INITIAL HEALTH STATUS
Acupuncture

Patient Name____________________________Birthdate___________Primary Language_________________Sex M/F
Last First

Address__________________________City________________State________Zip__________Phone_______________

Email___________________________________SSN_______________________Driver's Lic. # _____________

Employer________________________________Occupation______________________Work Phone________________

Subscriber Name________________________Subscriber ID #___________________Group #___________________

Primary Health Plan____________________________Patient Member ID #___________________________________

Emergency Contact (Name/Phone) ____

Primary Care Physician/Phone ____

Are you under the care of a physician? ▫No ▫Yes, for what conditions? _________________________________

____

Please describe your current health problem(s)____

____

How and when it began____

____

What treatment have you received for the above condition(s)? ▫ Surgery ▫ Medications ▫ Physical Therapy

▫ Injections ▫ Chiropractic ▫ Massage ▫ Other ____

Describe your progress: ▫ Worse ▫ No Change ▫ 25% Better ▫ 50% Better ▫ 75% Better or ____________

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back,

Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other __________________________

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to Carry on activities**

How often are your symptoms present? ▫ Constantly ▫ Frequently ▫ Intermittently ▫ Occasionally

Describe your current health condition ▫ Excellent ▫ Very Good ▫ Good ▫ Fair ▫ Poor

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient Signature____ **Date**________________

Please check all of the following that apply to you:

- ▫ Alcohol/Drug Dependence
- ▫ Abnormal Menstruation
- ▫ Allergies
- ▫ Angina
- ▫ Arthritis/Rheumatoid Arthritis
- ▫ Artificial Joints
- ▫ Asthma
- ▫ Blood Disorder
- ▫ Breast Lumps
- ▫ Cancer/Tumor
- ▫ Convulsions/Seizures
- ▫ Diabetes
- ▫ Diarrhea/Constipation
- ▫ Excessive Thirst
- ▫ Fainting or Dizziness
- ▫ Fatigue
- ▫ Fever
- ▫ Frequent Urination
- ▫ Headache
- ▫ Heart Attack
- ▫ Heartburn or Indigestion
- ▫ High Blood Pressure
- ▫ Kidney Disease
- ▫ Liver Problems
- ▫ Osteoporosis
- ▫ Pacemaker
- ▫ Palpitation/Arrhythmia
- ▫ Peptic Ulcer
- ▫ Pregnant, # Weeks _______
- ▫ Prostate Problems
- ▫ Sinusitis
- ▫ Stroke
- ▫ Tobacco Use – Type _____________
  Frequency _____________/ Day
- ▫ Thyroid Disease
- ▫ Weight Gain / Loss (circle one)
- ▫ Hospitalizations/Surgeries__
  ____
  ____
- Other ___________________________
  ____
  ____

Family History: ▫ Cancer ▫ Diabetes ▫ Heart Problems/Stroke ▫ High Blood Pressure ▫ Rheumatoid Arthritis ▫ Other: _____________

Are you currently taking any medications? (If more space is needed, please continue on another piece of paper.)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

If you are new to this office, how did you hear about us?
□Newspaper or phone book □Friend/family (name): ____
□Insurance provider list □Other (specify): ____

If you were referred by a friend or family member, may we send them a thank you note? □Yes □No

Patient Signature____ **Date**_____________________

NOTICE OF PRIVACY PRACTICES

Patient Name: ____

TO THE PATIENT: This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Do research
- Discuss your case with family
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Reporting to law officials
- Court hearing and filings
- Reporting to worker's compensation
- Health and safety reasons
- Reporting victims of abuse

You have the right to:

- Request a copy of your health record
- Amend your protected health information
- Ask us to limit the information we share
- Request a list of persons with whom we share your health information
- Request confidential communications
- Advise our staff if you believe your privacy rights have been violated

These privacy practices are effective October 2014.

We may recommend you use, as a part of our treatment program, one or more nutritional supplements. We recommend this supplement or these supplements because we believe your health will benefit from your use of them. We want you to know that, because of our belief in the integrity and effectiveness of these supplements, we are a distributor of these products and, in that role, we may receive a commission from your purchase of these supplements. Please ask to speak with us if you have any concerns about our recommendations in light of this information. For further information please contact the front desk.

EMAIL AND SOCIAL MEDIA DISCLAIMER

Lifestyle Chiropractic & Wellness does not have an email address that is checked regularly and therefore will not be held liable for unanswered emails. For your protection, we also ask that you refrain from sending emails or posting information on social media containing personal health information as our health professionals will not respond.

RELEASE OF LIABILITY

Lifestyle Chiropractic & Wellness requests your permission to use you in any audio, video, and/or photography for the purposes of promoting Lifestyle Chiropractic & Wellness through any type of media including, but not restricted to websites, print, blogs, social networking, etc. This permission will be granted without restriction, and Lifestyle Chiropractic & Wellness will be held harmless from any claim, lawsuit, or further liability concerning the types of media mentioned above. Be assured, no personal health history or contact information will be divulged unless specifically authorized by you.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, DISCLAIMER AND RELEASE OF LIABILITY

You may refuse to sign this document.

I have read, or have had read to me, the above explanation. I have discussed it with the staff at *Lifestyle Chiropractic & Wellness* and have had my questions answered to my satisfaction. By signing this document, I grant the above mentioned permission to Lifestyle Chiropractic & Wellness. Having been informed, I hereby acknowledge my rights of privacy and understand this disclaimer.

I, ____, have received a copy of the notice of privacy practices of the above named office.

____ ___________________________

Patient's Signature (Guardian's Signature If Patient Is a Minor) **Date**

Lifestyle Chiropractic & Wellness
Restoring and Maintaining Optimal Health Naturally...

Phone: (951) 929-0100