

Date \_\_\_\_\_

# J. Douglas Weinstein, M.Ac, M.OM, L.OM

203 W. Caracas Avenue, Suite 203

Hershey, PA 17033

717-832-4111

## New Patient Intake Form

Name _____	Home Phone _____
Address _____	Cell Phone _____
City, State, Zip _____	Work Phone _____
Occupation _____	Email _____
Age _____ Birth Date ____/____/____	Sex _____ Height _____ Weight _____
Family Physician _____	Physician Phone _____
In Case of emergency notify: _____	Contact's Phone _____
Relationship _____	How did you hear of us? _____
May we send you an Acupuncture email newsletter with helpful information and tips ? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**I. Goals:** What would you like to address through treatment?

\_\_\_\_\_

\_\_\_\_\_

**II. Medications / Supplements / Vitamins** Please include *prescription medication, over-the-counter medications,* and any *supplements* that you take on a regular basis. Please include: **Name, Dosage, and Purpose.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**III. Lifestyle**

1. Hours a week that you work \_\_\_\_\_

2. How many Servings/Per Day do you consume of the following?  
Water \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Soft Drinks \_\_\_\_\_ Alcohol \_\_\_\_\_

3. Cigarettes (packs per day) \_\_\_\_\_

4. Do you have a known history of exposure to *toxic* substances? \_\_\_\_\_

5. Describe your current exercise regimen: Frequency per week \_\_\_\_\_ Activities \_\_\_\_\_

6. Sleep: how many hours of sleep on an average night \_\_\_\_\_

*Please circle Yes or No*

Do you wake feeling well-rested? [ Y / N ]      Do you have difficulty **falling** asleep? [ Y / N ]

Do you get up at night to urinate? [ Y / N ]      →      If yes, how often? \_\_\_\_\_

7. Food Intake: Describe your diet in general (i.e. vegetarian, meat, etc.) \_\_\_\_\_

How many meals a day do you usually eat? \_\_\_\_\_ Do you normally eat breakfast? \_\_\_\_\_

**IV. Medical History**

Last physical exam / date \_\_\_\_\_

List surgeries / dates \_\_\_\_\_

Significant accidents or traumas / dates \_\_\_\_\_

**V. Health: Check all that apply.**

**Please Note: Oriental Medicine treats the individual, not just the symptom. Your answers will greatly support me in assessing your diagnosis. Even if some questions do not seem to be directly related to your condition, they are still relevant to ascertaining the underlying patterns related to your condition. Therefore, please fill out the following pages as thoroughly as you can. If any question is too personal, please feel free to not answer it.**

**Medical History**

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

**Cardiovascular**

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Press.	<input type="checkbox"/>	<input type="checkbox"/>	Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Edema
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Press.	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Blackouts / fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood clot	<input type="checkbox"/>	<input type="checkbox"/>	Hot hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve issues	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Generally too hot
<input type="checkbox"/>	<input type="checkbox"/>	Rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Generally too cold
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	

**Gastrointestinal**

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movement feels incomplete
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea-constipation
<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Loose stools	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Belching / Gas	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea			
<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Constipation			
<input type="checkbox"/>	<input type="checkbox"/>	Stomach acidity	<input type="checkbox"/>	<input type="checkbox"/>	Freq. laxative use			

**Musculoskeletal**

Pain/discomfort, where? \_\_\_\_\_

(Please circle): Stiffness / Muscle weakness / Muscle spasms / Numbness

(Please circle): Is it helped by: Pressure / Heat / Cold / Other \_\_\_\_\_

(Please circle): Is it aggravated by: Pressure / Heat / Cold / Other \_\_\_\_\_

**Eyes**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Eyeglasses
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Floating spots
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	<input type="checkbox"/>	Watery eyes
<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyes

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light
<input type="checkbox"/>	<input type="checkbox"/>	Feeling of pressure behind eyes

**Skin and Hair**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Dry skin
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes, Hives
<input type="checkbox"/>	<input type="checkbox"/>	Ulceration or sores
<input type="checkbox"/>	<input type="checkbox"/>	Recent change in mole

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	Sweaty hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Weak/brittle nails
<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair

**Emotional**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety / fear
<input type="checkbox"/>	<input type="checkbox"/>	Sadness or grief
<input type="checkbox"/>	<input type="checkbox"/>	Anger
<input type="checkbox"/>	<input type="checkbox"/>	Frustration
<input type="checkbox"/>	<input type="checkbox"/>	Easily irritated

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Worry
<input type="checkbox"/>	<input type="checkbox"/>	Obsessiveness / compulsiveness
<input type="checkbox"/>	<input type="checkbox"/>	Indecisiveness
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty handling stress

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to repress emotions
<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Manic episodes
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal feelings
<input type="checkbox"/>	<input type="checkbox"/>	Frequent crying

**Respiratory**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cough dry/wet
<input type="checkbox"/>	<input type="checkbox"/>	Cough, chronic

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis, chronic
<input type="checkbox"/>	<input type="checkbox"/>	Phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Phlegm, with blood
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ deep breath
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath

**Ears, Nose, & Throat**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<b>HEAD:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, or loss of balance
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Seizures

<b>EARS:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections, freq
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing
<input type="checkbox"/>	<input type="checkbox"/>	Deafness

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<b>SINUS:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	Facial pain
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds
<input type="checkbox"/>	<input type="checkbox"/>	Runny nose
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<b>MOUTH:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Jaw tension, or clicking (TMJ)
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth
<input type="checkbox"/>	<input type="checkbox"/>	Gum problems
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	Sores
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Lump or pit in throat
<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes

**Pregnancy and Gynecology (Women only):**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>PREMENSTRUAL:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Cramping
<input type="checkbox"/>	<input type="checkbox"/>	Bloating
<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Emotional sensitivities
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness
<input type="checkbox"/>	<input type="checkbox"/>	Fluid retention
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea

<input type="checkbox"/>	<input type="checkbox"/>	<b>MENSTRUAL:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Cramping during period

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Clots
<input type="checkbox"/>	<input type="checkbox"/>	Light flow
<input type="checkbox"/>	<input type="checkbox"/>	Heavy flow
<input type="checkbox"/>	<input type="checkbox"/>	Light-colored
<input type="checkbox"/>	<input type="checkbox"/>	Dark-colored
<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	Low backache

<input type="checkbox"/>	<input type="checkbox"/>	<b>PREGNANCY:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Nursing
<input type="checkbox"/>	<input type="checkbox"/>	Difficult deliveries
<input type="checkbox"/>	<input type="checkbox"/>	Morning Sickness
<input type="checkbox"/>	<input type="checkbox"/>	Cannot maintain pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Infertility

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>GENERAL:</b>
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Missed periods
<input type="checkbox"/>	<input type="checkbox"/>	Spotting between periods
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts
<input type="checkbox"/>	<input type="checkbox"/>	Breast cysts or lumps
<input type="checkbox"/>	<input type="checkbox"/>	IUD
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control

**FERTILITY PATIENTS:**

Number of Pregnancies _____	Number of Births _____
Miscarriages _____	Premature Births _____
Abortions _____	Age of Children _____
Hysterectomy, reason for: _____	Oophorectomy, reason for: _____
Age at first menses: _____	Age when menses stopped: _____
Starting date of last menses (when started bleeding = Day 1): _____	

**Urinary and Genital**

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Scanty urine
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Strong-smelling
<input type="checkbox"/>	<input type="checkbox"/>	Cloudy urine
<input type="checkbox"/>	<input type="checkbox"/>	Pain or burning
<input type="checkbox"/>	<input type="checkbox"/>	Dribbling
<input type="checkbox"/>	<input type="checkbox"/>	Unable to hold
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Urgency to urinate
<input type="checkbox"/>	<input type="checkbox"/>	Low sexual energy
<input type="checkbox"/>	<input type="checkbox"/>	Excessive sexual energy
<input type="checkbox"/>	<input type="checkbox"/>	Pain during intercourse

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Inability to maintain erection
<input type="checkbox"/>	<input type="checkbox"/>	Low sperm count
<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Sores on genitals
<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones

**Cancellation Policy:**

Our office **requires 24-hour Notice of Cancelled or Rescheduled appointments.** Please note that because I have a waiting list and time slots are very tightly scheduled, a missed appointment is both a loss to me and another person that might have been treated during that time slot. For this reason our office charges a "Late-Cancel Fee" or "No-Show Fee" of \$35 that will be due at your next office visit.

**Except for cases of extreme emergencies, you will be charged (\$35) for the session that you missed.** Please sign and date the form below, to indicate your understanding of this agreement.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

# HIPPA Compliance

## **Policy and Legal Guidelines**

The Health Insurance Portability and Accountability Act (HIPPA) was first introduced in 1996, and became effective April 23, 2003. The purpose of HIPPA is to protect your Private Health Information (PHI). Advancements in technology have made PHI more accessible than ever before. It is our goal to protect your PHI while providing you with the best healthcare possible. We will use internet, fax, phone, texting, and copiers to supply and retrieve information regarding insurance and health related issues. Communication between other facilities and health care providers may be necessary in order to care for you, our patient. All outside facilities with which we communicate are also required to be HIPPA compliant. PHI may be used without patient authorization in order to provide treatment and collect reimbursement.

### **When is PHI used?**

Education: We pride ourselves on delivering the highest standards of care and will continue to pursue educational opportunities. PHI will be used to train staff, interns, and associates using the minimal amount of information necessary. Identifying information will not be used or taken outside the office unless prior written authorization is received from the patient.

Phone Communications: Basic messages will be left using a minimal amount of information with other household members, office staff, and on answering machines in accordance with the phone numbers that we have on file. Our office calls include, but are not limited to: Confirming, scheduling, and rescheduling appointments; Verifying and requesting additional information to provide treatment and/or collect reimbursement.

Communication and Family/Caregivers: At our own discretion, decisions are made to give information about patient to family members and caregivers when deemed necessary for proper treatment.

### **Government Responsibilities and Legal Obligations**

PHI may be used for licensing, certifications, audits, and credentialing. A certain amount of information must be used to qualify participation in insurance programs and maintain valid contracts with legal entities. Agencies reviewing the information must also be HIPPA compliant. Governmental requirements to report abuse, neglect, violence, crime, public health issues and needs involving national security will be honored. Our office will use ethical judgment in reports given to the legal authorities using the minimum amount of PHI required by law.

### **Patient's Rights**

Requests to restrict guidelines for an individual must be made in writing. Reasonable restriction of PHI will be honored as long as information is not essential for patient care or financial reimbursement. We will amend incorrect PHI if deemed inaccurate and correct records created within our office. Patients have the right to review records, attain completed test results, access billing history, and validate insurance information. A fee may be assessed for copies and transfer of records. Patients may deny communication between our office and family members or request confidential information be sent through sealed communication only.

### **Grievance Policy**

Written disputes concerning HIPPA guidelines will be handled by office personnel. Following a written dispute regarding HIPPA, we have 30 days to address the situation. After 30 days, you may contact the Secretary of Health and Human Services for further assistance.

### **Commitment to our Patients**

We reserve the right to change our office policies without notice. Our office and its employees are happy to help with any questions or concerns you may have regarding our office policies.

I have read and agree with the HIPPA Policy and Guidelines.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date