Heartwood Holistic Health

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Chapel Hill, NC 27514

Chinese Medicine Patient Information Intake

In order to provide you the best possible holistic care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL

Patient Data

Name ______________________ Date ________ Referred By ______________________

Address & Contact Information

Address ______________________ City __________ State ______ Zip ________

Telephone (work) ____________ (home) ____________ E-Mail ______________________

Age ____ Birth Date ____________ Social Security # ____________ Number of Children ______

Occupation ______________________ Employer ______________________

Marital Status ________ Spouse's Name ______________ Spouse's Occupation ____________

Spouse's Employer ______________________ Spouse's Health Status ______________________

Emergency Contact ______________________ Phone ______________________

Current Complaints

What are the concerns for which you are seeking care? (symptoms, diagnosis and date of onset)

1) ______________________

2) ______________________

3) ______________________

What other treatments have you received for any of these conditions? ______________________

What makes your condition better? (movement, rest, heat, cold, eating, sleeping, crying, screaming, etc)

____

What makes your condition worse? (fatigue, stress, certain foods or times of day, heat, cold, hunger. Etc)

____

Significant Trauma, Hospitalizations, Surgery, X-Rays & Special Tests

Please include accidents, falls, illness, as well as emotional history. What month/year?

____

____

____

Allergies

Are you hypersensitive or allergic to any foods, drugs, chemicals or environmental substances?

____

Medications

What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you taking?

____

____

____

Check each that you are currently using:

___ Laxatives ___ Pain Relievers ___ Antacids ___ Cortisone

___ Antibiotics ___ Heart/Blood Medications ___ Allergy Medications ___ Thyroid Medications

___ Sleeping Pills ___ Anti-Depressants ___ Birth Control Pills ___ Hormones

Exercise, Energy and Diet

How much exercise per week? __________ Length of workout? ___________ Activities _________________________

How is your energy level? ______________ When is it lowest? ____________ Highest? _________________________

Typical Diet

Meals per day? _______ # of Snacks _______ Caffeinated Drinks _______ Alcohol per week _______

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

What foods are your weakness? ____

Water intake per day? _______________ Prefer warm or cold drinks? ______________ Excessively thirsty? __________

Special Diet? ____

Personal History

Please check any symptoms you have now or ever have had

____ Cancer ____ Diabetes ____ Seizures ____ Heart Disease

____ High/Low Blood Pressure ____ Kidney Disease ____ Hepatitis ____Thyroid Imbalance

____ Asthma ____ Eating Disorder ____ Arthritis ____ Ulcer

____ Chronic Fatigue ____ Alzheimer's ____ Autoimmune ____ Alcohol/Drug Addiction

____ Blood Clotting Disorder ____ Prolapsed Organ ____ Chronic Pain ____ Stroke

____ Anemia

Do you smoke? (Tobacco or Marijuna) For how long? ______________________ How much a day? __________________

Other serious Health Conditions? ____

Sleep

How long do you normally sleep? ___________ per night.

I have difficulty with (check all that apply) ____ Falling Asleep ____ Staying Asleep ____ Dream -Disturbed Sleep

____ Waking up throughout the night ____ Not being able to fall back asleep At what time/s do you wake up? _______

Emotional Health

Have you ever been treated for psychological concern? _______ Have you experienced sexual or physical abuse? ______

Have you ever considered or attempted suicide? ______ Have you ever considered or attempted suicide? ______

Please rate your overall stress level (please circle one) Low Medium High

Are you currently working with a counselor? ______ If so, who? ____

If possible, please describe the most challenging emotion you experience. ____

____

When do you most often feel this emotion?____

What experiences or activities bring you the most joy and nourishment? ____

Do you have a spiritual practice? ____

What goals do you have for your acupuncture treatments and anything else you would like to discuss?

____

____

For Women

Age of first period ________________ Date of last period _______________ Number of children (live births) ______

Number of days between periods (your cycle) __________ Number of days of flow ___________________________

Color of flow:	Amount of flow:	# of pads you use per day:	Pain and cramping:	
____ Pale/Light Red	____ Spotting	1st day ____	___ No	
____ Red	____ Light	2nd day ____	___ Yes	
____ Bright Red	____ Even Throughout	3rd day ____	____ Before flow	____ Mild
____ Dark Red	____ Heavy	4th day ____	____ During Flow	____ Moderate
____ Dark Red/Brown		+ days ____	____ After Flow	____ Severe
____ Clots				

Other symptoms related to menses

___ Discharge	___ Nausea	___ Swollen Breasts	___ Diarrhea
___ PMS	___ Diarrhea	___ Mood Swings	___ Insomnia

Attempting pregnancy currently? _______________ If so, for how long? ________________________________

Currently pregnant? ______________________ If so, how far along? ____________________________________

Currently breastfeeding? __________ If so, how long? ___________ Difficulty, scanty or painful lactation?_________

Postpartum difficulties? ______________ Premature deliveries? ______________ Difficult deliveries? ___________

Please, describe ____

Symptom Survey

Please check the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
____ excessive appetite	____ insomnia	____ cough	____ low back pain	____ eye problems
____ loose stool/diarrhea	____ palpitations	____ shortness of breath	____ knee problems	____ jaundice
____ digestive problems, indigestion	____ cold hands and feet	____ decreased sense of smell	____ hearing impairment	____ difficulty digesting oily foods
____ vomiting	____ nightmares	____ nasal problems	____ ear ringing	____ gall stones
____ belching, burping	____ mentally restless	____ skin problems	____ kidney stones	____ light-colored stool
____ heartburn/reflux	____ sadness	____ claustrophobia	____ hair loss	____ soft or brittle nails
____ stomach bloating	____ chest pains	____ constipation	____ urinary problems	____ easily angered
____ obsession in work, relationship, etc.	____ laughing for no reason	____ recent use of antibiotics	____ decreased sex drive	____ difficulty in making decisions
____ lack of appetite	____ sadness	____ blood in stool	____ easily bruised	____ high cholesterol
	____ poor memory	____ hemorrhoids	____ dental problems	____ bitter taste
		____ colitis /diverticulitis		

