11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

ADULT INTAKE

I really appreciate your willingness to fill out this form as completely as possible. It is invaluable information for developing a treatment plan tailored to your individual needs.

Name:_____Date: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Telephone (home):_____ (cell): _____

May we leave phone messages relating to your visits? YES NO

E-mail address (this is not shared): _____

May we add you to our monthly newsletter? YES NO

Age: _____ Date of Birth: _____ Identifying Gender: _____

Married: _____ Separated: _____ Divorced:_____ Widowed: _____ Single: _____ Partnership: _____

Live with: Spouse: _____ Partner: _____ Parents: _____ Children: _____ Friends: _____ Alone:_____

Occupation: _____ Hours per week: _____

How did you hear about this clinic?_____

Has any other family member already been a patient at the clinic? _____

Emergency contact: _____ Relationship:_____

Address:_____

Phone:_____

What are your most important health concerns? List in order of importance:

1. _____
2. _____
3. _____

Are you receiving other types of treatment for your health concerns listed?

_____

What would you most like to get out of your acupuncture treatment today?

_____

List any major medical events along with dates (include surgeries, hospitalizations, etc.):

_____

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Are you **hypersensitive** or **allergic** to any:

Medications?_____Foods? _____

Environmental/chemicals? _____

Medications:
Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

_____

_____

Family History:
Has anyone in your immediate birth family had any of the following? Please check all that apply:

☐ Diabetes	☐ Heart Disease	☐ Clotting disorder
☐ High blood pressure	☐ Kidney Disease	☐ Epilepsy
☐ Arthritis	☐ Glaucoma	☐ Mental Illness
☐ Stroke	☐ Anemia	☐ Autoimmune condition
☐ Asthma/Hay fever/Hives	☐ Cancer (please list type of cancer & whom)_____	

☐ Other: _____

Personal History:
Please check all that apply to you either presently or in the past:

☐ Diabetes	☐ Heart disease	☐ Autoimmune condition
☐ High blood pressure	☐ Kidney disease	☐ HIV
☐ Arthritis	☐ Anemia	☐ AIDS
☐ Stroke	☐ Clotting disorder	☐ Hepatitis
☐ Asthma	☐ Epilepsy	☐ Cancer (please list type): _____
☐ Smoker	☐ Mental illness	☐ Other: _____

Do you drink alcohol? _____ If yes, indicate approximately how many drinks per week _____

Are you pregnant? _____

Pain:
Please mark any areas of pain on the diagrams below using the following indicators:

xxx - sharp/stabbing pain	^^^ - burning
ooo – dull/aching	* * * - tingling
- - - - numbness	+++ - changes with weather

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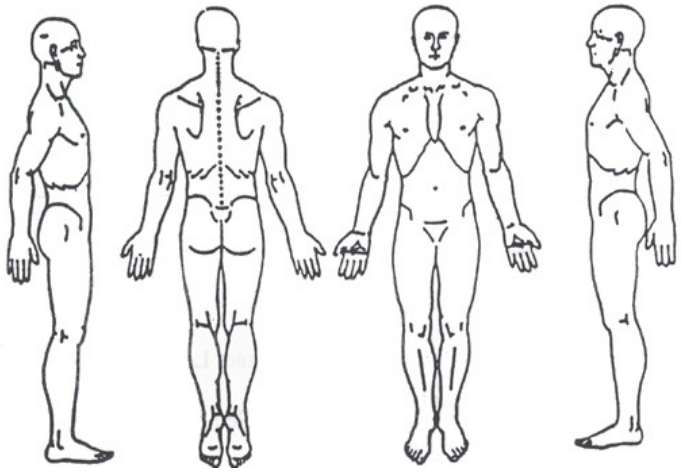

Patient System Review:

Please rate the following on a scale of 0-4 and circle the appropriate number. Circle Yes or No when appropriate.

