Richard W. DeTroye, L.Ac. 200 NE 20th Avenue, Suite 140 Portland, OR 97232 phone: 503-484-3513 fax: 503-239-1167

New Client Intake: Personal Information

Today's Date:_____/_____/_____

Last Name:_____First Name:_____MI:_____

Age:_____Date of Birth:_____/_____/_____Ht.:_____Wt.:_____Gender: ☐Female ☐Male

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email:_____
Can I add you to my email list for periodic updates & newsletters? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Partner ☐Separated ☐Divorced ☐Widowed

Employer:_____Occupation:_____

Emergency
Contact:_____Relationship:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Referred by:_____

New Client Intake: Personal Health History

What is the main reason you came in today?_____

How long have you had this condition?_____

Please list any prior treatments you have received for this condition:_____

_____

Does anything make this condition improve?_____

Does anything make this condition worse?_____

In general, is the condition: ☐Getting better ☐Getting worse ☐Constant ☐Comes & Goes

Please list any childhood illnesses, injuries, surgeries or traumas you have had with their

dates:_____

_____

_____

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Patient Name:_____DOB:_____

Please list any complications/problems that occurred during your birth:_____

_____

Please list any vaccinations you have received and any complications that developed as a result:

_____

_____

Please list any adulthood illnesses, injuries, surgeries or traumas you have had with their dates:_____

_____

_____

Please list the location(s) of any scars due to surgeries or injuries:_____

_____

Please list any medications you are currently taking with their dosages:_____

_____

_____

Please list any herbs or supplements you are currently taking with their dosages:_____

_____

Describe your intake/use of the following:

Alcohol_____ Coffee_____ Sweets_____

Tobacco_____ Recreational Drugs_____

Please list all major illnesses in your family members (parents, grandparents, siblings):_____

_____

_____

_____

_____

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Patient Name:_____DOB:_____

In the following sections, please check the appropriate box for each condition you currently have or have had in the past:

Psychological/Emotional

☐Mood swings	☐Anxiety	☐Easily angered	☐Personality disorder
☐Mental tension	☐Depression	☐Poor memory	☐Bi-polar disorder
☐Worry	☐Seasonal depression	☐ADD/ADHD	☐Suicidal thoughts
☐Fear	☐Frequent crying	☐Anorexia	☐Attempted suicide
☐Nervousness	☐Irritability	☐Bulimia	

Digestion

☐Abdominal pain	☐Heartburn/reflux	☐Bitter taste in mouth	☐Food allergies
☐Gas	☐Mouth sores	☐Gallbladder disease	☐Weight changes
☐Bloating	☐Nausea	☐Gallstones	☐Abdominal hernia
☐Bad breath	☐Vomiting	☐Gallbladder removed	☐Hiatal hernia
☐Hiccups	☐Belching	☐Liver disease	

Appetite: ☐Good ☐Excess ☐Poor ☐Changes

Thirst: ☐Always thirsty ☐Never thirsty ☐Never noticed

Do you prefer your water/drinks: ☐Cold ☐Hot ☐Room temp

How many glasses of water do you drink per day?_____

What do you tend to drink? ☐Water ☐Tea ☐Coffee ☐Milk ☐Diet Pop ☐Regular Pop

☐Alcohol ☐Other:_____

Bowels

☐Diarrhea	☐Loose stools	☐Constipation	☐Hemorrhoids
☐Mucous in stools	☐Blood in stools	☐Undigested food in stools	

