Ann Fielder, LAc, LLC   **153 Clear Creek Dr. Ashland, OR 97520**
18 Myrtle St. Medford, OR 97504

Initial Intake Form

To help us provide the best possible care, please fill out this form as accurately as possible. All the information will be kept confidential in your patient file. ***Please print.***

Today's Date: ____________

Name: ______________________________   Birthdate: _______________

Social Security #:______________________   Sex: F M   Age: ____________

Address: ______________________   City: _________   State: _____   Zip: ________

Phone: H: (____)___________   Occupation: ____________________
W: (____)___________   Employer:______________________
Mobile: (____)________   Work Address: ______________________
____

Marital Status: Single   Married   Have Partner   Divorced   ☐ Widowed

Emergency Contact: ______________________   Phone: H (____)_______________
Address: _______________________________   W (____)_______________

Whom may we thank for referring you? ______________________________________

Have you ever had acupuncture before?   Yes   No

Are you afraid of needles? Yes   Not really   No

Do you or your spouse have health insurance that covers acupuncture? Yes   No

Name of insured: ______________________   Birthdate of insured: ____________

Insurance Co: _________________________   Member #: ____________________

Please present your insurance card for copying.

Personal Physician: _______________________   Phone: (____)__________________

Practice/Group: _________________   City: _________________   State: _________

Are you currently being treated elsewhere? No Yes, Provider: ________________
For what health concern: ____

Are you currently using any prescription medicine? Yes No
If yes, please list medications: ____

Over-the-counter medications? (please list) ____________________________________

Are you currently using herbal medicine? Yes No
If yes, please list: ____
Other Supplements:____

To assist in evaluating your health, please answer the following. All information will be kept confidential in your patient file.

WHICH OF THE FOLLOWING ARE PART OF YOUR LIFESTYLE?

Exercise: __________ Type: ___________________________ How often?___________

Relaxation/Meditation: _________________________

Smoking: Tobacco ______________cigarettes per/ day week month
Other ________________ ________________

Alcohol drinking _________________ drinks per day week month

Caffeinated drinks: _________________ per/ day week month

Recreational drugs: ___________________________

Birth control pills: ______________ Special Diet: _______________________________

WHAT IS(ARE) YOUR MAIN HEALTH CONCERN(S) TODAY THAT YOU WOULD LIKE TO BE TREATED FOR?

____

____

____

MEDICAL HISTORY: Please check all below that are now or have been part of your health history. All information will be kept confidential in your patient file.

Hepatitis: ☐ A ☐ B ☐ C ☐ chronic ☐ **HIV Positive**

Cancer: ____ when?_____________

Surgeries/dates: ____

____

Cardiovascular

☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Irregular heart beat
☐ Circulatory problems
☐ Bleeding disorder
☐ PACEMAKER

Digestive

☐ Acid Stomach
☐ Reflux (GERD)
☐ Indigestion
☐ Bloating/gas
☐ Belching
☐ Stomach pain
☐ Intestinal cramping
☐ IBS
☐ Crohn's disease
☐ Constipation
☐ Diarrhea
☐ Anorexia/bulimia
☐ Liver disease:
☐ Gall bladder
☐ Pain/stones
☐ Nausea/vomiting

Nervous System

☐ Headaches
    ☐ Tension
    ☐ Frontal
    ☐ Migraine
Per Week: ____ Month: ____
☐ Dizziness
☐ Tremor/shaking
☐ Epilepsy/seizures
☐ Insomnia
☐ Fainting
☐ Nerve pain-
where?______________________
☐ Numbness of _______________
ADD/ADHD

Respiratory

☐ Allergies
    ☐ Pollens/Dust
    ☐ Wheat
    ☐ Sulphites
☐ Foods:______________________
☐ Asthma use inhaler? ☐ yes ☐ no
How often? ___________
☐ Post-nasal drip
☐ Lung disease _____________
☐ Frequent phlegm/congestion
☐ Catch colds easily
☐ Chronic cough

Urogenital

☐ Frequent bladder infections
☐ Incontinence
☐ Irritable bladder
☐ Difficult urination/retention

☐ Nighttime urination
☐ Kidney disease/stones

Musculoskeletal

☐ Pain- where_______________
☐ Injuries/year: _______________
____
☐ Muscle tension/aches
☐ Cramps/spasms
☐ Weakness
☐ Arthritis- where________________
☐ Rheumatoid ☐ Osteo
☐ Jaw clenching/tooth grinding

Ear, Nose, Throat, Eyes

☐ Chronic sore throat
☐ Swollen glands
☐ Ringing in ears
☐ Pressure/fluid in ears
☐ Hearing loss
☐ Ear infection

