Christine Gibbons
L.Ac.

CONFIDENTIAL INTAKE FORM

WWW.HARMONYINHEALING.COM

Patient Information Date:_____

Name: Age: Date of Birth:

Home Address:

Home Phone: Cell: Work Phone:

Email: SS#:

Emergency Contact: Relationship to Patient:

Emergency Contact Phone number:

Primary Care Physician (PCP): PCP Phone:

Date of last medical examination:

Occupation:

Have you received acupuncture treatment before? YES NO

- If yes, for what conditions and what was the outcome?

What are your main complaints?

Primary: _____ Distress Level: (Scale of 1-10) _____

Secondary: _____ Distress Level: (Scale of 1-10) _____

How long have you had this condition? (Please circle one)

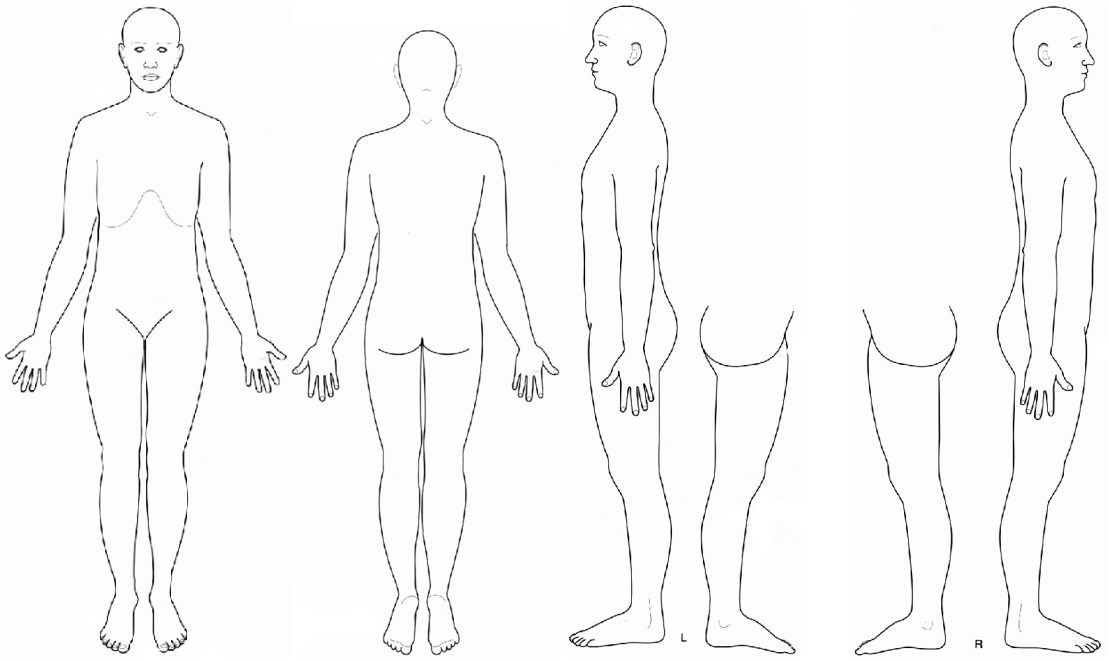
Primary: _____ Was it SUDDEN or GRADUAL?

Secondary: _____ Was it SUDDEN or GRADUAL?

What do you find makes your conditions better or worse?

What are your expectations in receiving Acupuncture care for these conditions?

On the diagram, please shade in the areas where you feel symptoms associated with your complaints. PLEASE NUMBER THE COMPLAINTS (Primary Complaint = #1; Secondary Complaint = #2):



MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

LIST ANY ALLERGIES (to food, environmental, medications, supplements, herbs, etc):

_____

PERSONAL MEDICAL HISTORY

BIRTH: Describe anything significant/traumatic about your birth: _____

CHILDHOOD ILLNESSES (0-12 years): Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE:_____ _____

ADOLESCENCE ILLNESSES (13-17 years): Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE: _____ _____

ADULTHOOD ILLNESSES (18 – 35 years): Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE:_____ _____

ADULTHOOD ILLNESSES (36 & up): Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:_____ _____

AGE:_____ _____

AGE:_____ _____

AGE:_____ _____

AGE:_____ _____

FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER_____

FATHER_____

SIBLINGS_____

MATERNAL GRANDPARENTS_____

PATERNAL GRANDPARENTS_____

SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are or have experienced. Circle if the symptom is acute, chronic or experienced frequently.