N=Never **O**=Occasionally **F**=Frequently

N O F - Poor Appetite	**N O F** - Organ prolapse (bladder, uterus, etc.)
N O F - Loose stools	**N O F** - Frequent colds
N O F - Weak limbs/heavy feeling in limbs	**N O F** - Bleeding gums
N O F - Gas/bloating	**N O F** - Abdominal pain
N O F - Allergies	**N O F** - Ravenous appetite
N O F - Tiredness in the morning	**N O F** - Reflux
N O F - Easy bruising	**N O F** - Teeth griding/TMJ
N O F - Cough	**N O F** - Phlegm/mucus production
N O F - Shortness of breath	**N O F** - Sinus/nasal congestion
N O F - Spontaneous sweating	**N O F** - General tiredness
N O F - Tendency to catch colds easily	**N O F** - Dry mouth or throat
N O F - Soreness/weakness of lower back	**N O F** - Early morning diarrhea
N O F - Frequent urination	**N O F** - Hypo/hyperthyroid
N O F - Incontinence	**N O F** - Premature ejaculation
N O F - Weak stream/dribbling urination	**N O F** - UTI's/Bladder infections
N O F - Edema (swelling)	**N O F** - Impaired Memory
N O F - Hearing loss/ringing in ears	**Yes No** - Infertility
N O F - Insomnia	**N O F** - Heart palpitations/flutter/irregularity
N O F - Nightmares/dream-disturbed sleep	**N O F** - Mouth sores
N O F - Chest pain/discomfort	**N O F** - Easily startled

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N	**O**	**F** - Irritability/feeling "wound up"	**N**	**O**	**F** - Sensation of a lump in your throat
N	**O**	**F** - Neck/shoulder tension	**N**	**O**	**F** - Red/dry/itchy eyes
N	**O**	**F** - PMS	**N**	**O**	**F** - Breast tenderness
N	**O**	**F** - Headaches	**N**	**O**	**F** - Easily angered
N	**O**	**F** - Stress relieved with exercise	**N**	**O**	**F** - Dry skin/hair/eyes
N	**O**	**F** - Frequent sighing	**N**	**O**	**F** - "Floaters" in field of vision
N	**O**	**F** - Night sweating	**N**	**O**	**F** - Inability to lose weight
N	**O**	**F** - Thirst for cold drinks	**N**	**O**	**F** - Fatigue after eating
N	**O**	**F** - Excessive sweating	**N**	**O**	**F** - Rashes/hives/eczema
N	**O**	**F** - Acne	**N**	**O**	**F**

Body Temperature:

Do you tend towards feeling hot or cold? If either, describe where in your body you feel these sensations:

Diet:

What does your daily diet look like generally? Indicate if you typically skip certain meals:

Breakfast

_____

Lunch _____

Dinner

_____

Snacks

_____

Beverages (coffee, soda, water intake)

_____

Sleep:

How is your sleep?

_____

About how many hours do you sleep, on average?

_____

Elimination:

Urination – check all that apply:

☐ Urinary frequency ☐ Cloudiness ☐ Burning ☐ Waking up >1x/night to urinate

☐ Urinary retention ☐ Difficulty ☐ Urgency ☐ Dark yellow urine

Bowel Movements – check all that apply:

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☐ Well-formed stool ☐ Undigested food in stool ☐ Hard stools

☐ Alternating constipation and diarrhea ☐ Blood in stool ☐ Sticky stools

☐ Incomplete feeling after bowel movement ☐ Mucus in stool ☐ Very foul smell

Reproductive Health:

Age of first period: _____ Date of last menstrual period: _____/_____/_____

Average #of days in your menstrual cycle? (from the start of bleeding of one period to start of next menstrual bleed): _____ Average #of days in your period (how long you typically bleed for): _____

Check all that apply:

☐ Bleeding between cycles/spotting ☐ Endometriosis ☐ Menopause

☐ Heavy bleeding during period ☐ PCOS ☐ Low libido

☐ Very light flow ☐ Ovarian cyst(s) ☐ Hot flashes

☐ Irregular menstrual cycle ☐ Fibroid ☐ Vaginal dryness

☐ Clots in menstrual blood ☐ Chronic yeast/bacterial infection ☐ Vaginal discharge

☐ Premature ejaculation ☐ Prostate problems ☐ Impotence

Anything else that you would like me to know?

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures (described below) within the scope of the practice of Acupuncture and Oriental Medicine on me (or on the patient named below, for whom I am legally responsible) by Corinne LeBlanc, L.Ac. I understand that acupuncturists licensed in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that if I receive moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Chinese materia medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. **Should I experience any problems which I associate with these substances, I should stop taking them and call Flow Natural Health Care as soon as possible.**

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Acupressure/Massage: I understand that I may also be given acupressure/massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that side effects of electrical stimulation may include electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, which would be beneficial to my health and may be recommended by this clinic.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

_____
Patient printed name

_____
Parent/guardian printed name (if patient is a minor)

_____
Patient Signature (or parent or guardian of patient is a minor)

_____
Date

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.

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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 all 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:

_____

_____
Patient name (Please print. Include parent/guardian name if patient is a minor).

_____ ____ / ____ / ____
Patient Signature (Parent/guardian signature if a minor) Date

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.

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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: _____