PATIENT DATA:

Date:_____

Name:_____

Address:_____

City/State/Zip:_____

Phone: (h)_____ (w)_____ (cell) _____

Date of Birth:_____ Age: _____ Email: _____

Circle One: single partnered married separated divorced widowed Gender: M F

Occupation: _____Name of Spouse/Partner or Parent (if child) _____

Emergency contact: (name) _____ (phone) _____

How did you learn about our office? _____

Current Physician _____Diagnosis by MD_____

Which of the following have you experienced before? **Circle all that apply:** Acupuncture Herbal Medicine

Chiropractic Massage Hypnosis Emotional Freedom Techniques Dietary Consultation

PRIMARY COMPLAINTS:

1.
2.
3.

MEDICAL HISTORY:

MEDICATIONS: Please list all prescribed (allopathic) drugs, non-prescribed medications, vitamins, herbs etc., you are taking, stating what they are used for.

1.
2.
3.
4.

Please check: Do you use or do any of the following on a regular basis?

Alcohol	Tobacco	Drugs	Coffee or Tea	Exercise	Soft drinks	Sugar	Soy Products	Wheat/ Gluten	Vegetarian diet

Please list any hospitalizations, accidents, and past illnesses. Include dates and ages.

1.
2.
3.
4.

Please list any serious diseases in your family history such as Cancer, Diabetes, Hypertension, Heart disease etc.

Mother: Father:

Grandparents: Siblings:

INFORMED CONSENT

I hereby request and consent to the performance of the following on me by a duly licensed practitioners of Oriental Health Solutions who now or in the future treat me while employed by, contracted by, working or associated with or serving as a back-up for Oriental Health Solutions, perform modalities such as acupuncture by a duly licensed acupuncturist; and hypnosis, imagery and Emotional Freedom Technique (EFT) by a duly licensed physician.

I consent to other procedures such as questioning me about my medical history, performing pulse and tongue evaluation, manual palpation on relevant areas of my body; range of motion evaluation; muscle, orthopedic and neurological testing; modes of manual or physical therapy such as massage; heat and/or cold therapy, the use of magnets and electrical stimulation; cupping (the application of suction cups, usually, on the back); the functional/nutritional interpretation of select laboratory tests; the prescribing of Chinese herbs, homeopathic medicines and dietary supplements; dietary recommendations; advice regarding exercise regimens; lifestyle counseling, hypnosis, imagery and EFT (meridian tapping).

I understand that the above therapies have helped millions people, no guarantee or cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of western medicine, in the practice of complementary medicine there are some risks to treatment. I understand that while extremely unlikely, possible risks include but are not limited to: bleeding, bruising, light-headedness, inflammation, infection, general aches, burns, puncture of organs, pain at the location where a needle is inserted or radiating from that location, nerve pain, and temporary aggravation of current symptoms. A meta-analysis showed that in 35 years there have been 202 adverse events related to acupuncture (*Altern Ther Health Med* 2003:9(1):72-83). I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the practitioner's judgment based on the facts known at the time.

I understand that if I am seeking to become or am pregnant during my treatments at OHS, the practitioner and I may discuss Chinese herbal therapy, or the use of supplements. The recommended herbs and/or supplements will be used only with my consent. While properly-recommended herbs and supplements generally aid in a healthy pregnancy, I understand that all pregnancies carry an innate amount of risk, and there are no guarantees of these herbs/supplements' benefits. While there are scientifically documented treatments for turning a breech baby, no implied guarantee can be made. My practitioner and I may discuss and apply treatments to facilitate the labor and delivery process, but no treatments for the express purpose of labor induction will be provided. By signing below, I agree to the above-named procedures if applicable to my specific situation. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

Appointments: All patients are seen on an appointment basis. Please be aware that the **full treatment fee** will be charged for broken appointments unless a 24-hour business day notice is given. This means for a Monday appointment notice needs to be given by Friday at 12:30 PM. It is the patient's responsibility to remember an appointment. Reminder text messages or phone calls are made only as a courtesy. **Payments:** We make every effort to keep the cost of care down. To assist this effort, you are expected to pay upon the completion of each visit. We accept major credit cards, debit cards, checks or cash. A $25.00 fee will be charged on all returned checks. We request a $20 minimum purchase for credit card charges. **Emails/Texts:** Email has been very helpful for our patients in answering health related questions efficiently between visits, and there has been such a demand for this option that we are now charging $10.00 per 5 min increment for the time it takes us to respond. Many patients find it convenient to communicate with our office by text and/or email, which are unencrypted methods of communication and deemed "unsecure" by Federal law (HIPAA). It is up to each patient to weigh the tradeoff between convenience and security. If you would like to receive appointment reminders via text and/or email, please confirm below by providing your authorization. We will keep your preferences in place, with no current expiration date unless you notify us otherwise.