How often do you have a bowel movement?_____

Do you use laxatives? ☐No ☐Yes - How often & what?_____

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Sleep

Do you sleep well at night? ☐No ☐Yes - Hours of sleep per night:_____

Do you take sleep aids? ☐No ☐Yes - How often & what?_____

☐Can't fall asleep ☐Night sweats ☐Wake rested ☐Nightmares

☐Waking at night ☐Sleep apnea ☐Wake exhausted ☐Vivid dreams

☐Waking hot at night ☐Restless leg ☐Snoring

Immunity

☐Fatigue ☐Thyroid issues ☐HIV/AIDS ☐Other STD

☐Muscular weakness ☐Body feels heavy ☐Herpes ☐Rheumatoid Arthritis

☐Joint inflammation

Cancer? ☐No ☐Yes – Type:_____

Other Autoimmune Disease? ☐No ☐Yes – Type:_____

Respiratory

☐Pneumonia ☐Frequent colds/flu ☐Tuberculosis ☐Bronchitis

☐Asthma ☐Persistent cough ☐Emphysema ☐Pleurisy

☐Allergies

Head, Eye, Ear, Nose & Throat

☐Headaches ☐Migraines ☐Concussion ☐Facial pain

☐Impaired vision ☐Eye pain/strain ☐Glasses/contacts ☐Cataracts

☐Tearing ☐Eye dryness ☐Bloodshot eyes ☐Glaucoma

☐Blurred vision ☐Floaters ☐Itchy eyes ☐Night blindness

☐Hearing loss ☐Ringing in ears ☐Ear ache/pain

☐Sinus problems ☐Runny nose ☐Nasal congestion ☐Nose bleeds

☐TMD/jaw pain ☐Teeth grinding ☐Tooth disease ☐Gum disease

☐Dry mouth ☐Excess saliva ☐Swollen glands ☐Chronic sore throat

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Cardiovascular

☐Heart disease	☐Heart murmur	☐Blood disorder	☐Anemia
☐Bleed easily	☐Chest pain/pressure	☐Irregular heartbeat	☐Bruise easily
☐High blood pressure	☐Varicose/spider veins	☐Stroke	☐Palpitations at rest
☐Low blood pressure	☐Fainting	☐Pacemaker	☐Phlebitis
☐Blood clots	☐Swollen ankles/feet	☐Cold hands/feet	

Neurological

☐Vertigo/dizziness	☐Loss of balance	☐Numbness/tingling	☐Paralysis
☐Tremors	☐Seizures/epilepsy	☐MS	☐Parkinson's Disease

Endocrine

☐Hyperthyroid	☐Hypothyroid	☐Hypoglycemia	☐Diabetes

Musculoskeletal

☐Neck pain	☐Shoulder pain	☐Arm pain	☐Wrist/hand pain
☐Leg pain	☐Knee pain	☐Ankle/foot pain	☐Upper back pain
☐Mid-back pain	☐Low back pain	☐Muscle spasms/cramps	

Urinary

☐Kidney disease	☐Kidney stones	☐Urinary infections	☐Painful urination
☐Urgent urination	☐Incontinence	☐Difficulty urinating	☐Burning urination
☐Blood in urine	☐Stream starts & stops	☐Urinary discharge	☐Dribbling
☐Scanty flow	☐Copious flow	☐Frequent urination	

☐Night urination – How often?_____What time?_____

Male Reproductive

☐Enlarged prostate	☐Erectile dysfunction	☐Genital pain	☐Testicular swelling
☐Testicular pain	☐Penile discharge	☐Premature ejaculation	☐Difficulty ejaculating
☐Painful intercourse	☐Increased sex drive	☐Decreased sex drive	

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Female Reproductive

☐Breast lumps	☐Breast tenderness	☐Nipple discharge	☐Vaginal discharge
☐Irregular periods	☐Painful periods	☐Heavy bleeding	☐PMS
☐Difficulty conceiving	☐Vaginal dryness	☐Hot flashes	☐Night sweats
☐Day sweats	☐Painful intercourse	☐Increased sex drive	☐Decreased sex drive
☐Fibroids	☐Ovarian cysts	☐Endometriosis	☐Polycystic ovaries
☐Infertility	☐Bleeding between periods		

Are you currently pregnant? ☐Yes - How many weeks?_____
☐No
☐Maybe - Please explain:_____

