*Columbia Acupuncture*
**Jim Martin, LAc., Dipl. Ac. (NCCAOM)**
**2251 A NE Cornell Rd, Hillsboro, OR 97124**
**503-640-3668**

# New Patient Information

**Welcome to Columbia Acupuncture!** Since 1983 I have assisted thousands of people like yourself with their health care issues and challenges. I very much look forward to working with you to achieve your current short and long term health and wellness goals.

On your first visit you will first be asked to complete the standard intake forms, including basic health information and insurance information if you have acupuncture coverage. Next we will discuss the specific problems for which you are seeking treatment. I will then explain your treatment options, including acupuncture, herbs and supplements, magnets or far infra-red heat therapy. You will receive a copy of these recommendations for your records. In relatively simple cases such as ankle sprain, we will proceed directly to the treatment. More complex cases, however, require a more detailed evaluation using Chinese diagnostic techniques. You will have ample opportunity to ask questions and clarify matters such as office procedures, your goals, and the treatment plan. Please allow at least at least one and a half hours for the first session, including the initial treatment. Follow up treatments will last about an hour, usually weekly. Sessions may include acupuncture and/or a variety of other complimentary therapies.

Payment for services is due at the time of treatment. Cash, checks and credit or debit are accepted. If you have medical insurance that may cover acupuncture treatment, I will call your company to confirm benefits, request pre-authorization if required and get other necessary details.

**Tips to optimize your acupuncture experience**

- Do not receive acupuncture on a very full or hungry, very tired or under the influence of alcohol. Avoid heavy meals for at least two hours preceding treatments. Light meals are generally OK.
- Allow ample travel time so as to avoid rushing through traffic or getting anxious en route. Take a few minutes to relax before treatment. If you need to use the restroom, please do so before your scheduled appointment time.
- Wear clothing that is loose fitting and comfortable. Shorts, tank tops and swimsuits are fine, permitting easy access to body areas to be treated. For treatments requiring removal of clothing, cover sheets will be provided. The main thing is that you are warm, relaxed and comfortable.
- Please inform me of any problems or concerns that may affect the treatment, such as difficulty lying in a particular position, predisposition to fainting or sensitivity to heat or cold.
- Allow a few minutes following treatment to sit and relax so your energies may settle and stabilize.

***continued.....***

## Acupuncture Needles

Acupuncture needles are sterile and disposable, made of surgical grade stainless steel. They are extremely thin and usually painless on insertion. Once in place, they are often manipulated to produce a stimulus such as heaviness, distension, or mild electrical sensation. Mild lingering discomfort, slight bleeding or bruising at a needle site is uncommon but possible. Please give me feedback as to what you are feeling at all times, so I know when I have located the correct point and evoked the desired stimulus.

## What to expect following the treatment

Results from a single treatment, as well as the number of treatments required to resolve any particular condition, may vary greatly among individuals, depending on such factors as the seriousness and duration of the condition as well as the patient's age, diet, attitude, and general level of health. A condition may improve immediately, gradually, or after initially worsening briefly. New symptoms may appear briefly as the body detoxifies or seeks balance. As such, do not be unduly concerned if your problem worsens for a day or two before showing improvement. Some problems will be completely eliminated, while others may be improved partially, or require periodic maintenance.

Occasionally a patient being treated in the sitting up position may start to feel light-headed. In such a case, please inform me immediately and the needles will be removed so you can lie down comfortably for a few minutes until the sensation passes. A drink of water or opening the window may help refresh you as well.

In any case, treatments are very safe and free of dangerous and unpleasant side effects common with drugs and surgical procedures. Acupuncture will help restore your mind and body to a state of balance, harmony and well-being. In many cases, the disease process has been developing for many years, and has been treated many times before coming here. Be patient and consistent. Allow your body time to heal, rejuvenate and rebuild.

