Doctor Copy

'Notice of HIPAA Privacy Practices'

This document is an abbreviated 'Notice of Privacy Practices'. It explains how health information about you may be used, and your rights, regarding the use of that information. Please review it carefully.

You have the right to:

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary)
- Ask to correct information that you believe is wrong in your health record
- Ask that your health information not be used for certain purposes, for example, research
- Ask that copies of your health record be sent to whomever you wish (charges may be necessary)
- Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes).
- Specify where and how you should be contacted
- Receive a paper copy of the full 'Notice of Privacy Practices'

Who is authorized to see confidential Patient Health Information (PHI)?

The "Notice of Privacy Practices" describes the ways in which your PHI may be used without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.

1. Treatment of the patient, such as consultation between treating providers
2. Payment of health care bills (insurance claim submission, authorizations and payment posting)
3. Health care operations and business operations, including research (when approved by the IRB and with a patient's written permission); health care communications between a patient and their health care practitioner.

Written Authorizations

To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand or know what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with your practitioner or the privacy coordinator. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

- I acknowledge receipt of the "Notice of Privacy Practices" and "Patient's Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
- I understand and acknowledge that I may receive appointment reminder calls, newsletters, and cards, and I agree to receive these.

Signature_____ Date_____

Date of Birth_____

Printed Name_____ Relation (if other than the patient)_____

Patient declined to sign receipt (signature of practitioner)_____

Patent unable to sign (witness signature)_____Reason unable_____

Acupuncture and Integrative Health Medicine
Cynthia Quattro, P.A., DAOM, L.Ac.
New Patient Intake Form

Today's Date ____/_____/_____

Name _____ SS#_____ Birthdate _____/_____/____

Address _____ City _____ State _____ Zip _____

Contact Number (____) _____ Email _____ Occupation _____

Emergency Contact Name _____ Phone (_____) _____

Referred by_____ Reason for today's visit _____

What is the history of this condition? _____

What treatments have you had for this?_____

What seems to make it better?_____ What seems to make it worse? _____

Have you had acupuncture before? ❑ Yes ❑ No Chinese herbal medicine? ❑ Yes ❑ No

Are you under the care of a physician now? ❑ Yes ❑ No If yes, for what?_____

Who is your physician? _____ Physician's Phone (_____) _____

Other current therapies_____

Family Medical History

Please indicate which family member:

❑ Allergies_____
❑ Asthma_____
❑ Alcoholism/drug use_____
❑ Cancer _____
❑ Diabetes_____
❑ Heart disease_____
❑ High blood pressure _____
❑ Mental illness_____
❑ Osteoporosis _____
❑ Seizures_____
❑ Stroke_____
❑ Thyroid disorders _____
❑ Other _____

Your Past Medical History

Check any of the following conditions you currently have, or have had in the past:

❑ Alcoholism
❑ Allergies
❑ Arthritis
❑ Asthma
❑ Cancer
❑ Diabetes
❑ Goiter
❑ Heart disease
❑ Hepatitis
❑ Herpes
❑ High blood pressure
❑ Pacemaker
❑ Pneumonia
❑ Polio
❑ Seizures
❑ Stroke
❑ Ulcers
❑ Thyroid disorders
❑ Tuberculosis/TB Test +
❑ Birth trauma (your own)
❑ Surgery (list)
_____
_____
_____
❑ Major trauma (car, fall, etc. – list)
_____
_____
❑ Other/Hospitalizations
_____
_____

Your Diet

Appetite ❑ Low ❑ High
Thirst ❑ Low ❑ High

What food do you craving?
_____
_____

What do you drink? How many? Per day/week
❑ Coffee/Tea _____/_____
❑ Soft drinks _____/_____
❑ Fruit juice _____/_____
❑ Water _____/_____
❑ Milk _____/_____
❑ Alcohol _____/_____
❑ Other _____ _____/_____

Daily protein source? How often? Per day/week
❑ Soy _____/_____
❑ Fish _____/_____
❑ Chicken _____/_____
❑ Turkey _____/_____
❑ Red meats _____/_____
❑ Other _____ _____/_____

Average Daily Menu

Breakfast	Lunch	Dinner	Snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies_____
Current Medications_____
Current Vitamins/Supplements _____
_____
_____

Current Lifestyle

Stress: ❑ Mild ❑ Moderate ❑ Severe

Stress related to: ❑ Family ❑ Relationships ❑ Work ❑ Other _____

Quantity
❑ Alcohol _____
❑ Tobacco _____
❑ Marijuana _____
❑ Drugs _____

Work environment _____
_____
Leisure Activities/Exercise _____
_____

General Symptoms (Mark with a double x if this is a current symptom)