____ fatigue	____ get sick easily	____ headaches
____ edema	____ I usually feel warm	____ I usually feel chilled
____ asthma	____ dizziness	____ allergies

Muscle, Joints and Bones

Do you have pain or tightness? ______________________________ Where? ____

Recent Injuries? ____________________________ Was this from an auto accident or work related? ______________________

The pain is (check all that apply):

______ Sharp ______ Deep Pain

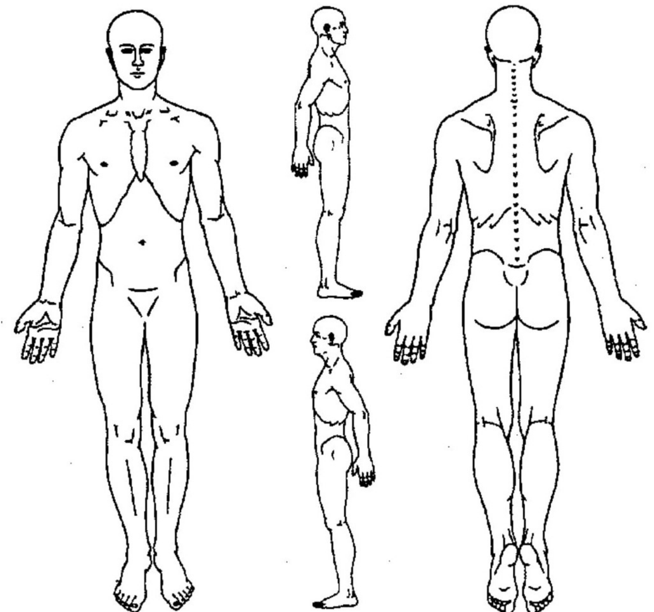
______ Numb ______ Superficial Pain

______ Burning ______ Tingling

______ Aching ______ Shooting

______ Dull ______ Pain worse with moveme

______ Pain in am/pm



I have (check all that apply):

______ Swollen Joints ______ Arthritis/Joint Pain

______ Tendonitis ______ Bone Pain

______ Muscle Cramps ______ Muscle Pain

______ Strain Injury

Have you fractured bones and have you had any surgery's? ____

____

____

Heartwood Holistic Health, PLLC
Chinese Medicine Patient Informed Consent

By signing below, I do hereby request and voluntarily consent to the performance of Chinese Medicine treatments and procedures within the scope of practice of Chinese Medicine on me (or on the patient named below, for whom I am legally responsible) by Alexis Wilson, MAOM and/or by practitioners who now or in the future may treat me while employed by, working or associated with Heartwood Holistic Health, PLLC or serving as back-up for Alexis Wilson.

I understand that acupuncturists practicing in NC are not primary care providers and that regular primary care by a licensed physician is recommended by Heartwood Holistic Health, PLLC. I understand that methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, Tui-Na (Chinese massage), Chinese herbal medicine , and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my practitioner of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: This light scraping technique is used on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

I understand the clinical and administrative staff may review my patient records and lab records 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 Chinese Medicine and 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 conditions and for any future condition(s) for which I seek treatment.
Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the practitioner before proceeding with treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Alexis Wilson MAOM is not primary care physicians.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

___________________________ ___________________________

Patient Name Printed *Patient Signature* *Date*

Heartwood Holistic Health

THIS OFFICE IS HIPAA COMPLIANT

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

As part of your healthcare, this practice originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning care and treatment
- A means of communication among the many health professionals that contribute to your care
- A source of information for applying your diagnosis and treatment information to your bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals

I understand that the **HIPAA Chiropractic Notice of Privacy Practice** is available to me upon request and online at http://heartwoodholistic.com/notice-of-privacy-practice.html The Notice provides a more complete description of information uses and disclosures. I understand that I have the right to review this Notice prior to signing this consent. I understand that the organization reserves the right to change its Notice and practices. I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance therein.

I wish to have the following restrictions to the use or disclosure of my health information (if applicable):

I fully understand and accept the terms of this consent.

______________________________ _______________
Patient Signature *Date*

______________________________ _______________
Staff Signature *Date*

Heartwood Holistic Health

Patient Election to Self-Pay for Services

Heartwood Holistic Health, PLLC has opted to be an out of network provider and DOES NOT file health insurance claims on behalf of its patients with in-network or out-of-network primary or secondary health insurance carriers. Heartwood Holistic Health, PLLC will furnish a visit statement (super bill) for services rendered to be filed by the patient. The Health Insurance Portability and Accountability Act (HIPAA) also allows me to choose to not file health insurance claims.

I understand and agree that I will pay Heartwood Holistic Health, PLLC directly for all services rendered with cash, check, or acceptable credit card.

______________________________ ______________________________

Patient Name Printed *Patient Signature* *Date*

Cancellation Policy

We respectfully ask that you give us at least 24 hours notice if you need to reschedule or cancel your appointment. Please call us at (919) 929-5610 to change your appointment.

More than 24 hours notice	Service will be canceled/rescheduled at no charge
Less than 24 hours notice	50% of the service price will be charged
Failure to show without notice	100% of the service price will be charged