**Thank you for allowing us the opportunity to be of service to you and your family.**

***Jim Martin, L. Ac., Dipl. Ac. (NCCAOM)***

# *Columbia Acupuncture*

**Jim Martin, LAc., Dipl. Ac. (NCCAOM)**
**2251 A NE Cornell Rd, Hillsboro, OR 97124**
**503-640-3668**

Name: _____ Date _____ Office Account no. _____

Age _____ Sex _____ DOB _____ SS No. _____ Height _____ Weight _____

Address _____
street apt no. city zip

Home phone _____ Work _____ Cell/other _____

Email _____ Occupation _____ Employer _____

Marital status S M D other Spouse name _____ Emergency contact _____

Emergency phone no. _____ How did you learn about our office _____

Primary care physician _____ Health insurance company _____

**Health History**

Major illnesses, hospitalizations or surgeries _____

_____

Allergies _____

Family health history (Please circle any conditions in your immediate family)

| | | | |
|---|---|---|---|
| Asthma | diabetes | high blood pressure | neurological problems |
| Arthritis | digestive disease | kidney disorders | stroke |
| Allergies | epilepsy | liver disease | respiratory disease |
| Cancer | heart disease | mental illness | thyroid disorder |

**Presenting problems (Please list in order of priority) :**

1.

2.

3.

4.

5.

Prior acupuncture treatment (what for, when and by whom?) _____

Treatment goals (What do you wish to achieve in coming here?) _____

Do you prefer quick, symptomatic relief, or to work on deeper levels over a longer period of time? _____

Comments:

effective date: April 14, 2003

# Notice
# Patient Privacy
(Short Form)

**Jim Martin, L Ac, Dipl Ac (NCCAOM)**
**Columbia Acupuncture**

**Health Insurance Portability and Accountability Act (HIPAA)**

Jim Martin, L Ac does business as Columbia Acupuncture and is dedicated to preserving your 'Protected Health Information' (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Jim Martin's duties with respect to your protected health information (PHI).

Jim Martin, L Ac, may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health clearinghouse, or an employer. This protected health information relates to your past, present or future physical or mental health or condition. It either identifies you, or provides details to the extent that there is a reasonable basis to believe the information may pertain to you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amend or correcting that information, obtain an accounting of our disclosures of your medical information, request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) that fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect from Jim Martin, L Ac, upon request.

We may advise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect. If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Jim Martin, L Ac, at (503) 640-3668 or (503) 543-7366.

Columbia Acupuncture
52485 SW 1st, PO Box 1108
Scappoose, OR 97056
503-543-7266

Release of Patient Confidential Information / Receipt of Notice of Privacy Practices

Patient Name:_____ Phone#_____
DOB:_____

Address:_____
City:_____ State:_____ Zip:_____

I acknowledge receipt of the Notice of Privacy Practices.

| Short / Long Form | Signature | Requested by | Date |
|---|---|---|---|
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| Restrictions | Who Requested | Date Req. | Begin Date | End Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Date | Information Disclosed | Purpose of Disclosure | Name/Address of Recipient | initials |
|---|---|---|---|---|
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# ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, 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 for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

AAC FED

PATIENT NAME:

# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated**: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

**AAC-FED**

*Columbia Acupuncture*
**Jim Martin, LAc., Dipl. Ac. (NCCAOM)**
**2251 A NE Cornell Rd, Hillsboro, OR 97124**
**503-640-3668**

# Payment Policy and Agreement

1. Payment for all services, products and copays are due at the time of treatment.

2. Cash, checks and credit/debit cards are accepted.

3. I understand that I am responsible for payment for appointments that are missed or not cancelled with at least 24 hours prior notice, for which the following rates will apply:

late cancellation (less than 24 hours notice): $25
missed appointment (no show): $45

## Insurance Billing

1. I authorize payment of medical benefits to Jim Martin, L. Ac., dba Columbia Acupuncture, for services provided.

2. I understand that I am personally responsible for any and all charges incurred should my insurance company fail to pay for any reason. This includes, for example, policies that are expired or not yet in effect at the time of service, or cases in which incorrect information is provided by the insurance company representatives.

