Ginkgo Wellness Chinese Medicine Center

Patient Intake Form

Profile information

First Name	Last Name	DOB	Assigned Sex
Preferred Pronouns		Nationality	Occupation
Street Address		City	Zip Code
Phone		Email	

*Referral

☐Google ☐Yelp ☐Facebook ☐Instagram

☐Family/friend ☐Other

Medical Condition

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them directly opposite on the right side. Be sure to mention any drugs, vitamin supplements, or other medicinal substances you are taking.

Complaints	**How long have you had this condition?**	**Treatment Received/Concurrent Therapies**	**What makes it better?**

Health History

Family Medical History

What other medication and/or supplements are you taking	How long have you been taking them?

Emotions: ___Normal ___Irregular

___Depression ___Sadness ___Panic attack ___Sensitive
___Worries ___Overly excited ___Angry ___Anxiety

Describe:

Energy: ___Normal ___Irregular ___Low ___Up and down

___Exhausted ___Hyperactive ___Nervous Energy ___Abundant

Describe:

Sleep Pattern: ___Normal ___Insomnia

Falling Asleep: ___Sometimes difficult ___Always difficult ___Sometimes very difficult
___Always very difficult ___Sleepy in daytime ___Take naps (Time: ____)

Waking up: ___Times per night ___Wake up too early
___Wake up at night and cannot go back to sleep again

Sleep quality: ___Deep ___Light ___Poor ___Many dreams
___Bad dreams ___Grinding teeth ___Talking in sleep ___Other

Describe:

Diet: Any special diet?

Food cravings: ___Sugar ____Salt ___Coffee ___Soft Drinks ___Artificial Sweetener
___Food Allergies

Appetite: ___Low ___High

Describe:

Temperature: ___Normal ___Insomnia

___Feel cold easily ___Cold hand ___Cold feet
___Feel hot easily ___Alternating hot & cold ___Hot flash ___Sensitive to weather change

Describe:

Sweating: ___**Normal.** ___**Abnormal** ___**Too easily** ____**Too much**

___Difficult ___Too little ___Night sweats ___Other

Describe:

Sensitivity and Allergy: ___**No** ___**Yes**

Temperature**:** ___Cold ___Hot ___Dampness ___Light

___Noise ___Airborne particles ___Drugs ___Other

Describe:

Appetite and Digestion: ___**Normal** ___**Abnormal**

___Rapid hungering ___Poor appetite ___Nausea ___Anorexia

___Hungry, but no desire to eat ___Bloating ___Gas ___Other

Describe:

Bowel Movement: ___**Normal** ___**Abnormal** ___**Time of day**

___Constipation ___Diarrhea ___Loose ___Watery ___Incomplete

___Hard and dry ___Strong smell ___With mucus ___With blood ___Other

Describe:

Body Weight: ___**Normal** ___**Overweight** ___**Underweight**

If overweight: ___How many pounds would you like to lose?

___How many years ago did you first start to gain weight?

___Are you following a weight control program at this time?

Describe:

Drinking: ___**Normal** ___**Abnormal**

___Thirsty ___Dry mouth ___Drink a lot

___Dry mouth but no desire to drink

___Not thirsty, but drink a lot of water anyway

Describe:

Urination: ___**Normal** ___**Abnormal**

___Frequent ___Urgent ___Burning ___Painful ___Cloudy

___Dark color ___Foul smell ___Bloody ___Difficult ___Retention

___Number of times per day ___Number of times you get up to urinate at night ___Other

Describe:

Eye, Ear, and Nose: ___**Normal** ___**Abnormal**

Describe:

Respiratory: ___ Tight chest ___Difficulty breathing ___Shortness of breath

___ Asthma/wheezing ___Cough (wet /dry/ clear/ phlegm?) ___Coughing blood

___Pneumonia

Describe:

Cardiovascular: ___High blood pressure ___Low blood pressure ___Chest Pain

___Blood clots ___Fainting ___Difficulty breathing ___Heart Palpitations

___Tachycardia (HR >100 beats/min) ___Heart Pacer

Describe:

Sexual Function: ___**Normal** ___**Abnormal**

Describe:

Menstrual Cycle:

