Mindful Body, Inc. New Patient Intake Form

Name_____ Today's Date ____/____/____

Hm Phone _____ Wk Phone _____ Cell Phone _____

Hm Address _____ City/State _____Zip _____

Employer _____ Occupation _____

Date of Birth _____ Marital Status _____

Emergency Contact _____ Relationship _____ Phone _____

Who may we thank for referring you to our office? _____

Have you received acupuncture before? Yes/No If yes, when was your last treatment? _____

What is the reason for your visit today?_____

_____

Health Insurance Info:

Insurance Co. Name _____Policy #_____

Address _____ Phone_____

City, State, Zip _____

Medical History (Please check any that you have experienced)

☐ Difficult concentration	☐ Cancer	☐ Polio	☐ Chronic Fatigue	☐ Asthma
☐ Anxiety	☐ Diabetes	☐ Aids	☐ High blood pressure	☐ Low blood pressure
☐ Depression	☐ Multiple Sclerosis	☐ Tuberculosis	☐ Epilepsy	☐ Seizures
☐ Post-traumatic Stress d/o	☐ Rheumatoid arthritis	☐ Fibromyalgia	☐ Digestive disorders	☐ Chronic Backache
☐ Nervous Tic	☐ Hepatitis	☐ Concussion	☐ Numbness/tingling (where?) _____	

Have you been treated by a physician for any health conditions in the last year? Yes/No
If so, please describe _____

Diet

Appetite ☐ low ☐ High

☐ Coffee/tea (amount) _____
☐ Soft drinks (amount)_____ __
☐ Alcohol (# per week)_____

☐ Sugar cravings ☐ Thirst for water:
☐ Salt cravings # glasses/day _____
☐ Eat breakfast? ☐ Milk/ ice cream

☐ Food sensitivities (explain) _____

Exercise (# of times per week) _____ Type: _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

_____

PRACTITIONER USE ONLY

MEDICATIONS – Please list all prescription medications you use. Incluse those which you may only use occasionally. Remember inhalers, eye drops & nose sprays.

Prescription Name	Purpose	How Long

SUPPLEMENTS – Please list all supplements you are currently taking, including vitamins, herbs, homeopathic remedies

Name	Purpose	How Long

GYNECOLOGY

Age menses began:_____ Duration of flow (days):_____ Length of cycle (day 1 – day 1)_____

Color of blood: _____ Date last period began:_____ Date last PAP:_____

Breast lumps:_____ # of Pregnancies:_____ # of Live Births:_____

Premature Births:_____ Age at Menopause:_____ Other: _____

☐ Irregular periods (explain)_____

☐ Clots ☐ Vaginal discharge

☐ Vaginal odor ☐ HPV ☐ Vaginal sores ☐ Painful periods

GENITO-URINARY

☐ Pain on urination ☐ Blood in urine ☐ Increased libido ☐ Decreased libido

☐ Impotence ☐ Frequent urination ☐ Unable to hold urine ☐ Bedwetting

☐ Premature ejaculation ☐ Urgent urination ☐ Incomplete urination ☐ Wake to urinate

☐ Kidney stone ☐ Nocturnal emission ☐ Sexually transmitted infection

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PRACTITIONER USE ONLY

SYMPTOMS *Please check if you have had these symptoms in the past or if you experience them now.*

LIVER/GALLBLADDER

Past Now
- ☐ ☐ Irritability/Anger
- ☐ ☐ Depression/stress
- ☐ ☐ Headaches/ Migraines
- ☐ ☐ Visual Problems
- ☐ ☐ Red/dry/itchy eyes
- ☐ ☐ Gall Stones
- ☐ ☐ Dizziness
- ☐ ☐ Blurred vision
- ☐ ☐ Feeling of a lump in throat
- ☐ ☐ Clenching teeth at night
- ☐ ☐ Muscle cramping/twitching
- ☐ ☐ Neck/shoulder tension
- ☐ ☐ Poor circulation
- ☐ ☐ Soft/brittle nails
- ☐ ☐ Emotional eater

HEART/SMALL INTESTINES

Past Now
- ☐ ☐ Heart Palpitations
- ☐ ☐ Irregular Heartbeat
- ☐ ☐ Chest Pain
- ☐ ☐ Insomnia/ sleep problems
- ☐ ☐ Easily Startled
- ☐ ☐ Restlessness/agitation
- ☐ ☐ Dream-disturbed sleep
- ☐ ☐ Lack of Joy in Life
- ☐ ☐ Anxiety
- ☐ ☐ Grief
- ☐ ☐ Depression
- ☐ ☐ Poor memory
- ☐ ☐ Mental confusion
- ☐ ☐ Spontaneous XS sweating