3. I understand that I am responsible for payment for appointments that are missed or not cancelled with at least 24 hours prior notice, for which the following rates will apply:

late cancellation (less than 24 hours notice): $25
missed appointment (no show): $45

**I have read, understand and accept the above terms.**

Signature _____

Printed name _____ Date _____

12/12

# *Columbia Acupuncture*

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Name _____ DOB ____-_____-_____ Office IDN _____ Date ____-_____-____

Please check the appropriate items. Indicate if problem is current **(C)** or past **(P)**. Circle those of most concern to you.

____ frequent or sever headaches
____ neck pains
____ neck lumps or swelling
____ dizzy spells or vertigo
____ fainting or blackouts

____ blurry vision
____ eyesight worsening
____ see halos or lights
____ eye pains or itching
____ watering eyes
____ difficulty hearing
____ ear aches
____ noises in ears
____ running ears

____ dental problems
____ sore or bleeding gums
____ sore tongue

____ wheezing or gasping
____ frequent coughing
____ cough up phlegm
____ cough up blood
____ chest colds

____ rapid or skipped heartbeat
____ chest pains
____ abnormal shortness of breath
____ swollen feet or ankles

____ allergy
____ arthritis
____ asthma
____ bronchitis
____ cancer
____ cholesterol high
____ diabetes
____ heart disease
____ herniated disk or degeneration
____ hepatitis or herpes (circle)
____ high blood pressure
____ kidney disease
____ liver disease
____ migraines
____ neurological problems
____ rashes or skin problems
____ sciatica
____ thyroid problems
____ parasites (candida, etc.)

____ recurring indigestion
____ frequent belching
____ nausea or vomiting
____ abdominal pain
____ abdominal bloating
____ constipation
____ loose bowels/diarrhea
____ black stools
____ pain in rectum
____ itching rectum
____ blood in stools
____ ulcers
____ burning on urination
____ brown or bloody urine
____ involuntary loss of urine
____ weak urine stream
____ difficulty starting urination
____ constant urge to urinate
____ frequent urination

MEN ONLY

____ burning or discharge
____ lumps/swelling testicles
____ painful testicles
____ prostate problems

WOMEN ONLY

____ missed periods
____ menstrual problems
____ bleeding between periods
____ tension/pain before period
____ heavy bleeding
____ bearing down feeling
____ vaginal discharge
____ genital irritation
____ painful intercourse
____ breast swelling or lumps
____ painful breasts
____ number of pregnancies
____ miscarriages
____ births
____ premature births
____ cesarians
____ abortions

____ peri menopausal
____ post menopausal
____ endometriosis
____ hysterectomy
____ fibroids or cysts

____ aching muscles or joints
____ swollen joints
____ back or shoulder pain
____ painful limbs
____ trembling
____ numbness or tingling
____ leg or arm cramps or spasms

____ scalp problems
____ itching or burning skin
____ bruise easily
____ hair loss
____ nervousness or anxiety
____ nervous around strangers
____ difficulty making decisions
____ lack of concentration
____ loss of memory/absentminded
____ lonely or depressed
____ frequent crying
____ hopeless outlook
____ difficulty relaxing
____ worry a lot
____ frightening dreams or thoughts
____ feeling of depression
____ shy or sensitive
____ dislike criticism
____ easily angered
____ annoyed by little things
____ family problems
____ problems at work
____ sexual difficulties
____ change of sexual energy
____ fertility problems, male or female
____ sought psychiatric help
____ nail biting
____ considered suicide
____ weight loss or gain
____ loss of appetite
____ always hungry

____ unusual weariness or fatigue
____ difficulty sleeping
____ fever or chills
____ motion sickness
____ excessive sweating
____ night sweats
____ hot flashes
____ often feel warm then cold
____ swelling in armpits or groin

____ substance abuse or sobriety program Please explain _____

Do you frequently consume alcohol ____ , nicotine ____ , prescription drugs ____ , recreational drugs ____ , soda pop ____, caffeine _____, herbs/supplements____