A = Acute (under 3 months) C = Chronic (over 3 months) F = frequently (on & off)

MUSCULOSKELETAL

A C F Joint clicking

A C F Limitation of movement
A C F Stiffness
A C F Spasms or cramps
A C F Swelling
A C F Weakness
A C F Pain: Full body
A C F Pain: Facial (e.g. jaw)
A C F Pain: Neck
A C F Pain: Upper Back
A C F Pain: Mid Back
A C F Pain: Low Back
A C F Pain: Shoulder
A C F Pain: Elbow
A C F Pain: Wrist
A C F Pain: Hand
A C F Pain: Hip
A C F Pain: Knee
A C F Pain: Ankle
A C F Pain: Foot
A C F OTHER (Please list)

_____

_____

EYES, EARS, NOSE & THROAT

A C F Loss of vision
A C F Eye pain
A C F Tearing or eye dryness
A C F Eye discharge
A C F Eye redness
A C F Ear discharge
A C F Ear itching
A C F Ear pain &/or infections
A C F Loss of hearing
A C F Ringing or buzzing in ears
A C F Problems with balance (vertigo)
A C F Olfaction (sense of smell) impaired
A C F Nose obstruction (stuffiness)
A C F Nose bleeds
A C F Sinus pain, pressure, infections
A C F OTHER (Please list)

_____

_____

RESPIRATORY

A C F Chest pain &/or tightness
A C F Bluish discoloration of skin
A C F Cough
A C F Coughing up blood (hemoptysis)
A C F Shortness of breath (dypsnea)
A C F Sore throat
A C F Sputum production
A C F Voice changes
A C F Wheezing
A C F OTHER (Please list)

_____

CARDIOVASCULAR

A C F Changes in skin temp. & color
A C F Chest pain &/or pressure
A C F Edema
A C F Fainting (syncope)
A C F Fatigue
A C F Palpitations
A C F Skin ulceration
A C F Swelling of the ankles &/or legs
A C F OTHER (Please list)

DIGESTIVE

A C F Abdominal distention/bloating
A C F Abdominal mass
A C F Abdominal pain
A C F Acid regurgitation &/or Heartburn
A C F Alternating constipation/diarrhea
A C F Rectal bleeding
A C F Constipation
A C F Diarrhea
A C F Gas
A C F Eating disorder
A C F Indigestion
A C F Jaundice (yellow tint to skin &/or eyes)
A C F Nausea
A C F Vomiting
A C F OTHER (Please list))

UROGENITAL

A C F Difficulty with urine flow
A C F Incontinence
A C F Painful urination (dysurea)
A C F Rashes
A C F Red urine
A C F Urinary tract infection (UTI)
A C F OTHER (Please list)

NEUROLOGICAL

A C F Changes in consciousness
A C F Confusion
A C F Difficulty concentrating
A C F Dizziness
A C F Dysphasia (impaired ability to speak)
A C F Gait disturbance
A C F Headache
A C F Numbness and/or tingling
A C F Loss of consciousness
A C F Paralysis
A C F Post shingles pain
A C F Problems coordinating movements
A C F Severe forgetfulness
A C F Tremor
A C F Visual disturbance
A C F Weakness

A C F OTHER (Please list)

INTEGUMENTARY (SKIN)

A C F Changes in hair
A C F Changes in nails
A C F Changes in skin color
A C F Itching (prurites)
A C F Never sweat
A C F Rash and/or skin lesion
A C F Unusual sweating
A C F Wounds that will NOT heal
A C F OTHER (Please list)

PSYCHOLOGICAL

A C F Feelings of grief
A C F Feeling of sadness
A C F Feeling fearful/anxious/nervous
A C F Difficulty managing anger
A C F Feeling manic
A C F Feeling worried/overly pensive
A C F Feelings of panic
A C F Feeling overwhelmed
A C F Extreme mood swings
A C F Extreme lack of emotion
A C F OTHER (Please list)

FOR WOMEN ONLY

A C F Abnormal vaginal bleeding
A C F Changes in hair distribution
A C F Fertility concerns
A C F Irregular menstruation
A C F Menopausal symptoms
A C F No menses
A C F Pain with menses (dysmenorrhea)
A C F Pain during, after sexual relations
A C F Pelvic pain
A C F Premenstrual symptoms
A C F Sexual dysfunction
A C F Unusual discharge
A C F OTHER (Please list)

At what age did you start menstruating? _____

How long is your cycle? _____

Are you pregnant OR trying to become pregnant?
YES NO
Have you ever been pregnant? YES NO
If yes, how many pregnancies: _____
Births _____# Miscarriages _____# Abortions ____

FOR MEN ONLY

A C F Fertility concerns
A C F Prostate problems

A C F Sexual dysfunction
A C F Unusual discharge
A C F OTHER (Please list)

_____

MEDICAL DISEASES/CONDITIONS:

Please check all that apply.