I authorize the practice to communicate with me by "unsecure" text; please use phone number
_____ (number) _____(signature/date);

I authorize for the practice to communicate with me by "unsecure" email; please use email address
_____ (email address) _____(signature/date)"

Chinese herbal refills: For herbal formula refills we kindly request a minimum of a 24 hour notice. **Insurance:** We do not bill insurance. We will be happy to assist you with filling out any relevant insurance claim forms but payment is expected after each visit. After filing your claim, your insurance carrier may reimburse you. Chinese herbs or supplements are not covered under any insurance plan. Thank you for calling this office. It is a pleasure to be of service to you.

To be completed by patient:

_____	_____	_____
Patient's Signature or guardian	**Print Patient's name**	**Date**

Please check current complaints

Musculoskeletal

Neck Pain	Hip Pain	Leg Cramps
Back Pain	Knee Pain	Muscle Atrophy
Hand/Wrist Pain	Foot/Ankle Pains	Muscle Pains
Elbow Pain	Hernia Pain	Muscle Spasms
Arm Pain	Deformities of Bones	Muscle Weakness
Shoulder Pain	Brittle Bones	Areas of Numbness & Tingling
Rib Pain	Joint Swelling	Other:

Neurophysiological/ Emotional

Seizures	Convulsions	Poor Memory/Concentration
Regions of Numbness	Dizziness	Anxiety
Head Injury	Lack of Coordination / Balance	Sadness
Bad Temper	Low Stress Tolerance	Weepy
Worry, Over-thinking	Fearful	Depression
Mood Swings	Suicidal	Paralysis
Confusion	Tremors / Tics	Mental Illness

General

Night Sweats	Sleep Too Much	Rashes
Fevers / Chills	Insomnia	Fungal Infections
Hot or Cold Intolerance	Nightmares	Psoriasis
Spontaneous Sweating	Bleed or Bruise Easily	Eczema
Weakness	Swollen Glands	Itchy or Dry Skin
Fatigue	Cravings	Acne
Sudden Energy Drop: time?	Weight Gain/Loss	Ulcerations
Auto-Immune disease	Dental amalgam fillings	Infections e.g. HIV+, Lyme, EBV
Immune issues like high ANA titer	Hair loss	Premature birth
Forceps delivery	Held in an incubator	Life threatening event

Cardiovascular

High Blood Pressure	Irregular Heartbeat	Swelling of Feet/Hands
Low Blood Pressure	Rapid Heartbeat / Palpitations	Blood Clots
Chest Pain	Fainting	Varicose Veins

Respiratory

Asthma	Bronchitis	Sinus Congestion
Allergies	Pneumonia	Production of Phlegm: Color?
Cough	Difficulty Breathing	Nose Bleeds
Coughing Blood	Catch Colds Frequently/Easily	Other:

Gastrointestinal

Increased Appetite	Bad Breath	Mouth Sores
Decreased Appetite	Belching	Excessive Thirst
Nausea	Hiccups	Problems Swallowing
Vomiting	Gas	Heartburn / Reflux / Indigestion

Food Sits in Stomach	Hiatal Hernia	Parasites
Peculiar Tastes / Smells	Constipation	Itchy Anus
Gallstones	Diarrhea	Food Allergies
Hepatitis	Loose Stools	Desire for Hot / Cold Foods
Hemorrhoids	Anal Fissures	Dark / Light / Bloody stools
Current Weight_____lbs	Rectal Pain	Other GI issue:

Genito-Urinary

Painful / Difficult Urination	Decrease in Flow	Urinary Tract Infection
Urgency to Urinate	Dark / Odorous Urine	Interstitial Cystitis
Frequent Urination	Unable to Hold Urine	Kidney Stones
Blood in Urine	Bedwetting	Genital Sores
Cloudy Urine	Night time Urination	Edema: where? _____

Head, Eyes, Ears & Throat

Headaches	Light Sensitivity	Earaches
Migraines	Red / Itchy Eyes	Ringing in Ears
Fainting	Poor Night Vision	Dizziness
Pressure in Eyes / Ears	Spots in Front of Eyes / Floaters	Sores on Lips / Tongue
Eye Pain	Poor Hearing	Grinding Teeth