Age of onset: ___years old Date of last period: ___/___/

___**Regular** ___**Irregular** ___How many days between cycles?

___How many days did it last?

Color: ___Pale red ___Dark red ___Bright red ___Purplish

Were there clots? ___Yes ___No

Menstrual Pain ___Yes ___No

___Before flow ___During flow ___After flow

___Abdomen ___Back ___Breast

Emotion around period: ___**Normal** ___**Abnormal**

___Before flow ___During flow ___After flow ___Depression

___Irritability ___Anger ___Sadness ___Crying ___Other

Describe:

Addictions:

__Tobacco ___Alcohol ___Opioids ___Others

Describe:

Any other disorders or abnormalities:

Describe:

Notice of Privacy Practices

I. Understanding Your Health Record/Information

Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, a record of your visit is made. Typicality, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment This information, often referred to as your health or medical record, serves as a:

a) basis for planning your care and treatment

b) means of communication among the many health professionals who contribute to your care

c) Legal document describing the care you received

d) means by which you or a third-party payer can verify that service billed were actually provided

e) atool for educating health professionals

f) a source of data for medical research

g) a source of information for public health officials charged with Improving the health of the nation

h) a source of data for facility planning and marketing

i) a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information ls used helps you to:

1) ensure its accuracy

2) better understand who, what, when, where, and why others may access your health information

3) make more Informed decisions when authorizing disclosure to others

II. Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

a) request a restriction on certain uses and disclosures of your information

b) obtain a paper copy of this Notice of Privacy Practices upon request

c) inspect and obtain a copy of your health record

d) amend your health record under certain circumstances

e) obtain an accounting of disclosures your health Information

f) request communications of your health Information by alternative means or at alternative locations

g) revoke your authorization to use or disclose health information except to the extent that action has already been taken

III. Our Responsibilities

This organization is required to:

a) maintain the privacy of your health Information
b) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
c) abide by the terms of this notice
d) notify you If we are unable to agree to a requested restriction
e) accommodate reasonable request you may have to communicate health Information by alternative means or at alternative locations.
We reserve the right change our practices and to make the new provisions affective for all protected health Information we maintain. Should our information practices change, we will mail a revised notice to the address you supply to us.
We will not use or disclose your health information without your authorization, except as describe in this notice.

IV. For More Information or to Report a Problem

If have questions and would like to have additional information, ask your provider for clarification. If you believe your privacy rights have been violated, you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. You can find the Office for Civil Rights for your state at: http://www.hhs.gov/ocr/ragmall.html. There will be no retaliation for filing a complaint.

V. Examples of Disclosures for Treatment, Payment and Health Operations

Needless-to-say, we will disclose your protected health information in communications with you. For example, we may use and disclose health Information to contact you as a reminder that you have an appointment for treatment here, or to tell you about or recommend possible treatment options or alternatives that might be of interest to you. We may use and disclose health information about you to tell you about health-related benefit or services that might be of interest to you. Other reasons to disclose your health information include the following.

1) We will use your health information for treatment.
For example: Information obtained by your practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his or her expectations of any other members of your healthcare team. Those tam members will then record the actions they take and their observations. In that way, the practitioner will know how you are responding to treatment.

2) We will use your health Information for payment
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Acknowledgement of Receipt of Notice of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.

b) Payment - To bill you or a third party for payment for services provided to you.

c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object

a) To you

b) As required by federal, state, or local law

c) If child abuse or neglect is suspected

d) Public health risks (for public health activities to prevent and control spread of disease)

e) Lawsuits and disputes (in response to a court or administrative order)

f) Law enforcement (to help law enforcement officials respond to criminal activities

g) Coroners, medical examiners and funeral directors

h) Organ or tissue donation facilities if you are an organ donor

i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.

b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request

b) Right to amend information in your health record you believe is inaccurate or incomplete

c) Right to know to whom we have disclosed your health information

d) Right to ask for limits on the health information data we give out about you

e) Right to receive communication from us about your health information in alternate ways

f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Consent to Treatment

I understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, QI Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or If I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which l have acknowledged receipt.

l understand that I can discuss risks and benefits further with my practitioner before signing lf I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance

companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient/Guardian Signature: _____

Date: _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature: _____	Parent / Guardian Signature _____	Witness Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____