Name _____ Date _____ TX _____

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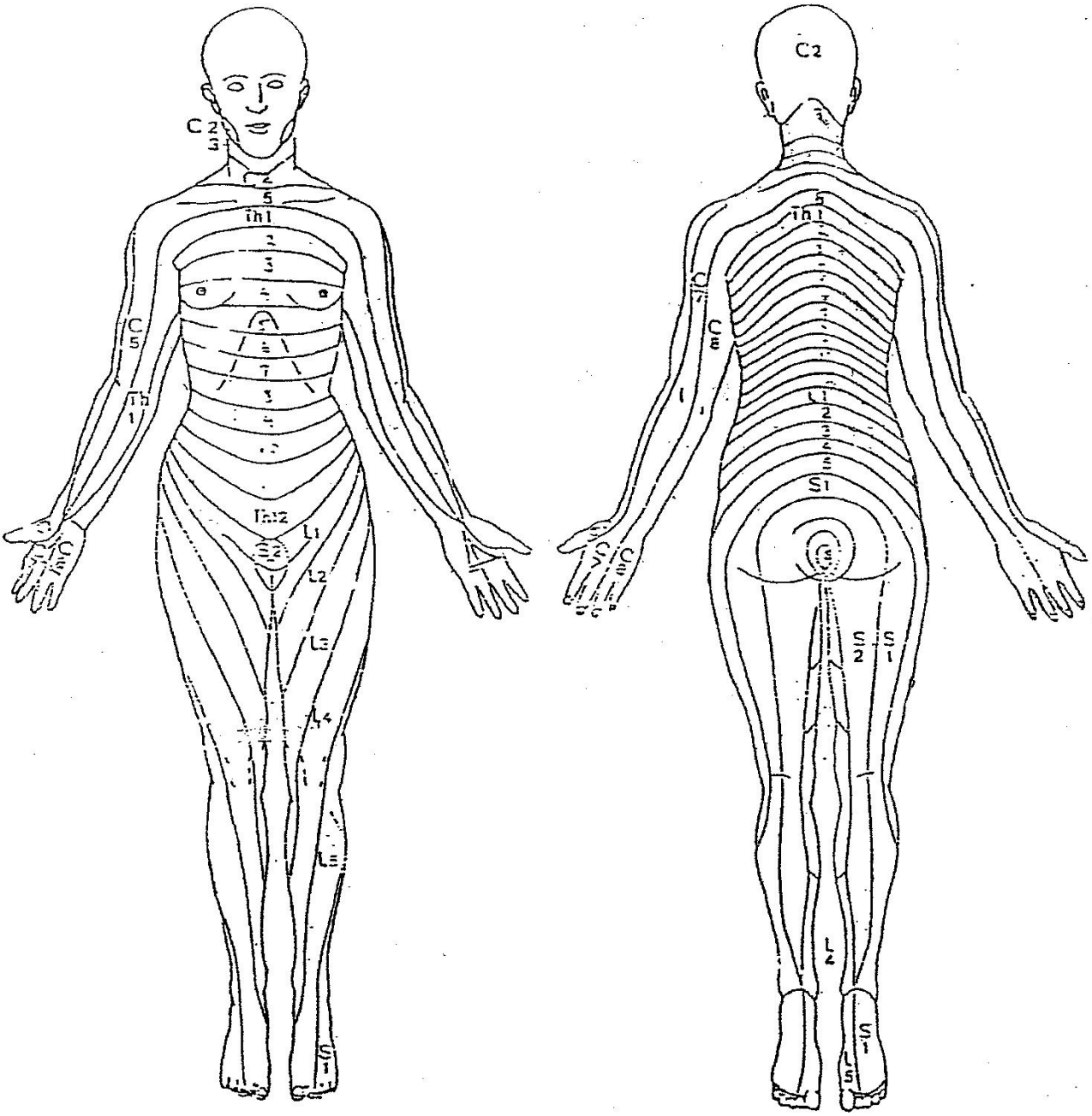
52485 S.W. 1st., PO Box 1108, Scappoose, OR 97056
503-543-7266




**INSTRUCTIONS**

1. Indicate each area of pain by circling, shading, crosshatching or coloring.
2. Indicate whether pain in each area is constant, intermittent, infrequent, or rare.
3. Indicate the center of pain areas or intensely painful spots with an X.
4. Use arrows to indicate where pain is moving or shooting.
5. Indicate whether pain in each area is 'mild', 'moderate' or 'severe'.
6. Rate each area for intensity using '**0**' for no pain and '**10**' for unbearable.