Women

Cycle Length: ____ days	Vaginal Dryness	Increased / Decreased Libido
Days of bleeding: ____ days	Endometriosis	Hot Flashes
Heavy or Light Periods	Method of Birth Control?	Night Sweats
Menstrual Blood Color: _____	Number of Pregnancies _____	Sexually Transmitted Disease
Menstrual Pain	Number of Children _____	HPV positive? Yes No
Clots	Number of Abortions _____	Vaginal Discharge/ Sores
PMS	Difficult Birth / Caesareans	Breast Problems
Polycystic Ovarian Disease (PCOS)	Are you pregnant? Yes No	Age Menses began _____
Irregular or No Periods	Date of last PAP? _____	Age at Menopause _____
Female Fertility issues	Infertility	Number of Miscarriages _____
Anovulation	Luteal Phase Problems	Pelvic Inflammatory Disease
Used birth control pills or Depo-Provera	Tested positive for Chlamydia? Yes No	# of IUI or IVF cycles? _____
FSH level _____ AMH level _____	Fibroids Adhesions Cysts	Low Progesterone

Males

Prostate Problems	Painful / Swollen Testicles	Discharge
Erectile Dysfunction	Increased / Decreased Libido	Sexually Transmitted Disease
Male Fertility issues	Infertility	Varicocele
Undescended testicles	Sperm Analysis normal? Yes No	Immune issues like Antisperm Antibodies

Anything else you would like us know: _____

Health Questionnaire

Please circle appropriate number: 0=never/least, 1=occasionally, 2=frequent, 3=all the time

SECTION - A	0	1	2	3	How often do you feel you lack artistic appreciation?	0	1	2	3
Is your memory noticeably declining?	0	1	2	3	How often do you feel depressed in overcast weather?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3	How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	How much are you losing enjoyment for your favorite foods?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	How much are you losing enjoyment of friendships and relationships?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3	How often do you have difficulty falling into deep restful sleep?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3	How often do you have feelings of dependency on others?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3	How often do you feel more susceptible to pain?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you have feelings of unprovoked anger?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	How much are you losing interest in life?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	**SECTION 2 - D**	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3	How often do you have self-destructive thoughts?	0	1	2	3
SECTION - B	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How high is your stress level?	0	1	2	3	How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3	How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3	How often do you have unexplained lack of concern for family and friends?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3	How easily are you distracted from your tasks?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3	How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3	How often do you feel your libido has been decreased?	0	1	2	3
SECTION C1	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3	**SECTION 3 – G**	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3	How often do you feel anxious of panic for no reason?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3	How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3	How often do you feel knots in your stomach?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3	How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3	How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3	How difficult is it to turn you mind off when you want to relax?	0	1	2	3
SECTION - C2	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
Do you get fatigued after meals?	0	1	2	3	How often do you worry about things you were not worried about before?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3	How often do you have feelings of inner tension and inner excitability?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3	**SECTION 4 - ACH**	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3	Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3	Do you feel your verbal memory is decreased?	0	1	2	3
Do you suffer from frequent urination?	0	1	2	3	Do you have memory lapses?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3	Has your creativity been decreased?	0	1	2	3
Do you experience weight gain when under stress?	0	1	2	3	Has your comprehension been diminished?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3	Do you have difficulty calculating numbers?	0	1	2	3
SECTION 1 – S	0	1	2	3	Do you have difficulty recognizing objects & faces?	0	1	2	3
Are you losing your pleasure in hobbies and interests?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	Are you experiencing slower mental response?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3					
How often do you feel sad or down for no reason?	0	1	2	3					
How often do you feel like you are **not** enjoying life?	0	1	2	3					

Notice of Federal Privacy Practices

The confidentiality of patient health information is of the utmost importance at our clinic. All information of a personal nature with which this office has been entrusted in the course of treatment has been and will continue to be kept confidential, consistent with the rule of law and the standards of professional practice. The purpose of this notice is to inform you as to how your health information may be used and disclosed and how you can get access to this information via the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All medical-related clinics are subject to these rulings.

What is health information? According to HIPAA law, your *'protected health information'* is any information that can identify you. This includes such items as your name, telephone number, address and dates such as birthdays, start of treatment and appointments.

How your Health Information may be used: Your health information will be used only for the purposes of providing your treatment, obtaining payment and conducting our clinic and academic operations. Your health information may be shared, with your explicit permission, with referring physicians, pharmacies, or other health practitioners providing you with treatment. Health information will not be used for any other purposes, unless you have signed written permission for us to do so. In order for you to obtain insurance reimbursement, we will provide you with an itemized superbill for you to submit to your insurance company.

In rare instances, this clinic is attended by medical students from UNC or Duke or acupuncture students who may be observing treatment as part of their training. In this circumstance, should you allow a student to observe your treatment, the student will be asked to sign a HIPAA Confidentiality Agreement to maintain standards of confidentiality with regards to your personal history information. You have the right to decline a student observer.