C = Current condition P = Past condition, but is now resolved.

C P AIDS/HIV
C P Alcoholism &/or substance addiction
C P Allergies (If yes, pls indicate diagnosis & history)

_____
_____

C P Anemia
C P Asthma
C P Bell's Palsy
C P Blood clotting disorder (If yes, pls indicate diagnosis & history)

_____
_____

C P Bipolar disorder
C P Cancer (please describe)

_____
_____

C P Chron's Disease &/or colitis
C P Chronic Fatigue Syndrome (CFIDS)
C P Depression (Major)
C P Diabetes
C P Eczema
C P Endometriosis
C P Fibroids
C P Infertility
C P Lung disease, e.g. COPD (explain)

_____
_____

C P Fibromyalgia
C P Gallstones
C P Heart disease (explain)

_____
_____

C P Hepatitis A / B / C
C P Hernia
C P Herpes
C P Hypertension
C P Hypoglycemia
C P Irritable Bowel Syndrome (IBS)
C P Joint Replacement (explain)

_____
_____

C P Kidney Stones &/or Disease (explain)

_____

C P Lupus
C P Lyme Disease
C P Lymph node removal

C P Mitral valve prolapse
C P Mood Disorder
C P Mononucleosus
C P Multiple Sclerosis
C P Organ removal or transplant (explain)

_____
_____

C P Osteoarthritis
C P Osteoporosis
C P Pacemaker (heart or stomach)
C P Parkinson's Disease
C P Pelvic Inflammatory Disease
C P Polio
C P Psoriasis
C P PTSD (Post-Traumatic Stress D/O)
C P Reflux esophagistis (GERD)
C P Rheumatic fever
C P Rheumatoid arthritis
C P Scarlet Fever
C P Schizophrenia
C P Scoliosis
C P Seizures and /or epilepsy
C P Shingles
C P Sleep Disorder
C P Stroke
C P Schizophrenia
C P Thyroid disease (explain)

_____
_____

C P Ulcer
C P Trigeminal Neuralgia
C P Tuberculosis
C P Vascular disease, e.g. phlebitis (explain)

_____
_____

C P OTHER (pls list)

_____
_____

LIFESTYLE INFORMATION

Stress, Energy Level & Sleep

How would you rate your stress level? LOW MEDIUM HIGH

How would you rate your energy level? LOW MEDIUM HIGH

Do you have any problems with sleep? (trouble falling asleep, dream disturbed, wake up & cannot fall back to Sleep)?

How many hours of sleep do you get a night?

How is your sexual energy?

Smoking, Alcohol & Drugs

Do you smoke tobacco? YES NO

Do you drink alcohol? YES NO

Do you use recreational drugs and/or prescription medications that your physician does not know about?

YES NO

Diet and Nutrition

Do you believe that your diet has any impact on your complaints? YES NO

Are you concerned about your weight and/or appetite? YES NO

Do you have any food cravings? If yes, please describe.

Additional Information:

Is there any information you feel would be helpful in sharing that was not covered on this form? Please use the space below to explain.

****

How did you hear about Christine Gibbons, L.Ac.? Who referred you? _____

Christine Gibbons
L.Ac.

Consent to Treatment

I understand that by voluntarily signing this form that I am consenting to acupuncture treatments and procedures, as defined by Oriental Medicine, to be performed by Christine Gibbons, L.Ac.
I understand that the method of treatment may include but is not limited to acupuncture, acupressure, moxibustion, cupping, gua sha, electrical stimulation and herbal liniments.

I have been informed that there may be adverse effects to acupuncture, which could include, but are not limited to local bruising, mild pain in the area treated, sore or aching muscles, brief generalized fatigue, tingling or numbness. I understand that I am encouraged to communicate any discomfort I may feel during the needling process so that the needles can be adjusted and/or removed. I also understand that there are no guarantees concerning the use of acupuncture and its effects.

I have been informed that I am free to stop treatment at any time, as well as being free to refuse modalities that may be offered as part of the treatment.

I understand that I should not change my position or move suddenly while the needles are in place.
I understand that it is important for me to maintain good personal hygiene.
I understand that I should avoid treatment when excessively fatigued, hungry, or full.
I understand that I will not be treated if I am intoxicated and/or are abusing substances.
I understand that payment is due upon receipt of services.