# Drug, Herb and Supplement History

Name _____ DOB _____ Today's date _____-_____-_____

**Please list medications and supplements you are currently using or have used in the last five years, <u>starting with the most recent</u>**

| **Product** | **Purpose** (diagnosis or condition) | **Dates used** (from when to when) | **Outcome/Result** |
|---|---|---|---|

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Name _____

DOB _____ Today's date _____

PAIN anywhere in the body. Acute or chronic. Where, how long, treatment?

ORGAN or TISSUE DISORDERS

HEAD / EENT (eyes, ears, nose, throat, sinus, mouth: pain, infections, injuries, sensory problems, blockage, headaches)

NECK & SHOULDERS (pain, stiffness, injuries, spinal problems)

BACK / SPINE / POSTURE / SKELETAL (pain, injuries, stiffness, disorders, treatments, etc.)

LIMBS/JOINTS (pain, injuries, stiffness, swelling, inflammation, numbness/tingling, treatments, etc.)

CHEST (pain, tightness, etc.)

RESPIRATORY SYSTEM (difficulty breathing, pain, shortness, wheezing, illnesses, coughing, etc.)

CARDIAC / HEART (Pain, angina, irregularities, fast/slow beat, disorders, prior heart attacks)

VASCULAR/CIRCULATORY SYSTEM (vericose veins, pain, clots)

ABDOMEN (pain, sensations, swelling, noises, hard lumps, etc.)

APPETITE & DIGESTION (Is appetite good or not? Do you experience pain, gas, swelling, nausea? If so, when?)

BOWEL ACTIVITY & CONDITION ( BM ease, frequency, pain, straining, bleeding, hemorrhoids, texture, gas, undigested food )

URINARY ACTIVITY & CONDITION (Frequency, pain, itching, bleeding, strength of stream, dribbling, complete evacuation, etc)

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Name _____

DOB _____ Today's date _____

LABWORK / TESTS ( Blood Chemistry, Cholesterol, Liver Function, Allergy, Heart, etc.)

INFECTUOUS DISEASES (Herpes, Hepatitis, Staph, etc.)

SYSTEMIC ILLNESSES OR DISORDERS (Diabetes, chronic fatigue, fibromyalgia, arthritis,etc. )

EXPOSURE TO HAZARDOUS CHEMICALS (dry cleaners, farm, petroleum, asbestos, aluminum, household, construction, etc.)

MAJOR ILLNESSES / INJURIES / HOSPITALIZATIONS / SURGERIES

PARASITES (Candida, Giardia, Cryptosporidium, etc.)

ALLERGIES

PRIOR MENTAL or EMOTIONAL DISORDERS or TRAUMAS and TREATMENT (depression, breakdowns, bipolar disorder, etc.)

ENERGY LEVEL (high/low, daily fluctuations, etc.)

SLEEP (how long, how soundly, dreams. Do you awake rested? Do you require medications?)

HOT/COLD (sensations in/on body, sensitivity to, preferences for in environment or foods/drinks, hot flashes)

PERSPIRATION (nite sweats, excess, lack of or inappropriate sweating)

SKIN (dry, easily bruises, rashes, sores, itching, tingling or numbness)

HAIR (premature grey or falling, dry, brittle, etc.)

THIRST & CONSUMPTION OF LIQUIDS (how much and what)

RECENT WEIGHT LOSS OR GAIN

CRAVING FOR TASTES: Check any which you crave excessively: sweet ( ), hot spicy ( ), salty ( ), sour( ), bitter ( )

SEASONAL OR REGIONAL INFLUENCES (eg better or worse in summer or winter, or in dry climate)

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Name _____

DOB _____ Today's date _____

JROGENITAL / SEXUAL / OB / GYN

MEN: prostate condition, impotence, infertility, injuries other functional or structural problems, etc.

WOMEN: pregnancy history, surgeries, diseases, fertility problems, menopausal disorders ,birth control history
menstrual regularity, length, flow-heavy/light, blood color-clear/bright red/dark., pain, odors, PMS, etc.