WOMEN

Breast Health

☐ Fibrocystic
☐ Currently breastfeeding
☐ Cancer- year_________
☐ Surgery- year________
☐ Implants

Menstrual Period

☐ Regular
☐ Irregular
☐ Heavy flow
☐ Spotting
☐ Cramps
☐ Headache
☐ Low back pain

Number of

Children _____
Regular deliveries_____
C-sections_____

☐ **PMS**

☐ Irritability/anger
☐ Sensitive/tearful
☐ Breast tenderness/swelling
☐ Abdominal bloating
☐ Feeling warmer/hot

☐ **Peri menopausal**

☐ Hot flashes
☐ Night sweats
☐ Mood swings
☐ Hair loss
☐ Dry skin/vagina

☐ Abnormal pap smear
☐ HPV
☐ Cervical dysplasia
☐ Infertility
☐ Frequent yeast infections
☐ IUD
☐ Frequent bacterial infections
☐ Herpes
☐ Endometriosis
☐ Fibroids
☐ Ovarian cysts
☐ Birth control pills

Men

- ☐ Enlarged Prostate
- ☐ Erectile Dysfunction
- ☐ Frequent Urination

Metabolism

- ☐ Hypothyroid (low)
- ☐ Increased thirst
- ☐ Hyperthyroid (high)
- ☐ Alcoholism
- ☐ Hypoglycemia
- ☐ Cholesterol – high
- ☐ Diabetes
- ☐ Fatigue
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Sweating Easily/Excessively

Emotional/Mental

- ☐ Anxiety
- ☐ Bi-polar Disorder
- ☐ Stress Level
- ☐ Hyperactivity
  - ☐ High ☐ Moderate ☐ Low
- ☐ ADD/ADHD
- ☐ Depression
- ☐ Brain Fog/Unfocused
- ☐ Grief
- ☐ Poor Memory
- ☐ Suicidal Thoughts

Other:___________________________

____

FOR YOUR INFORMATION:

(1) Only sterile, disposable needles will be used for your acupuncture treatment.

(2) It is common to feel very relaxed after an acupuncture treatment. Sometimes you may feel a bit lightheaded. If that is the case, please sit for a few minutes in the waiting room and have some sweetened tea if you wish. The sensation should pass in a few minutes.

(3) Occasionally, you may get a small hematoma (a small dime-sized bruise or bump under the skin) after an acupuncture needle is removed. This is not a cause for concern- it will go away in a few days. Gentle pressure applied to the site will stop any small amount of bleeding that is occurring under the skin.

(4) Herbal prescriptions and patent medicines (pills and prepared forms) are intended only for the person for whom they are prescribed. Do not give herbal medicines to anyone else without your practitioner's consent.

I HAVE READ AND UNDERSTAND THE ABOVE CAUTIONS. Initials: __________

CONSENT FOR TREATMENT

My signature authorizes Ann Fielder, Lac, to treat me (or the patient for whom I am legally responsible) with acupuncture and Chinese medicinal herbs within the licensure granted by the Oregon State Board of Medical Examiners. I wish to rely on the acupuncturist to exercise judgment during the course of the treatment which the acupuncturist feels at the time, based upon the facts then known, is in my best interest. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment. I authorize the release of any medical or other information necessary for insurance claim processing.

Signature: ___________________________________ Date: ____________________

(Patient, parent or guardian)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____________________________ , have received a copy of this office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

□ We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)

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FINANCIAL POLICY

Payment is due at the time of service. If you have insurance that covers acupuncture, it is your responsibility to know the extent and details of your coverage. It is highly recommended that you call your company and get this information (including whether or not you have a deductible to meet first, the co-pay or co-insurance amount, and yearly limits for acupuncture) prior to your first visit. Any co-payments or percentages not covered will be due at the time of service, and if the extent or details of your acupuncture coverage is unsure, you will be expected to either pay the cash rate, or give a credit card number to be kept on file to cover your first, until coverage is verified by our office. We provide insurance billing service as a courtesy to you. Any co-payments or percentages not covered will be due at the time of service. We will make every effort to obtain payment, but if for any reason payment is denied, then you are responsible for the balance due.

CANCELLATION POLICY

Because we value your time and ours, we ask that you please give at least **24 hours notice** if you need to change your appointment time. This way, we can give the time to someone else who may need it. There will be a **$50.00 missed appointment fee** if you do not show or call to cancel at least 24 hours prior to the scheduled appointment time.

Exceptions will be made for a true emergency, such as a transportation breakdown, family emergency, or significant illness.

I have read and understand the above policies.

Signature ________________________________ Date ____________________