ADVISORY TO CONSULT PHYSICIAN

I understand that Oriental Medicine does not replace the care of my primary care provider. It is recommended that I consult a physician regarding any conditions for which I am seeking acupuncture treatment. I have also been informed that I am responsible for seeking the advice and treatment of a physician should my symptoms change for the worse, or should any new condition arise.

I understand that if I am having any untoward side effects or concerns after treatment, in addition to contacting Christine Gibbons, L.Ac at 347-574-7969 or emailing her at **christine.gibbons@yahoo.com** , that I must call my primary care provider and/or visit the emergency room.

By voluntarily signing below, I am giving consent to be treated by Christine Gibbons, L.Ac. I understand that my consent verifies that I have read or have had read to me the above information. I have been informed of the risks and benefits of acupuncture and other procedures and have been given the opportunity to ask questions.

_____	_____	_____
I have read and understand the above statement Signature of Client	Date	Legal representative (clients under 18)

_____
Print name of Client

Christine Gibbons
L.Ac.

Financial Policy

The responsibility for payment of fees for these services is the direct obligation of the patient. It is also your responsibility to know if your insurance has specific rules or regulations.
Patients are responsible for their own referrals. If you need a referral with your insurance plan and we do not receive it at the time of your visit, you will be held responsible for the entire cost of the office visit.
Co-payments, deductibles, co-insurance, non-covered service: Full payment is due at the time of the service.

CANCELLATION POLICY:
I understand that I can cancel and/or reschedule my appointment within 24 hours of the scheduled appointment WITHOUT penalty.
I agree to pay $40 if I do not notify Christine Gibbons, L.Ac. and fail to appear for my scheduled appointment.
I understand that by providing my credit card information below, that I give Christine Gibbons, L.Ac. permission to charge $40 to this credit card in order to collect the fee.
I understand that I will be notified by email and/or text message when this charge occurs.
I understand that a first time offense will be excused.

RETURN CHECKS: I agree to pay a $20.00 fee should my check bounce.

I certify that I have read and understand the above information. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I authorize payments of medical benefits to Christine Gibbons, L.Ac. I request that payment of authorized benefits be made on my behalf for the duration of my care to Christine Gibbons, L.Ac.

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Christine Gibbons, L.Ac. I have also been advised as to how I can obtain access to and control of this information.

_____ _____
I have read and understand the above statement Date
Signature of Client

_____ _____
Print name of Client Legal representative (clients under 18)

Christine Gibbons
L.Ac.

Fees for services rendered at the time of the visit:

$100 - Initial Intake (2 hours)

$80 - all follow-ups (1.5 hours)

FINANCIAL HARDSHIP PAYMENT AGREEMENT

I hereby certify that I have been informed of the usual fees for the examination and treatment that has been recommended. I am unable to pay those fees at this time without substantial financial hardship. I have no expectation of being able to recover those expenses from any third party.

To enable me to obtain the recommended services, Ms Christine Gibbons, L.Ac. and I have agreed to a special payment arrangement under which I will pay $ 80.00 for the intake and $60.00 per each session following.

It is my responsibility to make these payments without any need for periodic bills or other reminders of payments due.

_____ _____

Patient Signature Date Witness Signature Date

_____ _____

Print Name Date Print Name Date

Christine Gibbons, L.Ac.
christine.gibbons@yahoo.com
www.harmonyinhealing.com
347.574.7969

Christine Gibbons
L.Ac.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Respect for patient privacy is highly valued. As required by law, I will protect the privacy of your health information that may reveal your identity and provide you with a copy of the notice, which describes the health information privacy procedures when providing health care services.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION
I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct office operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
I use health information about you for treatment to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. I may use your health information or share it with others in order to conduct the office's operations. I may disclose identifiable health information about you without your authorization in several situations, but beyond those situations, I will ask for your written authorization before using or disclosing any identifiable health information about you.

YOUR RIGHTS
In most cases, you have the right to look at or get a copy of health information about you at my office. You also have the right to receive a list of certain types of disclosures of your information that I made. If you believe that information in your record is incorrect, you have the right to request that I correct the existing information.

MY LEGAL DUTY
I am required by law to protect the privacy of your information, provide this notice about my information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice. If there is any significant change made to this notice, you can obtain a copy at any time.

COMPLAINTS
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me to discuss the matter. You also may send a written complaint to the U.S. Department of Health and Human Service.

Christine Gibbons, L.Ac.
christine.gibbons@yahoo.com
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347.574.7969