Patient Intake and Health History Form

Submit

Name: _____ Date: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

Age: _____ Height: _____ Weight: _____ Birthday: _____ Sex: ❑ Male ❑ Female Occupation: _____

Physician: _____ Referred by: _____ Emergency No.: _____

Main Problem: _____ Onset (When): _____

Other Concurrent Therapies: _____

Past Medical History (Include Dates)

Significant Illnesses: Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____
Hepatitis _____ Seizures _____ Rheumatic Fever _____ Thyroid Disease _____
Other (Please describe) _____

Surgeries: _____

Significant Trauma (Auto Accidents, Falls, etc.): _____

Birth History (Prolonged Labor, Forceps Delivery, etc.): _____

Allergies (Drugs, Chemicals, Foods, etc.): _____

Medicines taken within last two months (Include Vitamins, Over-the-counter Drugs, Herbs, etc.):

_____

Occupational Stresses (Chemical, Physical, Psychological, etc.): _____

Exercise: _____

Comments: _____

Habits

Cigarettes Coffee Tea Cola/Soda Alcohol Drugs Sugar Salt Other _____

Family Medical History

Diabetes Cancer High Blood Pressure Hearth Disease Stroke Seizures Asthma Allergies Alcoholism
Other _____

Notes _____

General

Poor Appetite Heavy Appetite Poor Sleep Heavy Sleep Insomnia Fatigue
Tremors Vertigo Cold Hands Cold Feet Cold Back Cold Abdomen
Fevers Chills Night Sweats Sweats Easily Localized Weakness Poor Coordination
Change in Appetite Sudden Energy Drop (note time of day) _____ Strong Thirst (Cold/Hot Drinks) _____
Bleed or Bruise Easily (note where) _____ Other _____

Skin and Hair

Rashes Ulcerations Hives Itching Eczema Pimples
Dandruff Loss of Hair Change in Hair/Skin Texture _____
Other Hair/Skin Problems _____

Head, Eyes, Ears, Nose, and Throat

Dizziness Concussions Eye Strain Eye Pain Cataracts Ear Aches
Ringing in Ears Poor Hearing Nose Bleeds Sinus Problems Mucus Dry Throat
Dry Mouth Teeth Problems Grinding Teeth Facial Pain Gum Problems Spots in Eyes
Recurrent Sore Throat (note number of times per month) _____ Other _____

Cardiovascular

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Irregular Heart Beat ☐ Dizziness
☐ Cold Hands ☐ Cold Feet ☐ Other _____

Respiratory

☐ Cough ☐ Coughing Blood ☐ Asthma ☐ Bronchitis ☐ Pneumonia
☐ Difficulty Breathing When Lying Down ☐ Production of Phlegm (describe) _____ (what color?) _____
☐ Other Lung Problems _____

Gastrointestinal

☐ Nausea ☐ Reflux ☐ Diarrhea ☐ Bowel Movement: _____ Frequency
☐ Gas ☐ Belching ☐ Bad Breath _____ Color
☐ Rectal Pain ☐ Hemorrhoids ☐ Constipation _____ Odor
☐ Bloody Stools ☐ Pain or Cramps ☐ Bloated after Eating _____ Texture/Form
☐ Laxatives Used (what type?) _____ (number of times per week?) _____

Genito-Urinary

☐ Pain on Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Urgency to Urinate ☐ Unable to hold Urine
☐ Kidney Stones ☐ Wake up to Urinate (number of times per night?) _____ (at what time(s)?) _____
☐ Other G-U Problems _____

Pregnancy and Gynecology

☐ Pregnancies (number) _____ ☐ Births (number) _____ ☐ Premature Births (number) _____ ☐ Miscarriages (number) _____
Period Duration _____ Flow (describe) _____ Age of first Menstruation _____
Last PAP _____ Last Menses _____
☐ Irregular Periods ☐ Clots ☐ Menopause ☐ Vaginal Discharge ☐ Vaginal Sores ☐ Breast Lumps
☐ Birth Control (type and duration) _____
☐ Changes in Body/Psyche prior to Menstruation _____

Musculoskeletal

☐ Neck Pain ☐ Osteoporosis ☐ Muscle Pain
☐ Back Pain (describe type/where) _____
☐ Joint Pain (describe type/where) _____
☐ Other Joint or Bone Problems _____

Neuropsychological

☐ Seizures ☐ Poor Memory ☐ Concussion ☐ Depression
☐ Anxiety/Panic Attacks ☐ Treated for Emotional Problems
☐ Other Neurological or Psychological Problems _____

Comments

_____

Acupuncture Informed Consent to Treat

By signing below, I do hereby request and voluntarily 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 the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as backup for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by licensed physicians recommended by this clinic's practitioners. I understand that methods of treatment may include, but are not limited to **Acupuncture**, **Moxibustion**, **Cupping**, **Electrical stimulation**, **Tui Na** (Chinese massage), **Chinese herbal medicine**, and **nutritional counseling**.

- **Acupuncture:** This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will occasionally leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or lightheadedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture, and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

- **Traditional Chinese Herbal Medicine Treatments:** Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

- **Heat treatments with Moxa or a TDP Lamp:** These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over warming, but the rare possibility of mild burns exists.

- **Cupping:** This technique involves a localized suction produced by heating a small glass cup. There is a possibility of a local non painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat. The skin marks from this procedure may take 3-7 days or longer to dissipate.

- **Gua Sha:** Gua Sha is light scraping on the skin in a small area using a smooth or edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

- **Electro-Acupuncture:** A mild electric microcurrent similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pacemaker or have any heart or neurological condition prior to having this treatment.

- **Acupressure and Massage:** Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage.

I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records 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, the above 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 or my present conditions for any future condition(s) for which I seek treatment. Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Licensed Acupuncturists are not primary care physicians. I have read and understand all of the above informaton and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

ACUPUNCTURIST: Melissa Kopple, L.Ac.

Patient's Signature: _____ **Date:** _____

Email this form to info@optimalha.com upon completion.

Patient Financial Responsibility Agreement

Optimal Health Acupuncture
6485 SW Borland Road, Suite G Tualatin, OR 97062
PH (541) 708-1803

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. Your insurance company may adjust payment rates and request refunds of claim payments. In the event this occurs the patient agrees to pay for the treatment with claim amounts to be determined by the fee schedule limits set by the State of Oregon.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Patient Name: _____ **Date:** _____

Patient Signature: _____

OHA HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for **Melissa Janette Kopple, M.S., L.Ac. Dipl. NCCAOM** to share the information listed in Section II of this document with her insurance billing agency and any other entities involved in the insurance billing process.

Section II – Health Information

I give the aforementioned healthcare provider permission to transmit health records electronically as-needed for the purpose of filing insurance claims, and understand that only as much information as is necessary will be sent, and that my information will only be transmitted over a secure network.

I understand that my private health information must be transmitted as described above in order to submit insurance claims. This information includes my name, address, sex, birthdate, policy details, and treatment data (including procedures used, diagnoses treated, and dates of service).

Section III – Duration of Authorization

This authorization to share my health information is valid until revoked. I understand that I may revoke this authorization via **any form of written communication**, including but not limited to email, text, or paper mail.

I understand that, if my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

Section IV – Signature

Signature: _____ **Date:** _____

Print Name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of Person Completing This Form: _____

Signature of Person Completing This Form: _____

Describe below how this person has legal authority to sign this form: