Please thoroughly complete this intake form in ink. This form and your private health information are confidential, except as required by law or outlined in Privacy Practices. Ask if you have any questions!

Name_____ Sex M ___ F ___ Date _____

Address _____ City _____ State _____ Zip _____

Email _____ Date of Birth _____ Age _____ Height _____ Weight_____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Single _____ Married _____ Divorced _____ Widowed _____ Living with _____ Partnered_____

Emergency Name & Number _____Referred by _____

Main reason for treatment_____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What treatments/remedies have you tried? _____

What treatments/remedies are you currently using? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___Work ____ Other (explain) _____

Other concerns or goals: _____

_____

FAMILY HISTORY - Place an "X" in the appropriate box or boxes for any ailment ever experienced.

	Self	Mother	Father	Sibling	Children	Spouse
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Blood transfusion (if before 1985)						
Hepatitis or Liver disorders						
Kidney disorders						
Thyroid disorders						
Musculo-skeletal disorder						
Age of death	N/A					

PERSONAL LIFESTYLE HABITS

Tobacco (type & amount per day) _____ Caffeinated drinks (oz per day) _____

Recreational Drugs _____ Alcohol (type & # drinks per week) _____

Water (oz per day) _____ Anything else you consume regularly_____

Dietary restrictions _____Food cravings _____

What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What activities do you enjoy doing? (reading, TV, meditation, music, golf, etc.)

_____

MEDICINES:
Prescription & non-prescription drugs, supplements, herbs: Reason for use:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies : _____ _____

MAJOR HOSPITALIZATIONS: Include **all hospitalizations or emergency care for any medical illness or procedure**, except normal pregnancies. Include the insertion of any biomedical devices like pacemaker or artificial joints.

YEAR	PROCEDURE or REASON FOR CARE

Physician(s) Name & Address _____

Physician(s) Phone # _____Date of last physical examination:_____

Use additional paper to include ALL your medications (prescription and OTC), hospitalizations, major procedures, and ALL current providers.

General
Past Current
□ □ General weakness
□ □ Sudden energy drop
□ □ Overall Fatigue
□ □ Strongly like cold drinks
□ □ Strongly like hot drinks
□ □ Recent weight loss/gain
□ □ Cold hands or feet (circle)
□ □ Chills
□ □ Generally cold or hot (circle)

Part A
Past Current
□ □ Cough Wet or Dry (circle)
□ □ Phlegm
□ □ Difficulty breathing
□ □ Shortness of breath
□ □ Wheezing
□ □ Asthma (hard to breathe out)
□ □ Chronic cough
□ □ Nasal Congestion / Discharge
□ □ Cough up phlegm/blood
□ □ Shortness of breath
□ □ Hoarseness
□ □ Chest tightness
□ □ Pneumonia or Bronchitis
□ □ Hay fever or Allergies
□ □ Frequent sore throat or colds
□ □ Hives or Rashes
□ □ Eczema or Psoriasis
□ □ Sweating easily or excessive
□ □ Dry skin
□ □ Changes in moles, lumps
□ □ Itching
□ □ Loss of sense of smell

Part B
Past Current
□ □ High/Low blood pressure
□ □ Chest pain or tightness
□ □ Palpitations
□ □ Rapid heart beat
□ □ Irregular heart beat
□ □ Poor circulation
□ □ Heart attack
□ □ Heart murmur
□ □ Tongue / Mouth Sores
□ □ Shortness of breath
□ □ Jittery / Restless
□ □ Sense of impending doom
□ □ Hot palms / Hot feet
□ □ Night Sweats
□ □ Wake up startled
□ □ Can't fall asleep

Part C
Past Current
□ □ Nausea
□ □ Indigestion
□ □ Stomach pain
□ □ Diarrhea
□ □ Constipation
□ □ Poor appetite
□ □ Excessive hunger
□ □ Vomiting
□ □ Gas
□ □ Hiccups
□ □ Bloating / Belching
□ □ Laxative use
□ □ Blood / Mucus in stool
□ □ Hemorrhoids
□ □ Bad breath
□ □ Gums bleed easily
□ □ Fatigue after eating
□ □ Nosebleeds
□ □ Bruise easily
□ □ Sweet/sugar craving
□ □ Foggy thinking
□ □ Poor short/long term memory
□ □ Heavy limbs
□ □ Muscle weakness
□ □ Intolerant to damp/humidity

