PATIENT MEDICAL HISTORY
Confidential

GeneralInformation

Name (First, Middle Initial, Last):_____

Address:_____City:_____

State:_____Zip Code:_____Home Phone:_____

Work Phone:_____Other Phone:_____

Email Address:_____(*Your email address is kept secure and not shared with anyone.*)

Gender:_____Age:_____Date of Birth:_____Marital Status:_____

Height:_____Weight:_____Occupation:_____

Who is your medical doctor?_____Date of last visit:_____Reason:_____

Have you received acupuncture/Chinese herbs in the past?_____

MajorComplaint

What is your primary reason for this visit?

_____

_____

_____

What do you think is the cause of this condition?

_____

How long have you had this condition?_____Is it getting worse?_____

What seems to make it better?_____

What seems to make it worse?_____

Does this condition interfere with your ☐ Sleep ☐ Work ☐ Other_____

Have you received treatment for this complaint? ☐ Yes ☐ No

If yes, what was done?_____

Did it help? ☐ Not at all ☐ Somewhat ☐ Very effective ☐ Not sure

Do you have any specific questions that you would like to discuss today?_____

_____

_____

_____

FamilyHealthHistory

Place a mark to indicate if a *blood relative* has had any of the following:

☐ Alcoholism	Asthma	Diabetes	Seizures
☐ Allergies	Cancer	Heart Disease	Stroke
_____	_____	☐ High Blood Pressure	☐ Vascular Disea

YourHealthHistory

Place a mark to indicate if *you* have had any of the following:

☐ AIDS/HIV	Diabetes	Jaundice	Obesity	Thyroid Disorders
☐ Alcoholism	☐ Epilepsy	☐ Kidney Disease	☐ Pacemaker	☐ Tuberculosis
☐ Allergies	☐ Glaucoma	☐ Measles	☐ Pneumonia	☐ Typhoid Fever
☐ Asthma	☐ Heart Disease	☐ Meningitis	☐ Polio	☐ Ulcers
☐ Bleed Easily	☐ Hepatitis	☐ Mental Disorder	☐ Rheumatic Fever	☐ Vascular Disease
☐ Cancer	High Blood Pressure	Migraines	Scarlet Fever	Venereal Disease
☐ Chicken Pox	☐ High Fevers	☐ Multiple Sclerosis	☐ Seizures	
☐ Colitis	IBS	Mumps	Stroke	

Male (♂)

☐ Impotence ☐ Nocturnal emissions ☐ Premature ejaculation

Female (♀)

Age menses began:_____
Days of menstrual flow:_____
Length of cycle (day 1 to day 1):_____
Number of pregnancies: _____
Number of live births:_____
Number of premature births:_____
Age at menopause:_____

☐ Vaginal discharge
☐ Irregular periods
☐ Painful periods
☐ Clots in menstrual blood
☐ PMS
Date of last PAP:_____
Date last period began:_____

AdditionalQuestions

List any medications you are currently taking:_____
_____
List illnesses for which you have been hospitalized:_____
_____
_____
List any other serious injuries, broken bones, scars, etc:_____
_____
List allergies or sensitivity to any medicines or other substances:_____
_____

Comments (anything else you would like to tell us):_____
_____

How did you hear about us?_____
_____

I authorize treatment by the practitioners at Bodhi Acupuncture and Wellness, LLC. All information on this form is correct to th best of my knowledge. I understand that I am responsible for payment of applicable fees to Bodhi Acupouncture and Wellness, LLC on the day that services are rendered unless other arrangements have been made in advance.

_____ _____

PATIENT SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

Bodhi Acupuncture and Wellness

INFORMED CONSENT FOR ORIENTAL MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Oriental medicine on me (or on the patient named below for whom I am legally responsible) by the licensed acupuncturists named 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 practitioners named below, including those working at Bodhi Acupuncture and Wellness, LLC or any other office or clinic, whether signatories to this form or not.

There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile and Clean Needle Technique procedures are followed. I understand that all practitioners at Bodhi Acupuncture and Wellness, LLC are certified in Clean Needle Technique a use only sterile, single-use, disposable needles.

I have had an opportunity to discuss with the practitioner the nature and purpose of Oriental Medicine. I understand that results are not guaranteed.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgment which the practitioner feels at the time is in my best interest, based upon the facts then known, during the course of the procedure.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that the practitioner is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

_____ _____

PATIENT SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my identifiable health information by Bodhi Acupuncture, LLC. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosis or treatment of me at Bodhi Acupuncture, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Bodhi Acupuncture, LLC is not required to agree to the restrictions that I may request. However, if Bodhi Acupuncture, LLC agrees to a restriction that I request, the restriction is binding upon Bodhi Acupuncture, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that Bodhi Acupuncture, LLC has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Bodhi Acupuncture, LLC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Bodhi Acupuncture, LLC. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Bodhi Acupuncture, LLC with respect to my identifiable health information.

Bodhi Acupuncture, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____

PATIENT SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

Bodhi Acupuncture and Wellness

NOTICE OF PRIVACY PRACTICES

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with worker's compensation (and your employer as well in this instance), or with other medical practitioners *that you authorize*.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- About your financial transactions with us (billing transactions).
- From health care providers, insurance companies, worker's compensation and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 312-961-3678.

Best regards,

John Emanoil, L.Ac.. Dipl. Ac.