It is also possible that health information will be disclosed during audits by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, accreditation, or credentialing activities.

Other Circumstances Where Health Information may be shared: Government authorities may be notified if there is reason to believe that a patient is the 'victim' of abuse, neglect or domestic violence. This disclosure will be made only when we are compelled by ethical judgment, when there is reason to believe we are specifically required or authorized by law, or with the patient's agreement. We may also be required to disclose to government officials health information necessary to complete an investigation related to public health. We may share your health information, only with your permission, with those you tell us will be helping you with your care. In the case of emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information and only when it will be important to those participating in providing your care. We may use your anonymous health information for medical outcomes research so we may track how effective we are for which conditions as set forth in the Quality Monitoring section in the *Practices Regarding Disclosure of Patient Health Information* below. This allows us to get better results with you and future patients. Other than what has been stated above, or where Federal, State or Local law requires us, we will not disclose your health information.

Health Records: Your health information is kept in your file on an encrypted, password protected computer. The only person having access to this information (except as otherwise stated above) is your practitioner. Other than by your specific request, as in the case of *Attending Practitioner's Statement* or *Superbill for Services Rendered*, none of your health care information is shared without your written consent. No faxes or emails containing your health information will be sent to anyone unless you specifically request it.

Patient Rights Regarding Health Records: You have the right to request reasonable restrictions on certain uses and disclosures of your health information, and we will make every effort to honor your requests. For example, you have the right to review and make a copy of your health information, including your chart. Duplication of this material will involve a per page fee. In addition, you have the right to request that we communicate with you in a certain way. You may wish us, for example to only contact you at a specific number, etc. You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. We encourage you to express any concerns you may have regarding the privacy of your health information. You have the right to file a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised.

I understand my health information will be used and disclosed consistent with these Notices.

Client/Patient Signature/Guardian if Minor: _____ **Date:**_____

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

Treatment – Information obtained by your practitioner at OHS will be entered in your record and used to plan the course of treatment. Your health information may be shared with other practitioners employed or contracted by OHS who are involved in your care or provide consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.
Payment – Your record will be used to receive payment for services rendered by OHS. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.
Quality Monitoring – The staff in this office will use your health information to assess the care you received and compare your treatment outcome to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA) – This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
Worker's Compensation – This office will release information to the extent authorized by law in matters of worker's compensation after you authorize consent.
Public Health – This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.
Law Enforcement – (1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

It is OHS's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, OHS will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

Contractors – Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Contractors to follow the same standards held by this office through terms detailed in a written agreement.
Communications with Family – Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.
Marketing and Fundraising – OHS may send information to you about treatment alternatives and other health-related benefits that you may find useful.

Directions to Oriental Health Solutions, LLC.

907 Broad St., Durham, NC 27705, 919-286-9595:

From Chapel Hill: take 15-501 North (bypass), exit onto Durham Freeway 147 South (Exit # 108B), then exit onto Swift Ave (Exit # 14), turn left off exit onto Swift Ave. As you cross the Main St intersection Swift changes its name to Broad St. Pass 3 lights (Perry, Markham and Green), 907 Broad is the second building on the left past Green. Look for a large white sign with red lettering: Oriental Health Solutions, LLC. Park in the large parking lot to the left and rear of the building; please enter the upstairs building from the front.

From Raleigh: take I-40 West, take Durham Freeway 147 North (Exit # 279B), exit Swift Ave (Exit # 14), turn right off exit onto Swift Ave. As you cross the Main St intersection Swift changes its name to Broad St. Pass 3 lights (Perry, Markham and Green), 907 Broad is the second building on the left past Green. Look for a large white sign with red lettering: Oriental Health Solutions, LLC. Park in the large parking lot to the left and rear of the building; please enter the upstairs building from the front.

From Eastern Virginia: take I-85 South, exit on Guess Rd (Exit # 175), turn left onto Guess Rd; go to the next light and make a 130° right turn onto Broad St. Pass one light (Club Blvd), pass Englewood, Knox, and 907 Broad is the 5th building on the right. Look for a large white sign with red lettering: Oriental Health Solutions, LLC. Park in the large parking lot to the left and rear of the building; please enter the upstairs building from the front.

From Greensboro: take I-85 North, exit on Guess Rd (Exit # 175), turn right onto Guess Rd; go to the next light and make a 130° right turn onto Broad St. Pass one light (Club Blvd), pass Englewood, Knox, and 907 Broad is the 5th building on the right. Look for a large white sign with red lettering: Oriental Health Solutions, LLC. Park in the large parking lot to the left and rear of the building; please enter the upstairs building from the front.