www.BEAMwellness.org

Beacon East Asian Medicine **Karen Y. Gordon LAc, DAOM** 김연재 한의원 96 West Villa Street, Pasadena, CA 91103 (213) 448-4254

Patient Health History and Intake Form

Date____________________

Name____ Birthdate________________ Age_________

Occupation____ Physician's name_________________________________

Address____

City____State___________________Zip______________________

Email____

Work Phone__________________________Home Phone_________________________Mobile_____________________

Emergency Contact____ Phone_____________________________

Referred by____

Reason(s) for this visit?

____

____

Please indicate if you have any of the following:

[] Cardiac pacemaker
[] Seizure disorder
[] Bleeding disorder
[] Fainting disorder
[] Believe you are or may be pregnant
[] Hepatitis B
[] HIV
[] Other: ________________________________

Any previous surgeries:

____

Please mark if you take any of the below medications/supplements on a regular basis:

[] aspirin	[] ibuprofen	[] Tylenol	[] blood thinners	[] antacids
[] tranquilizers	[] laxative	[] insulin	[] anti-anxiety	[] anti-depressants
[] sleeping pills	[] blood pressure	[] vitamins	[] omega 3	[] probiotics
[] herbs	[] fertility drugs	[] clomid	[] oral contraceptives	

List all medications or supplements you are currently taking:

____

Please check any symptoms you currently have or have had in the last year:

General

[] chills or and fever	[] insomnia	[] sweat spontaneously	[] catch colds easily
[] allergies	[] nervousness	[] night sweating	[] see floating black spot
[] fatigue	[] numbness	[] lack of sweating	[] sensitive to light
[] excess thirst	[] palpitations	[] aversion to heat or cold	[] difficulty breathing
[] heat sensation in hands/feet/chest		[] feverish in the afternoon	[] bleeding, swollen painful gums

Libido

[] normal	[] low	[] high

Skin and Hair

[] dry skin	[] recent moles	[] fungal infection	[] loss of hair
[] nail problem	[] change in moles	[] warts	[] athlete's foot
[] eczema	[] itching	[] skin discoloration	[] corns
[] psoriasis	[] dandruff	[] acne	[] change in skin color
[] open sore	[] hives	[] rashes	[] change in hair

Head and Neck

[] headache	[] mouth sores	[] nose bleeds	[] sore throat
[] migraines	[] sores on the lips	[] sores on tongue	[] glasses/contact
[] concussion	[] sores on tongue	[] sudden vision change	[] horse voice
[] facial pain	[] grinding teeth	[] glaucoma	[] difficulty swallowing
[] TMJ	[] dizziness/vertigo	[] poor vision	[] night blindness
[] poor hearing	[] jaw clicks/locks	[] eye strain/pain	[] floaters/spots
[] dental problem	[] gum problem	[] blurry vision	[] earache
[] color blindness	[] sinus problem	[] nasal congestion	[] ringing in the ears

Respiratory

[] cough	[] phlegm	[] difficult breathing	[] difficulty inhaling
[] wheezing	[] tight chest	[] shortness of breath	[] pain with deep breath
[] sweat easy	[] allergies	[] asthma	[] emphysema
[] pneumonia	[] bronchitis	[] cough blood	[] difficulty breathing lying down
[] difficulty exhaling	[] difficulty inhaling		

Cardiovascular

[] palpitations	[] insomnia	[] high blood pressure	[] chest pain/pressure
[] fainting	[] cold hands/feet	[] difficulty falling asleep	[] irregular heart beat
[] difficulty staying asleep	[] low blood pressure	[] swelling of hands/feet	

Gastrointestinal

[] low appetite	[] abdominal pain	[] bleed/bruise easily	[] black/tar like stools
[] change in appetite	[] rectal pain	[] nausea	[] rib pain
[] high appetite	[] gas	[] acid reflux/GERD	[] anemia
[] weigh loss/gain	[] loose stools	[] blood in stool	[] bad breath
[] strong thirst	[] muscle weakness	[] IBS	[] indigestion
[] constipation	[] diarrhea	[] hernia	[] chronic laxative use
[] hemorrhoids	[] cravings	[] vomiting	[] jaundice
[] belching	[] colitis	[] alt. diarrhea & constipation	[] fatigue