SPLEEN/STOMACH

Past Now
- ☐ ☐ Heaviness in body
- ☐ ☐ Fatigue (esp. after eating)
- ☐ ☐ Hard to get up in morning
- ☐ ☐ Edema (swelling)
- ☐ ☐ Muscle weakness
- ☐ ☐ Easily bruises
- ☐ ☐ Bad breath
- ☐ ☐ Lack of appetite
- ☐ ☐ Excessive appetite
- ☐ ☐ Crave sweets
- ☐ ☐ Hypoglycemia
- ☐ ☐ Difficulty digesting foods
- ☐ ☐ Nausea/vomiting
- ☐ ☐ Gas/belching
- ☐ ☐ Insulin sensitivity
- ☐ ☐ Hemorrhoids
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea or soft stools
- ☐ ☐ Abdominal pain
- ☐ ☐ Indigestion/ heartburn
- ☐ ☐ Excess thinking/ worry
- ☐ ☐ Tendency to gain weight
- ☐ ☐ Brain foggy

KIDNEY/URINARY BLADDER

- ☐ ☐ Urinary problems
- ☐ ☐ Bladder infection
- ☐ ☐ Lack of bladder control
- ☐ ☐ Weakness/ pain in low back
- ☐ ☐ Decrease bone density
- ☐ ☐ Often feel cold
- ☐ ☐ Low sex drive
- ☐ ☐ Excess sex drive
- ☐ ☐ Poor memory
- ☐ ☐ Loss of hair
- ☐ ☐ Premature grey hair
- ☐ ☐ Hearing problems
- ☐ ☐ Ringing in the ears
- ☐ ☐ Teeth problems
- ☐ ☐ Craving/ avoiding salty foods
- ☐ ☐ Fear
- ☐ ☐ Hot flush/ Night sweating

LUNG/LARGE INTESTINE

- ☐ ☐ Dry cough
- ☐ ☐ Cough with sputum (color_____)
- ☐ ☐ Nasal discharge (color_____)
- ☐ ☐ Post-nasal drip
- ☐ ☐ Sinus infection/ congestion
- ☐ ☐ Itchy, red or painful throat
- ☐ ☐ Dry mouth/ throat/ nose
- ☐ ☐ Skin rashes/ hives
- ☐ ☐ Snoring
- ☐ ☐ Grief/ sadness
- ☐ ☐ Shortness of breath
- ☐ ☐ Allergies/ asthma
- ☐ ☐ Low resistance to colds/ flu
- ☐ ☐ Sneezing
- ☐ ☐ Mild fever that comes & goes
- ☐ ☐ Smoking (tobacco/ marijuana)
- ☐ ☐ Abnormal sweating (or lack of)

HEAT

- ☐ Prefer cold drinks
- ☐ Usually feel warm/ hot
- ☐ Hot palms/ feet
- ☐ Unusual sweating
- ☐ Hot, or sweating at night

COLD

- ☐ Prefer hot drinks
- ☐ Usually feel cold

MUSCULOSKELETAL PAIN

- ☐ Muscle cramps (where?)
- ☐ Joint Swelling (where?)
- ☐ Tendonitis (where?)
- ☐ Bursitis (where?)
- ☐ Arthritis (where?)
- ☐ Muscle pain (where?)

Quality of pain: ☐ Burning ☐ Aching ☐ Stabbing ☐ Pressure ☐ Throbbing

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PRACTITIONER USE ONLY

Mindful Body, Inc.

Informed Consent for Acupuncture Treatment

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

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy, massage therapy, Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

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

By voluntarily signing below I show that I have read, or have had read to me this consent to treatment.

Practicioner: Margaret Blaser, LAc, LMT

Name of Patient (please print) _____

Signature of Patient_____ **Date**_____

Mindful Body
415 Uluniu St. Ste. A
Kailua, HI 96734

NOTICE OF PRIVACY POLICIES

Margaret Blaser, doing business as Mindful Body, is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways;

- Information we receive from you the patient.
- Information we receive from other healthcare providers.
- Information we receive from third party payers

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations. You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing
Mindful Body may send you newsletters, appointment reminders and invitations to Mindful Body events by calls, post cards or letters. Mindful Body will not use your health information for marketing communications without your written consent. Please advise this office in writing at our contact address below if you do not wish to receive such communications.

Disclosure
This office may use or disclose your Protected Health Information when required by law.

Patient Rights
Upon written request you have the right to access, review or receive copies of your healthcare records.

1. Upon written request you have the right to receive a list of items this office disclosed about your Healthcare information.
2. You have the right to request that this office place additional restrictions on disclosure of your Protected Health information.
3. You have the right to request that we amend your Protected Health Information; the request must be in writing.
4. You have a right to receive all notices in writing.

If you have questions or want more information please contact Margaret Blaser at (808) 292-3786, or contact by mail at 415 Uluniu St. Kailua, HI 96734.

Complaints
Complaints about your privacy rights or how your privacy is handled at this office can be directed to Meg Blaser, by calling this office or directing a letter to her attention as indicated above. If you are not satisfied with how this office handles your complaint you may send a written complaint to the U.S. Department of Health and Human Service. DHHS (Office of Civil Rights), 200 Independence Ave S. W. Room 509 F HHH Building, Washington, DC 20201.

Disclosure of Patient Information Required by Law

X_____ **Date**_____