Flow Natural Health Care
11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

CHINESE MEDICINE INTAKE FORM

Personal Information

Date: _____

Name: _____ Gender: _____ Age: _____

Home Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

May we leave a message on your home phone? Yes ___ No ___

E-mail Address: _____

Would you like to receive our clinic newsletter? Yes___ No ___

Date of Birth: _____

Marital Status: single: ___ married: ___ partnership: ___ divorced: ___ widowed: ___

Partner's Name: _____

# of Children: _____

Employer: _____ # of Years Retired: _____

Occupation: _____

Emergency Contact

Name:_____

Relationship to You: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Referral Information

Who may we thank for referring you to this clinic?

_____

CURRENT HEALTH

Main Purpose of this Appointment:

_____
_____
_____
_____
_____

To what extent does this problem interfere with your daily activities?

_____
_____
_____

Other Current Health Concerns:

_____
_____
_____
_____
_____

What treatments have you received for these concerns?

_____
_____
_____

Are there other members of your family with any of the same conditions? Yes ____ No ____
If Yes, Please explain:

_____
_____
_____

Please list all medications, herbs, supplements and home remedies that you are taking (please include amount, frequency, and duration):

_____
_____
_____
_____
_____

HEALTH HISTORY

Do you have any infectious diseases? Yes ___ No ___ If yes, please list:

_____

Have you been treated for any health conditions during the last year? Yes: ___ No: ___
If yes, Please explain:

_____

_____

_____

_____

Please explain any history of major illnesses/injuries/traumas (include date):

_____

_____

_____

_____

Please explain any allergies (to drugs, chemicals, foods, etc.):

_____

_____

_____

_____

Family history of cancer or other significant illness (include who and type):

_____

_____

_____

_____

Do you smoke or chew tobacco products? Yes: ___ No: ___
If yes, what type and how much per day? _____
If you are a former tobacco user, what was your former usage and when did you quit?

_____

Are you routinely exposed to second-hand smoke? Yes: ___ No: ___
If yes, how and how much per day? _____
Do you drink alcohol? Yes: ___ No: ___ If yes, what and how much/day?

_____

Do you drink caffeinated beverages? Yes: ___ No: ___
If yes, what and how much/day? _____
Do you use recreational drugs? Yes: ___ No: ___
If yes, what and how much/day?

_____

WOMEN ONLY

Please check all conditions that apply to you:

___ Menstrual irregularities ___ Menstrual cramps ___ Excessive discharge
___ PMS ___ Breast lumps or pain ___ Vaginal dryness
___ Vaginal pain or infections ___ Genital herpes ___ Sexual difficulties

Have you ever had an abnormal PAP smear? Yes: ___ No: ___
Date of last PAP: _____ Date of last mammogram: _____

Age when menstruation began: _____
Length of cycles (from day 1 of one period to day 1 of the next period): _____
Number of days of menstruation: _____
Is your typical flow light, medium or heavy? _____
Do you see clots in your menstrual flow? Yes: ___ No: ___
Any unusual symptoms or difficulties with menstruation? Yes: ___ No: ___
If yes, please explain:

_____
_____
_____

Have you completed menopause? Yes: ___ No: ___ If so, when? _____
Please list all contraception methods ever used, including length of use:

_____
_____

Current method:

_____

Please list:

Number of pregnancies: ___
Number of live births: ___
Number of abortions: ___
Number of Cesareans: ___

If you have received a Hysterectomy, when was the date of surgery? _____
Please explain any other reproductive or other female concerns not addressed:

_____
_____
_____
_____

Please CHECK the box next to any conditions you are currently experiencing, and UNDERLINE any conditions you have experienced in the past:

Emotional

- □ Mood Swings
- □ Stress
- □ Anxiety
- □ Frequent or Excessive Anger
- □ Frequent Fearfulness
- □ Frequent Sadness
- □ Feelings of Depression

Energy and Immunity

- □ Fatigue
- □ Difficulty Waking
- □ Energy Crashes
- □ Slow Wound Healing
- □ Chronic Infections
- □ Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, & Throat

- □ Impaired Vision
- □ Eye Pain/Strain
- □ Glasses/Contacts
- □ Tearing/Dryness
- □ Glaucoma
- □ Impaired Hearing
- □ Ear Ringing (Tinnitis)
- □ Earaches
- □ Headaches
- □ Sinus Problems
- □ Hay Fever
- □ Frequent Nose Bleeds
- □ Frequent Sore Throats
- □ Teeth Grinding
- □ TMD/Jaw Problems

Respiratory

- □ Allergies
- □ Frequent Colds
- □ Shortness of Breath
- □ Asthma
- □ Persistent Cough
- □ Emphysema
- □ Tuberculosis
- □ Pneumonia
- □ History of Smoking
- □ Other Respiratory Problems

