

Kate Chilson, LMP, LAc

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Patient Information

Name _____

Date of Birth _____

Address _____

City/State/Zip _____

Phone: Home _____

Work _____ Cell _____

Email _____

Employer _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell _____

Relationship: single in a relationship

married/dp divorced/separated widowed

Health Care Providers

Name _____ Specialty _____

Clinic _____ Phone _____

Name _____ Specialty _____

Clinic _____ Phone _____

Name _____ Specialty _____

Clinic _____ Phone _____

I give Kate Chilson permission to contact my health care providers regarding my health and treatment.

Comments _____

Initials _____ Date _____

Current Health Information

List primary reason(s) for coming in:

1. _____

Is this a mild moderate or major concern?

Or rate it on 0-10 scale (10 is worst): _____

2. _____

Is this a mild moderate or major concern?

Or rate it on 0-10 scale (10 is worst): _____

3. _____

Is this a mild moderate or major concern?

Or rate it on 0-10 scale (10 is worst): _____

Exercise and stress reduction

Activity _____ Frequency _____

1. _____

2. _____

3. _____

How much of the time do you enjoy your job?

How many hours do you work per week?

Please list all medications, vitamins, supplements you are taking _____

Diet

Do you eat 3 meals per day at regular times?

Yes No

Number of 8oz water glasses per day: _____

Have you ever been on a restricted diet?

Yes No

If yes, please explain: _____

Foods you crave: _____

Foods that are difficult to digest: _____

Are you satisfied with your current diet?

Yes No

If no, please explain: _____

Habits

Cigars or cigarettes per day: _____

Quit smoking, when: _____

Coffee/cola per day: _____

Alcohol per week: _____

Health History Please list and explain. Include dates and treatment received.

Major illnesses:

Significant dental work:

Surgeries or hospitalizations:

Allergies to drugs, chemicals, food, environment:

Major accidents or injuries:

What do you know about your own birth?

- forceps
- breech
- cord wrapped
- mom had c-section
- vacuum extraction
- shoulder first
- mom was induced
- mom had anesthesia

Location of scars:

Check All Current and Previous Conditions Please Explain

General

- now past
- fatigue or low energy
- frequent colds
- weight loss or gain
- fever or chills
- HIV
- sleep difficulties
- Ave hrs sleep/night _____
- Overall energy (1=low, 10=high) _____

Nervous System

- now past
- numbness or tingling
- dizziness
- poor balance or coordination
- concussion or head injury
- poor memory
- foggy headed
- other _____

- poor vision / glasses
- spots in front of eyes
- difficulty swallowing
- swollen glands

Skin

- now past
- rash or itching
- dryness
- acne
- psoriasis or eczema

Muscles and Joints

- now past
- arthritis
- osteoporosis
- scoliosis
- broken bones
- spinal problems
- spasms, cramps
- sprains, strains
- tendonitis, bursitis
- stiff or painful joints
- weak or sore muscles
- neck, shoulder, arm pain
- low back, hip, leg pain

Emotions

- now past
- anxiety
- depression
- grief or sadness
- easily stressed / on edge
- mood swings
- manic periods
- irritable

Heart and Lungs

- now past
- chest pain or tightness
- racing or fluttering heartbeat
- irregular heartbeat
- shortness of breath
- asthma or wheezing
- chronic cough
- bronchitis or pneumonia

Head (EENT)

- now past
- headaches or migraines
- sinus congestion
- TMJ / jaw problems
- facial pain
- dry eyes or throat or mouth
- bleeding nose or gums
- ringing ears
- hearing or smell or hair loss
- eye strain

Circulation

- now past
- difficult temp. regulation
- swollen ankles, hands, face
- cold hands / feet
- anemia
- bruise easily
- varicose veins
- blood clots

- heat or cold intolerance
- night sweats
- excessive day sweats
- high or low blood pressure
- high cholesterol
- bleeding disorder

Digestion

- now past
- poor appetite
 - nausea
 - gas or bloating
 - ulcer
 - belching / burping
 - heartburn or acid reflux
 - abdominal pain or cramps
 - excessive thirst or hunger
 - gall stones
 - hepatitis
 - diarrhea or constipation
 - hemorrhoids
 - diabetes
- Ave # BM/day _____
- Stools are generally:
- formed loose/unformed
 - dry soft
 - undigested food in stool