Birth control? ☐Yes ☐No Type:_____How long?_____

Date of Last Pap/pelvic exam:_____Results:_____

Age at first menses:_____Date of last menses:_____

Length of menses:_____Length of monthly cycle: _____

Number of pregnancies:_____Number of births:_____

Number of miscarriages:_____Number of abortions:_____

Number of ectopic pregnancies:_____

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Patient Name:_____DOB:_____

Consent for Treatment

1. Acupuncture and Oriental medicine procedures are considered safe and effective methods of care.
2. Acupuncture involves the insertion of fine, solid, stainless steel needles under the skin.
3. All needles used in my practice have been sterilized at the factory before packaging.
4. All needles used in my practice are disposable and are used for one treatment only.
5. In some cases, treatment by acupuncture may cause a worsening of symptoms. This generally lasts only 24-48 hours after treatment.
6. Occasionally, acupuncture may cause dizziness, lightheadedness or fainting during a treatment. I will make every effort to prevent this from occurring and to guarantee the comfort of a patient if it does. **These instances can be avoided by eating a light snack before each treatment.**
7. Some mild complications may arise with the use of Chinese herbal formulas, and herbal products. These possible side effects will be discussed in the event that herbal treatment is recommended for your condition.
8. While the chances of experiencing complications are limited, it is my policy to inform patients about them. Additional information about side effects and complications is available upon request.
9. On occasion, I will suggest the use of additional modalities for treatment. These may include gua sha, cupping, Tui Na, Microcurrent Positional Tui Na (MPT) and moxibustion. I will explain the benefits of these techniques and discuss any side effects of their use with you. You have the option of accepting or refusing treatment using any of these methods.

I have read and understand the above statements regarding treatment and possible side effects. I understand that there is no guarantee or assurance for a specific cure or result. I give my permission for treatment.

Patient Signature:_____Date:_____

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Patient Name:_____DOB:_____

Payment For Treatment

1. Appointment times are reserved exclusively for each patient. A 24-hour notice is required for cancellations. **In the event of a same day cancellation or a missed appointment, the full treatment fee will be assessed to the client.**
2. Payment by cash, check or credit card is due at the time of each visit unless other arrangements have been made prior to treatment (i.e., insurance).
3. A minimum $20.00 service fee will be charged for all returned checks.
4. Arrangements for insurance billing can be made for patients whose health insurance provides for adequate acupuncture coverage.
5. All insurance copays are due at the time of each visit.
6. Patients are responsible for payment for any items (i.e., herbs, liniments, supplements) that their insurance plan does not cover.
7. In the event that payments or portions of payments are denied by the patient's insurer, the patient assumes full responsibility for the payment of their account balance.
8. The right to waive any of the above fees or policies is reserved on a patient by patient basis.

I have read and understand the above information, and agree to abide by these policies.

Patient signature:_____Date:_____

To be signed by clients with insurance benefits only:
I authorize payment of all applicable insurance and medical benefits to Richard W. DeTroye, L.Ac. for all services provided by him, while I am in his care. I also authorize the release of any medical information required to process my insurance claims.

Patient signature:_____Date:_____

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Consent to Use or Disclose Clinical Information

I authorize Richard W. DeTroye, L.Ac. to use and disclose the health and clinical information

of_____for the purposes

of **Treatment, Payment and Health Care Operations**.*

Treatment includes activities performed by a practitioner, facility, program, nurse, office staff and other types of health care professional providing care to you, doordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any practitioner who covers my practice in person or by telephone as the on-call practitioner.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for clinical necessity, justification of charges, pre-certification and pre-authorization.

Health Care Operations includes the necessary administrative and business functions of my office.

You may review my "Notice of Privacy Practices Long Form" for additional information about the uses and disclosures of information described in this consent prior to signing this consent.

Because I have reserved the right to change privacy practices in accordance with the law, the terms contained in the Notice may also change. A summary of the Notice will be posted in the lobby of my office indicating the effective date of the Notice in the upper right hand corner of the then current Notice. I will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how I use and disclose your protected health information for treatment, payment and health care operations purposes. I am not required to agree to your request. If I do agree, I am required to comply with your request unless the information is needed to provide you with emergency treatment. Other practitioners/providers who provide call coverage for my office are required to use and disclose your protected health information consistent with the Notice.

Please verify that you have reviewed a copy of my "Notice of Privacy Practices Short Form" by placing your intitials here:_____.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Richard W. DeTroye, L.Ac. has already used or disclosed information in reliance on this Consent.

Patient Signature:_____Date:_____

OR

Adult Guardian Signature:_____Date:_____