Genito-Urinary

[] painful urination [] cloudy urine [] excessive urine [] increased libido
[] unable to hold urine [] weak urine stream [] dribbling after urination [] genital itching
[] frequent urination [] UTI [] bladder infection [] abnormal discharge
[] urgent urination [] bed wetting [] low back pain [] yeast infection
[] edema [] genital sores [] kidney stones [] burning urination
[] night urination [] scanty urine [] decreased libido [] increased libido

Neuropsychological

[] seizures [] mood swings [] loss of balance [] panic attacks
[] lack of coordination [] tremors [] difficulty concentrating [] depression
[] area of numbness [] poor memory [] mood disorder

Other

[] hot flashes [] thickening or lump in breast or elsewhere [] indigestion or difficulty swallowing
[] night sweat [] nagging cough or hoarseness [] unusual bleeding or discharge
[] none healing sores [] sensation of something stuck in the throat [] obvious change in wart or mole

Body temperature

[] cold hands/feet [] hot hands/feet [] warm and get hot easily [] cold need to bundle up

Please rate your energy level (on the scale of 1-10). ______________________________

Pain

When did your pain begin? __________________How did it begin? ______suddenly ______gradually

On a scale of 1-10, please rate the level of your pain __________________________

<u>Quality of pain. Check all that apply.</u>

[] stiff [] achy [] sharp [] stabbing [] shooting [] radiating [] dull
[] tightness [] burning [] tingling [] numb [] tense [] other __________

<u>The pain is better with</u> [] cold [] warm [] massage [] lying down [] standing up
[] activity [] meditation [] rest [] other __________

<u>The pain is worse with</u> [] cold [] warm [] massage [] emotional upset
[] standing up [] rest [] activity [] meditation
[] lying down [] other______________________________

Infectious diseases

[] HIV [] TB [] hepatitis [] HPV [] MRSA [] gonorrhea
[] Chlamydia [] hepatitis [] syphilis [] genital warts [] herpes simplex

FAMILY MEDICAL HISTROY

[] Heart Disease [] Stroke [] Diabetes [] Cancer [] High Blood Pressure
[] Seizures [] Asthma [] Allergies [] Other_________________________

Diet & Nutrition

What foods do you eat on regular basis? Circle all that apply.

Beef	Sushi	Cheese	Salads	White rice
Chicken	Seaweed	Fast food	Raw Vegetable	Brown rice
Pork	Eggs	Ice cream	Cooked Vegetable	Oatmeal
Turkey	Yogurt	Fried food	Bread	Nuts
Lamb	Butter	Tea	Sweets	Cookies
Fish (Ocean)	Soda	Whole Grains	Spicy food	Pasta
Fish (Freshwater)	Salt	Tofu	Sugar	Juices
Seafood	Milk	Health foods	Fruit	Energy drink

Do you drink Coffee? If yes, how many cups per day and what kind?

____

How much water do you drink per day? _______ cup(s)

Do you prefer?

____ room temperature drinks/foods ____warm drinks/foods _______cold drinks/foods

What types of foods do you crave? (sweets, salty, spicy and fried foods for example)

____

Do you feel tired, sleepy, bloated and/or fatigue after eating? Y/N

(circle all that apply above and explain others)

____

Your appetite is normally? ________ Large ________ Hunger after eating _______ Low

Do you follow a particular diet?

(vegan, vegetarian, gluten free, dairy free, high protein/low carb, low fat and others)

____

Do you drink alcohol? If yes, how many per week? ____ beer ____wine ___ hard liquor

____

Do you smoke cigarettes? Y / N If yes, how many a day? ______________________________

Sleep: On average, how many hours of sleep do you get each night? (hours)

difficult falling asleep	Y/N	wake up to urinate during the night	Y/N
wake up during the night	Y/N	excessive dream disturbance	Y/N
feel tired waking up	Y/N	difficulty getting out of bed	Y/N

Emotions: Do you often feel any of the following emotions?

[] depression
[] worry
[] nervous
[] irritability
[] anger
[] timid or shy
[] fear
[] frustration
[] paranoid
[] regret
[] indecisiveness
[] anxiety
[] loneliness
[] rage
[] overwhelmed
[] restlessness
[] stress
[] grief/sad
[] unmotivated
[] other ____________

Exercise Routine:

Interest/hobbies:

What do you do for relaxation?