Part D
Past Current
□ □ Gall Bladder disorder
□ □ Glasses/ contact lenses
□ □ Blurred vision
□ □ Poor night vision
□ □ Spots / Floaters in eyes
□ □ Tired / Sore eyes
□ □ Frequent sighing
□ □ Depression
□ □ Pains increase with stress
□ □ Irritability / Frustration
□ □ Anger easily
□ □ Hiccups
□ □ Vertigo (spinning sensation)
□ □ Dizziness
□ □ Brittle nails
□ □ Twitches / Spasms
□ □ Muscle cramps
□ □ Muscle tightness
□ □ Body stiffness
□ □ Headaches #/wk_____
□ □ Migraines #/wk_____
□ □ High Blood Pressure
□ □ Numbness / Tingling
□ □ Pain/itching of genitalia
□ □ Blood clots

Part E
Past Current
□ □ Pain/burning on urination
□ □ Frequent or Urgent urination
□ □ Unable to hold urine
□ □ Incomplete urination
□ □ Bedwetting
□ □ Wake to urinate
□ □ Kidney stones
□ □ Kidney infections
□ □ High or low libido (circle)
□ □ Morning diarrhea
□ □ Asthma (hard to breathe in)
□ □ Low back pain
□ □ Knees Weak / Sore
□ □ Bone pain
□ □ Joint pain
□ □ Salt craving
□ □ Swelling in ankles/feet
□ □ Intolerant to cold/bone cold
□ □ High or low libido (circle)
□ □ Morning diarrhea
□ □ Asthma (hard to breathe in)
□ □ Ringing in ears
□ □ Hearing loss

Male
Past Current
□ □ Impotence
□ □ Premature ejaculation
□ □ Nocturnal emission
□ □ Lumps in testicles

Female
□ □ Irregularly timed periods
□ □ Heavy or light bleeding
□ □ Cramps
□ □ Endometriosis
□ □ Discharge
□ □ Breast tenderness
□ □ Pregnancy__# __# live births

Please list ANY symptom you regularly experience not otherwise noted:

_____

_____

_____

_____

_____

_____

_____

Notice of Privacy Practices Wells Acupuncture, LLC — Effective August 23, 2018

Dr. Kathryn Wells, Licensed Acupuncturist

As a healthcare professional I am required by law to maintain the privacy of your protected health information and the records I create documenting your treatment. The Health Insurance Portability and Accountability Act (HIPAA) also requires that I provide you a Notice of Privacy Practices and that you sign acknowledging receipt. I will provide notification within 60 days of any material changes to this policy.

I will use and disclose your Protected Health Information (PHI) only for purposes of treatment, payment, treatment scheduling, when required by law, and/or when responding to a subpoena or lawsuit. Office staff have access to your contact information, treatment schedule, and payment information however no authorized access to your treatment record. Furthermore, I, or office staff, may contact you for appointment reminders, appointment changes, and general office needs using the home/cell phone number, email address and/or mailing address you provide here:

_____

Email Address Number to Text

_____

Mailing Address Home Phone

- Upon written request, you have the right to review or obtain copy of your health record. A small administrative fee will be assessed to provide a copy of your record, which may take up to 21 business days to process.
- Upon written request, you have the right to request that I amend your Protected Health Information.
- Your Protected Health Information is kept confidential and not shared with anyone unless you sign a separate consent form. You have the right to rescind a release form at any time. I will notify you promptly if there is a breach that compromises your information.
- Upon written request, I will provide you a list of whom I've shared your information with.
- Upon written request, you have the right to impose additional restrictions on the use and disclosure of your Protected Health Information, including limiting the means by which I contact you. Please list any specific disclosure restrictions: _____

_____

If you have any questions about your rights or believe your privacy rights have been violated, please let me know. You also have the right to file a complaint with the U.S. Secretary of Health and Human Services (Office of Civil Rights: 1-800-368-1019) with no fear of retaliation.

By signing below I acknowledge I have received and understand this Notice of Privacy Practices.

_____ _____

Printed Patient Name (parent or guardian if client is a minor) Date

_____

Patient Signature (parent or guardian if client is a minor)