with 24 hour notice by either phone: 515-868-1212or email: laura@iowatotalfamilywellness.com when cancelling or rescheduling your appointment. If you do not, you may be charged up to the full amount of your missed appointment. If you have an emergency, please let me know.

I understand the above policy.

Signed:_____

Printed:_____

Date:_____/_____/_____

Medication & Supplement List

Patient name:_____DOB:_____/_____/_____

Date	Medication/Supplement	Dosage	Start Date	Stop Date	Initials