Women's Fertility History

How old were when you started your period? ___________________________

Date of first day of your last menstruation. _____________________________

On average, how long is your menstrual cycle? (From first day of period to first day of next period) ________________

How many days does your period last? (days you are bleeding) _______________________

Are you currently pregnant? _____ yes _____ no ______currently trying to conceive

Number of past pregnancies. ________________

Reproductive History

[] painful periods	[] heavy flow	[] light flow	[] abnormal bleeding
[] irregular cycle	[] regular cycle	[] oral contraceptives	[] bleeding between periods
[] vaginal infection	[] PCOS	[] endometriosis	[] abnormal pap
[] clots in menstrual flow	[] breast lump	[] breast cancer	[] PID
[] cervical dysplasia	[] PMS	[] menopause	[] infertility
[] tubal ligation	[] tubal ligation	[] IUD [] hot flashes	[] HPV
[] lack of period longer then 6 months not due to pregnancy or menopause			[] painful/itching genitalia

Do you experience any of these symptoms right before your period?

[] bloating	[] breast distention	[] headache	[] irritability	[] cramps	[] anger	[] dizziness
[] frustration	[] back/pelvic pain	[] emotional	[] fatigue	[] insomnia	[] other____________________	

Date of last pap smear?____

Have you taken any medications for gynecological conditions other than contraceptives? ______ yes ______ no

medications/reasons/for how long?

____

____

Do not write below this line. For office use only.

Other signs/symptoms ____

____

T ____P____

Shen/Color/Eyes____

TCM Diagnosis ____

Western Diagnosis ____

Treatment Protocol ____

Points ____

Formula ____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for) by Karen Gordon, who is a Licensed Acupuncturist in the state of California, and or other licensed acupuncturists Karen Gordon, who now or in the future treat me while employed by, working or associated with or serving as back-up for Karen Gordon, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional and fertility counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days with chance of dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).

I have been informed the side effects of acupuncture for facial rejuvenation include bruising on the face, redness on the face, and/or bleeding on the face. I understand the contraindications of facial acupuncture include high blood pressure, dizziness, diabetes, pregnancy, facial sunburn, asthma, those who have had recent botox or restalyn injection, microdermabrasion, chemical peel, acute herpes outbreak on the face, have cold/flu, pituitary tumors or Cushing's diseases, hemophiliacs, those on blood thinners, taking aspirin, vitamin E, and/or fish oil, those prone to migraines, epilepsy or seizers, lymphoderma in the face, cancer, AIDS, or coronary diseases. If I have any of these above conditions, I will inform the acupuncturist before starting treatment.

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, animal, and mineral 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 will notify a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient records and lab reports, 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 acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover entire course of treatment for my present conditions and for any future condition for which I seek treatment.

Please print patient's name ____

Patient Signature ______________________________________ Date ____________________

www.BEAMwellness.org
Beacon East Asian Medicine **Karen Y. Gordon LAc, DAOM** 김연재 한의원 96 West Villa Street, Pasadena, CA 91103 (213) 448-4254

HIPPA Notice of Privacy Policies

We are required by law to:

- Maintain the privacy of protected health information.
- Give you the notice of legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that is currently in effect.
-

How We May Use and Disclose Health Information:

- We will use and disclose health information only with your written permission.
- You may revoke such permission at any time by writing to our practice's privacy officer.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my 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 care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- 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.
- To revoke this consent in writing, except to the extent that the organization has already taken actions in reliance thereupon.

I have read and agree to the above terms: Date ___________________________________

Please print patient's name ____Patient Signature ___________________________________

FINANCIAL AGREEMENT, INSURANCE POLICY, & CANCELLATION POLICY

FINANCIAL AGREEMENT

Payment is due at the time of service. For your convenience we accept cash, check and all major credit cards.
There is a $25 service fee for returned checks.

INSURANCE POLICY

When using insurance, you are responsible for the full payment of service at the time of service. The acupuncturist will provide you with a receipt of payment (super bill) that you can submit to your insurance for reimbursement. This is not a guarantee that they will reimburse you. Please check with your insurance provider before you first appointment to see if you have coverage.

CANCELLATION POLICY

We have a 24-hour cancellation policy. We ask that if you would like to cancel that you give us at least 24 hours notification before the scheduled appointment. If a 24-hour notice is not given, you may be charged $40 for missed appointment.

I have read and agree to the above terms: Date ___________________________________

Please print patient's name ____Patient Signature ___________________________________