Cardiovascular

- □ Chest Pain
- □ Palpitations/Fluttering
- □ Heart Murmurs
- □ Arythmia
- □ High Blood Pressure
- □ Swelling of Ankles
- □ Stroke
- □ Heart Disease
- □ Varicose Veins

Gastrointestinal

- □ Low Appetite
- □ Excessive Appetite
- □ Nausea/Vomiting
- □ Epigastric Pain
- □ Abdominal Pain
- □ Ulcers
- □ Frequent Gas
- □ Frequent Belching
- □ Heartburn
- □ Gall Bladder Disease
- □ Liver Disease
- □ Hepatitis B or C
- □ Hemorrhoids

Genito-Urinary Tract

- □ Painful Urination
- □ Frequent Urination
- □ Impaired Urination
- □ Incontinence
- □ Frequent UTIs
- □ Blood in Urine
- □ Kidney Stones
- □ Kidney Disease

Female Reproductive

- □ Irregular Cycles
- □ Painful Periods
- □ Heavy Flow
- □ Clotting
- □ Premenstrual Symptoms
- □ Bleeding between Cycles
- □ Breast Lumps/Tenderness
- □ Nipple Discharge
- □ Excessive Vaginal Discharge
- □ Menopausal Symptoms
- □ Difficulty Conceiving

Male Reproductive

- □ Sexual Difficulties
- □ Prostate Problems
- □ Testicular Pain/Swelling
- □ Penile Discharge

Musculoskeletal

- □ Neck/Shoulder Pain
- □ Muscle Spasms/Cramps
- □ Muscle Pain (if so, where?)_____
_____
- □ Joint Pain (if so, where?):_____
_____

Neurological

- □ Vertigo/Dizziness
- □ Numbness/Tingling
- □ Poor Balance
- □ Paralysis
- □ Seizures/Epilepsy

Endocrine

- □ Hypothyroid
- □ Hyperthyroid
- □ Diabetes
- □ Hypoglycemia
- □ PCOS
- □ Other Endocrine Problem

Skin

- □ Rashes
- □ Eczema
- □ Frequent Hives
- □ Dry Skin
- □ Oily Skin
- □ Acne

Other

- □ Anemia
- □ Easy Bruising
- □ Cold Hands/Feet
- □ Night Sweats
- □ Feeling Hot or Cold
- □ Cancer (if so, what kind?):
_____
_____

PRENATAL, INFANCY, AND CHILDHOOD HISTORY

Please provide as much information as you are able. You can talk to family members to fill in gaps.

How old were your parents when you were born? Mother _____ Father _____
How many siblings do you have and how close are you in age to each of them?

_____

_____

_____

Was there anything notable about your mother's experience during pregnancy? (Did she have any illnesses, adequate nutrition, emotional shocks, take any medications, smoke or drink, etc.?)

_____

_____

_____

_____

Please describe any unusual or notable circumstances surrounding your birth (were you early or late, was the birth natural or induced, etc.)

_____

_____

_____

_____

Were there any physical or emotional traumas in your infancy? _____

_____

_____

_____

Did you have any recurrent health issues during childhood, or major illnesses, surgeries, or traumas? _____

_____

_____

_____

As a child, did you experience any abuse? Physical ___ Emotional ___ Sexual ___
If so, please briefly describe, including your age at the time: _____

_____

_____

_____

GENERAL COMMENTS

If you have any comments or additional information, please use this space:

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. **It is important that you understand that your information can be used and shared in the following ways**:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- Obtain payment from third party payers

In order to provide you with service that best meets your privacy needs, please tell us how to best contact you when needed. If you have no specific requests we will use your information provided on the intake form. Please check <u>all</u> that apply:

☐ Please do not phone me at _____Use this alternate phone number:_____

☐ Please do not leave messages at/on: Cell phone Work Home

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address:

Signature Date

Printed Name Date

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OFFICE POLICIES & FINANCIAL AGREEMENT

Please read and **initial** the following statements:

____ Payment for all services and medicinary items is due at the time of the your visit. In the event that your insurance company denies benefits or makes a partial payment, you are responsible for any balance due.

____ We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a $35.00 NSF fee.

____ Most insurance companies do not cover pharmacy items that may be prescribed and/or dispensed at Flow Natural Health Care or elsewhere.

____ You will be charged a Missed Appointment Fee of $40.00 for any missed appointments or cancellations of less than 24 hours notice. Insurance companies do not cover late cancellation fees.

I have read and understand the above stated policies of Flow Natural Health Care LLC and will comply with them in all respects.

_____

Patient Name (Please print. Parent or guardian if patient is a minor).

_____ _____

Patient signature (Parent or guardian if patient is a minor) Date

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For Patients with Insurance:

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Flow Natural Health Care.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apple to insurance companies that I am under contract with.

Signature:_____ Date: _____