❑ Strongly like cold drinks
❑ Strongly like hot drinks
❑ Recent weight change:
  ❑ Loss _____
  ❑ Gain _____
❑ Poor sleep
❑ Heavy sleep
❑ Dream disturbed sleep
❑ Fatigue
❑ Lack of strength
❑ Bodily heaviness
❑ Cold hands or feet
❑ Poor circulation
❑ Shortness of breath
❑ Fevers
❑ Chills
❑ Night sweats
❑ Sweat easily
❑ Muscle cramps
❑ Vertigo or dizziness
❑ Bleed or bruise easily
❑ Peculiar taste (describe):
_____
_____

Head, Eyes, Ears, Nose, Throat

❑ Glasses
❑ Eye pain
❑ Red eyes
❑ Itchy eyes
❑ Spots in eyes
❑ Blurred vision
❑ Glaucoma
❑ Cataracts
❑ Teeth problems
❑ Grinding teeth
❑ TMJ
❑ Facial pain
❑ Dry mouth
❑ Gum problems
❑ Sores on lips or mouth
❑ Difficult to swallow
❑ Excessive saliva
❑ Sinus problems
❑ Excessive phlegm
❑ Color of phlegm
_____
❑ Recurrent sore throat
❑ Swollen glands
❑ Lumps in throat
❑ Enlarged thyroid
❑ Nose bleeds
❑ Ringing in ears
❑ Poor hearing
❑ Earaches
❑ Headaches
❑ Migraines
❑ Concussions
Other head or neck problems (explain):
_____

Respiratory

❑ Asthma/wheezing ❑ Coughing blood ❑ Frequent colds ❑ Pneumonia

❑ Cough: Wet or dry? _____ Thick or thin? _____ Color of phlegm _____

Cardiovascular

❑ High blood pressure
❑ Low blood pressure
❑ High cholesterol
❑ Blood clots
❑ Fainting
❑ Chest pain/tightness
❑ Difficulty breathing
❑ Heart palpitations
❑ Pace maker
❑ Heart murmur
❑ Phlebitis
❑ Irregular heartbeat

Gastrointestinal

❑ Nausea
❑ Vomiting
❑ Heartburn
❑ Gas
❑ Hiccups
❑ Bloating
❑ Indigestion
❑ Bad breath
❑ Diarrhea
❑ Constipation
❑ Laxative use
❑ Black stools
❑ Bloody stools
❑ Mucous in stools
❑ Gallbladder pain
❑ Intestinal pain or cramping
❑ Itchy/burning anus
❑ Rectal pain
❑ Hemorrhoid
❑ Anal fissures
Bowel movements:
Frequency _____
Color _____
Texture/form _____
❑ Strong odor

Musculoskeletal

❑ Neck/shoulder pain
❑ Muscle pain
❑ Upper back pain
❑ Low back pain
❑ Joint pain
❑ Rib pain
❑ Limited range of motion
❑ Limited use _____
❑ Other:
_____

Skin, Hair & Nails

❑ Rashes
❑ Hives
❑ Ulcerations
❑ Eczema
❑ Psoriasis
❑ Acne
❑ Dandruff
❑ Itching
❑ Hair loss
❑ Change in hair/skin texture
❑ Fungal Infections
❑ Brittle nails
❑ Other hair or skin problems: _____
_____

Neuropsychological

❑ Seizures
❑ Numbness
❑ Tics
❑ Dizziness
❑ Poor memory
❑ Depression
❑ Anxiety
❑ Headaches
❑ Irritability
❑ Easily stressed
❑ Abuse survivor
❑ Paralysis
❑ Considered/attempted suicide
❑ Seeing a therapist
❑ Psychiatric hospitalization
❑ Other (specify):
_____
_____

Genito-urinary

❑ Pain on urination
❑ Frequent urination
❑ Urgent urination
❑ Dark urine
❑ Blood in urine
❑ Unable to hold urine
❑ Incomplete urination
❑ Urine odor
❑ Venereal disease
❑ Bedwetting
❑ Wake to urinate ___times
❑ Kidney stone
❑ Increased libido
❑ Decreased libido
❑ Impotence
❑ Premature ejaculation
❑ Genital warts
❑ Nocturnal emission
❑ Prostate enlargement
❑ Bladder infection

Gynecology

Age menses began: ___
Length of cycle (day 1 to Day 1): _____
Duration of flow: _____
❑ Irregular periods
❑ Painful periods
❑ PMS
❑ Menstrual clots
❑ Abnormal Pap smear
❑ Vaginal discharge (color): _____
❑ Vaginal sores/soreness
❑ Vaginal odor
❑ Breast lumps/tenderness
Contraception _____
#Pregnancies _____
#Live births _____
Premature births _____
❑ Menopausal symptoms
_____
Age at Menopause _____
Date of last PAP: _____
Mammogram: _____
Date last period began:
_____

What is your health plan goal? _____

How would you like to improve your health? _____

Other comments: _____