EXERCISE (what, how often, etc.)

FAMILY MEDICAL HISTORY (parents and siblings: major illnesses or problems common to several members)

LIFE PHILOSOPHY, RELIGIOUS or SPIRITUAL BELIEFS and PRACTICES

RELATIONSHIPS WITH FAMILY, FRIENDS, ASSOCIATES, ETC. (satisfactory and fulfilling, stressful, emotional, etc.)

SOCIAL ACTIVITIES

OB & CAREER (satisfaction, stress, etc.)

CREATIVITY & SELF EXPRESSION (do you and, if so, how or what)

OVERALL EMOTIONAL CONDITION & SELF IMAGE (positive, negative, non-existent, or whatever)

RATE 0 (min) to 10 (max):

Anger_____, Frustration_____, Irritability_____, Indecision_____, Depression_____, Willpower___, Mental Overwork_____,

Concentration_____, Centeredness____, Groundedness_____, Joy_____, Anxiety_____ Sadness_____, Grief_____,

Fear_____, Fright_____, Stuck/blocked feelings_____, Hopelessness_____, Loneliness_____.

Comments or explanation:

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Name _____

DOB _____ Today's date _____

## DIET & NUTRITION

Describe your diet type (eg) typical American, junk food, health food, vegetarian, medical or weight loss program, etc.

Are you satisfied with this diet? If not, why not?

Are you willing to make some helpful changes in this diet?

Do you:

| | | | |
|---|---|---|---|
| rush your meals? | chew food well? | skip meals? | undereat? |
| snack between meals? | eat late at night? | overeat? | enjoy your food? |

Describe a typical meal:

Breakfast

Lunch

Dinner

Do you eat out? How often, what kind of food?

Have you ever eaten superfoods such as blue green algae, flower pollen or wheat grass? What and when?

Have you used supplements such as vitamins, enzymes, or antioxidants? What and when?

Which of the following foods and substances do you eat or use and how often?

| | |
|---|---|
| red meat | dairy (milk, cheese, ice cream, yoghurt) |
| fish | whole grains (rice, oats, etc.) |
| poultry | beans/legumes |
| fresh vegetables | canned/frozen veg |
| fresh fruits | pastries/candies |
| pastas | soy products |
| alcohol | tobacco |
| caffeine | recreational drugs |
| MSG (in Chinese food) | Aspartame/NutraSweet, Splenda, etc. |

Comments:

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DOB _____ OAN _____ Today's date _____

# Insurance Information

## Patient:

**Name**: _____ Address: _____

Phone: _____ Date of Birth:_____ SSN:_____ Marital status: ( ) single, ( ) married, ( ) other

Relationship to insured: ( ) self, ( ) spouse , ( ) child, ( ) other ( ) employed, ( ) full time student , ( ) part time student

s condition related to: ( ) employment, ( ) auto accident, ( ) other accident date of loss (first symptom or injury) _____

Referring physician _____ ( ) Personal Insurance, ( ) Auto Accident , ( ) Workmens Comp

## Primary Insured:

**Name**: _____ Address: _____

**D No**_____ Policy or Group No: _____ Claim No.: _____

**Date of birth**: _____ Phone: _____ **Employer**: _____

**nsurance company**: _____ Administrating company: _____

Phone No.: _____ Billing Address: _____

Group Name _____ Plan /program name: _____ Agent/contact name: _____

## Secondary Insured:

Name: _____ Address: _____

D No_____ Policy or Group No: _____ Claim No.: _____

Date of birth: _____ Phone: _____ Employer: _____

nsurance company name: _____ Administrating company: _____

Phone No.: _____ Billing Address: _____

Group Name _____ Plan /program name: _____ Agent/contact name: _____

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or office use only:

Date _____ O ___ Rep _____ **Confirm ben**: _____ Effective _____ **Copay** _____ **Coins** _____

**Deductibles**: _____ met _____ MD referral _____ Pre-authorization _____ Chart notes required _____

No TX _____ Time period _____ Policy period _____ Dollar amount _____ Other _____

**Auth. No**. _____ **TX Codes** _____ **DX Codes** _____