Date________

Live Well Medicine, LLC

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 ____________Insurance____________

In Case of emergency notify: ______________________ Contact's Phone ____________Relationship__________

Please circle how you heard of us: Facebook Ad / Web Search / Road Sign / Patient Referral / Other____________________

May we send you an Acupuncture email newsletter with helpful information and tips ? ☐ Yes ☐ 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 have difficulty **falling** asleep? [Y / N]

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

____

Allergy to Food or Medications:____

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.

Medical History

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
☐	☐	Diabetes	☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Heart Disease	☐	☐	Epilepsy	☐	☐	Hepatitis A/B/C
☐	☐	Pacemaker	☐	☐	Sudden weight loss	☐	☐	HIV/AIDS
☐	☐	Bleeding disorder	☐	☐	Thyroid disease	☐	☐	Other __________

Cardiovascular

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

Gastrointestinal

Past	*Current*	*Condition*	*Past*	*Current*	*Condition*	*Past*	*Current*	*Condition*
☐	☐	Poor appetite	☐	☐	Ulcer	☐	☐	Bowel movement feels incomplete
☐	☐	Excessive appetite	☐	☐	Hiatal hernia			
☐	☐	Bloating	☐	☐	Nausea/Vomiting	☐	☐	Alternating diarrhea-constipation
☐	☐	Indigestion	☐	☐	Loose stools			
☐	☐	Belching / Gas	☐	☐	Diarrhea			
☐	☐	Reflux	☐	☐	Constipation	☐	☐	Hemorrhoids
☐	☐	Stomach acidity	☐	☐	Freq. laxative use	☐	☐	Blood in stool

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

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
☐	☐	Glaucoma	☐	☐	Floating spots	☐	☐	Sensitivity to light
☐	☐	Cataracts	☐	☐	Dry eyes	☐	☐	Feeling of pressure behind eyes
☐	☐	Eyeglasses	☐	☐	Watery eyes			
☐	☐	Blurred vision	☐	☐	Itchy eyes			

Skin and Hair

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
☐	☐	Dry skin	☐	☐	Rashes, Hives	☐	☐	Acne
☐	☐	Itching	☐	☐	Ulceration or sores	☐	☐	Sweaty hands / feet
☐	☐	Eczema	☐	☐	Recent change in mole	☐	☐	Weak/brittle nails
☐	☐	Psoriasis				☐	☐	Loss of hair

Emotional

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
☐	☐	Depression	☐	☐	Worry	☐	☐	Tendency to repress emotions
☐	☐	Anxiety / fear	☐	☐	Obsessiveness / compulsiveness	☐	☐	Mood swings
☐	☐	Sadness or grief	☐	☐	Indecisiveness	☐	☐	Manic episodes
☐	☐	Anger	☐	☐	Difficulty handling stress	☐	☐	Suicidal feelings
☐	☐	Frustration				☐	☐	Frequent crying
☐	☐	Easily irritated						

Respiratory

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
☐	☐	Allergies	☐	☐	Bronchitis, chronic	☐	☐	Emphysema
☐	☐	Asthma	☐	☐	Phlegm	☐	☐	Pain w/ deep breath
☐	☐	Cough dry/wet	☐	☐	Phlegm, with blood	☐	☐	Wheezing
☐	☐	Cough, chronic	☐	☐	Pneumonia	☐	☐	Shortness of breath

Ears, Nose, & Throat

Past	Current	Condition
HEAD:		
☐	☐	Headache
☐	☐	Migraines
☐	☐	Dizziness, or loss of balance
☐	☐	Concussion
☐	☐	Seizures
EARS:		
☐	☐	Ear infections, freq
☐	☐	Difficulty hearing
☐	☐	Deafness

Past	Current	Condition
SINUS:		
☐	☐	Sinus congestion
☐	☐	Facial pain
☐	☐	Frequent Colds
☐	☐	Runny nose
☐	☐	Nose bleeds
☐	☐	Decreased sense of smell

Past	Current	Condition
MOUTH:		
☐	☐	Jaw tension, or clicking (TMJ)
☐	☐	Grinding teeth
☐	☐	Gum problems
☐	☐	Dry mouth
☐	☐	Sores
☐	☐	Sore throat
☐	☐	Difficulty swallowing
☐	☐	Lump or pit in throat
☐	☐	Swollen lymph nodes

Pregnancy and Gynecology (Women only):

Past	*Current*	*Condition*
PREMENSTRUAL:		
☐	☐	Cramping
☐	☐	Bloating
☐	☐	Irritability
☐	☐	Emotional sensitivities
☐	☐	Headache
☐	☐	Breast tenderness
☐	☐	Fluid retention
☐	☐	Constipation
☐	☐	Diarrhea
MENSTRUAL:		
☐	☐	Cramping during period
☐	☐	Clots
☐	☐	Light flow
☐	☐	Heavy flow
☐	☐	Light-colored
☐	☐	Dark-colored
☐	☐	Irregular cycle
☐	☐	Low backache
PREGNANCY:		
☐	☐	Pregnant
☐	☐	Nursing
☐	☐	Difficult deliveries
☐	☐	Morning Sickness
☐	☐	Cannot maintain pregnancy
☐	☐	Infertility
GENERAL:		
☐	☐	Hot flashes
☐	☐	Night sweats
☐	☐	Missed periods
☐	☐	Spotting between periods
☐	☐	Endometriosis
☐	☐	Vaginal discharge
☐	☐	Uterine fibroids
☐	☐	Ovarian cysts
☐	☐	Breast cysts or lumps
☐	☐	IUD
☐	☐	Birth Control

FERTILITY PATIENTS:

Number of Pregnancies ____________________________

Miscarriages ____________________________

Abortions ____________________________

Hysterectomy, reason for: ____________________________

Age at first menses: ____________________________

Number of Births ____________________________

Premature Births ____________________________

Age of Children ____________________________

Oophorectomy, reason for: ____________________________

Age when menses stopped: ____________________________

Starting date of last menses (when started bleeding = Day 1): ____________________________

Urinary and Genital

Past	*Current*	*Condition*
☐	☐	Scanty urine
☐	☐	Frequent urination
☐	☐	Strong-smelling
☐	☐	Cloudy urine
☐	☐	Pain or burning
☐	☐	Dribbling
☐	☐	Unable to hold
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Low sexual energy
☐	☐	Excessive sexual energy
☐	☐	Pain during intercourse
☐	☐	Inability to maintain erection
☐	☐	Low sperm count
☐	☐	Infection
☐	☐	Sores on genitals
☐	☐	Bed wetting
☐	☐	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

HIPAA Compliance

Policy and Legal Guidelines

The Health Insurance Portability and Accountability Act (HIPAA) was first introduced in 1996, and became effective April 23, 2003. The purpose of HIPAA 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 HIPAA 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. Email Communications: patients have the ability to communicate with their provider via email, but must recognize that information passed over the internet through email may not be secure. While our email accounts are HIPAA compliant, yours may not be, so talking with your provider over email is done so at your own risk. 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 HIPAA 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 HIPAA guidelines will be handled by office personnel. Following a written dispute regarding HIPAA, 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 HIPAA Policy and Guidelines.

______________________________	________________	____________
Signature of Patient or Representative	Print Name	Date