Kidneys and Bladder

- now past
- frequent infections
 - painful or difficult urination
 - frequent urination
 - kidney stones
- Ave # urinate/night _____
- Color of urine:
- pale yellow orange
 - bright yellow cloudy

Men

- now past
- sexual difficulties
 - genital discharge or sores
 - other _____

Women

- now past
- birth control
- what type and how long? _____
- _____
- # of pregnancies _____
- # of births _____
- # of premature births _____
- # of miscarriages _____
- # of abortions _____

- age at first menses _____
- # of days of cycle _____
- # of days of period _____
- date of most recent period _____
- menopause, age _____
- Periods:
- now past
- painful
 - irregular
 - light or heavy flow
 - clots
 - mid-cycle spotting
- Color of blood:
- pale dark bright red
- now past
- PMS
 - breast pain / swelling
 - breast lumps or discharge
 - fibroids or cysts
 - infertility
 - abnormal PAP smear
 - sexual difficulties
 - genital discharge or sores

CONSENT FOR TREATMENT

Treatment may include, but is not limited to these **methods to stimulate specific acupuncture points**: inserting sterile hair-thin needles, manual pressure, creating a vacuum with a glass cup on the skin, application of minute intradermal needles or pellets for 3-5 days, attaching a positive/negative polarity device to needles, drawing a small amount of blood with a sterile lancet, burning mugwort directly or indirectly on the skin, vibrating sound with tuning forks or Manaka wooden hammer.

Acupuncture is a generally safe treatment but it may have some side effects including, but not limited to, discomfort or pain; minor bruising; minor blistering where direct heat is applied; nausea, fainting; or temporary aggravation of symptoms. Infection is another risk, but the clinic uses sterile single-use needles and maintains a safe and clean environment. Potential benefits include relief of symptoms and stimulation of the body's own self-balancing mechanisms in order to restore health within the body.

Please notify your practitioner prior to treatment if you have any of the following conditions: bleeding disorder, currently taking anticoagulant medications; weakened immunity; neuropathy; pace-makers or other implanted devices. Also if you are or become pregnant.

Financial policy: I understand that I need to give 24 hours notice if I need to cancel my appointment. If adequate notice is not given, I understand that I will be charged the full fee for the missed appointment.

By signing below I recognize that no guarantees or claims are being made to the improvement or cure of my presenting condition and that I am giving my consent on a voluntary basis to the above-mentioned acupuncture procedures. I understand that I am free to withdraw my consent and discontinue treatment sessions at any time.

I, _____ recognize the potential risk and benefit of these procedures.
Patient's Printed Name

Patient's Signature

Date

NOTICE OF PRIVACY PRACTICES

Effective 11/16/09

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure of Your Health Care Information

Health information includes your name, contact information, intake forms, chart notes (including communication among health care providers), progress reports, and billing statements.

This health information will be protected by storing it in a locked file cabinet in a locked office as well as on a password-protected computer. All electronic data transmission will use a firewall-protected secure internet connection. I may disclose your health information for purposes of treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example, I may need to share information with other health care providers or specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, I may disclose treatment information when billing an insurance company for services provided to you by my office.

Health Care Operations include the business aspects of running my practice. This includes contacting you to set up appointments and communicate about your care.

Other Disclosures: Unless you request otherwise, I may disclose health information to a family member, friend, or other individual to the extent necessary to help with your health care (for example in the case of an emergency) or with payment for your health care. I will use my professional judgment in disclosing your health information as required by law.

Your Health Information Rights

You have the right to:

- request restrictions on certain uses and disclosure of your health information
- inspect and copy your health information
- request amendments be made by this office to your protected health information file
- receive an accounting of disclosures of your protected health information
- request to be contacted at an alternate location
- to file a complaint
- receive a paper copy of this Notice of Privacy Practices at any time upon request

By signing below, I signify that I have read the **Notice of Privacy Practices**. I give Kate Chilson my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Patient's Signature

Date