Mind in Heart Healing

Lucía G. Perillán, M.Ac., L.Ac., RCST
8720 Georgia Avenue, Suite 808, Silver Spring MD 20910
301.908.2238

New Patient Intake

Please help Mind In Heart Acupuncture provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name _____ Sex M ___ F___ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____Place of birth _____ Age ____ Height _____ Weight_____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

_____ Single _____ Married _____ Divorced _____ Widowed _____ Living with

Education _____ Occupation _____

Referred by: _____

Reason for visit today _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___Work ___other (what?) _____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes No

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: ***What might you eat on a typical day?***

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What recreational activities do you enjoy? (reading, TV, meditation, music, etc.) _____

_____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
Diabetes						
blood or bleeding disorders/anemia						
Seizures						
high blood pressure/heart disease						
Allergies						
Stroke						
drug abuse						
depression or mental illness						
age of death						
Hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

MEDICINES:

Prescription drugs you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

_____ _____

Over-the-counter medication you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: _____

Name, address and phone no. of physician _____

GYNECOLOGY
(Women)

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes/no/when: _____ Length of cycle _____

Color of menstrual blood:palebright reddark redbrown other _____

Texture of menstrual blood: thickthinwaterynormal

Pain: yes/no/when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant?Yes/no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear:normalabnormalDate of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

_____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes/no/ Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

_____

_____

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General
__ Insomnia
__ Dreams/ nightmares
__ Irritability
__ Depression
__ Mood swings
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Infections
__ Earache
__ Hearing aids
__ Vertigo

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts

Nose, Throat & Mouth
__ Sinus infection
__ hay fever/ allergies
__ Frequent sore throat
__ difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems
__ Dry mouth

Skin
__ Hives
__ Rashes
__ Eczema/ psoriasis
__ Night sweating
__ Excess sweating
__ Dry skin
__ Easy bruising
__ Changes in moles, lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Difficulty breathing when lying down
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitation
__ Rapid heart beat
__ Irregular heart beat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ History of heart attack

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Mucus in stool
__ Hemorrhoids
__ Gall Bladder disorder

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Other (describe)

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain
__ Paralysis
__ Poor coordination
__ Other (describe)

Genito-urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Increased libido
__ Decreased libido
__ Kidney stones
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Lumps in testicles

Infection Screening
__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis risk: self or partner
__ History of sexually transmitted disease: self or partner
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes: oral/ genital

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION.

I may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for the purposes of providing you treatment, obtaining payment for you and for your care and conducting health care operations.

Treatment- Your health information will be recorded and used to determine the course of treatment that should work best for you. The sharing of your health information may include other health care providers involved in your care within the confines of my practice.

Payment- your health care information will be used in order to assist you to be able to receive reimbursement payments for services. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations- Your health care information will be used as necessary in order to improve the quality and effectiveness of the care and services I provide. For example, with your written consent, I may discuss your case with another health care provider to increase my understanding of your unique situation.

Appointment reminders- I may contact you with appointment reminders.

Treatment Alternatives- I may contact you with information about treatment alternatives and other health-related activities that may be of interest to you.

Patient Education- I may contact you to inform you of new services that I offer or event that I am hosting or attending.

Communication with Family- In an urgent situation, a family member, or close personal friend, identified by you, may be given information relevant to your care.

Research/Education- Your information will be disclosed to researchers or educators upon the assurance that protocols have been established to ensure the privacy of your health information.

Law Enforcement- Your health information will be disclosed when it is required under Federal, State or Local law.

Other than stated above when applicable, I agree not to use or disclose your health information without your written authorization. Other than activity that has already occurred, you may revoke this authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Your health record is the physical property of the health care practitioner of facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your

rights include being able to review or obtain a paper copy of your health information (a copy fee may be requested), and to receive an accounting of the disclosures that have been made of your health information (after the effective date of this Notice) for most purposes other than treatment, payment or health care operations. Other disclosures excluded are direct disclosures to yourself, family or friends involved in your care. You may also request communications of your health information be made by reasonable alternative means or to reasonable alternative locations. You will need to provide details about how to contact you, including a valid alternative address. If we are unable to contact you using the information you provide, we may contact you using any information on file. We will not require you to explain why you want this communication. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using any information on file. You may want to communicate with us via e-mail. Because e-mail may contain your personal health information and e-mail is not a secure communication, we will ask for your specific authorization.
All requests must be submitted to me in writing (Lucía G. Perillán, 305 Hilltop Road, Silver Spring, MD 20910-5402). You have the right to a paper copy of this Notice and may request one at any time by contacting me at 301.908.2238. You have the right to file a complaint with me or the Secretary of Health and Human Services, with no fear of retaliation.

MY RESPONSIBILITIES

I am required by law to maintain the privacy of your health information and to provide you this Notice of Duties and Privacy Practices. I am required to abide by the terms of this Notice and to notify you if I am unable to grant your requested restrictions or desires. I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that I maintain. If I change this Notice, you will be informed at your next office visit.

Patient Comments:

_____ _____

Patient Signature Date

This notice is effective 1 March 2008.

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Consent to Treatment Form

Voluntary:
I hereby voluntarily consent to be treated by acupuncture. The procedures involved in this treatment have been explained to me. I understand that my questions about the safety of acupuncture and the precautions taken by my acupuncturist are most welcome and will be answered as fully as possible.

I understand I may be treated with the insertion of needles and/or with the application of heat to the skin. I understand that with acupuncture treatments I may see positive changes in many areas of my life, in addition to those for which I am specifically seeking treatment. And, I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Responses:
I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment.

Medical Referral:
I understand that if there is any worsening of my ailment or condition, if it does not show any signs of improvement, or if a new ailment or condition arises that I should consult a licensed physician.

Infectious Disease/Clean Needle Procedures:
I understand that there are infectious diseases carried through the air, through physical contact, and through blood and body fluids. I understand that my acupuncturist follows universally prescribed precautions to guard against the spread of infection.

I agree to inform my acupuncturist prior to receiving treatment if I am infectious so that she may take appropriate steps to control the spread of infection. I also understand that my practitioner will need to reschedule my appointments in the case that she is infectious.

Patient Responsibility:
I understand that it is my responsibility as a patient to inform my acupuncturist about all aspects of my health and that, as treatment progresses, to inform my practitioner of any changes that occur. I understand that I must be an active participant in my wellness and that I will work in partnership with my practitioner towards meeting my wellness goals. I also understand that acupuncture treatment is a process of promoting wellness and not an overnight cure.

I understand that it is my responsibility to give at least 24 hours notification if I have to cancel an appointment. If I cancel a scheduled appointment with less than 24 hours notice, I understand that I am responsible for paying the full treatment fee to my practitioner.

I have read this form carefully. I have felt free to ask questions regarding this process, and it has been satisfactorily explained to me.

_____

Signature of Patient Date

_____

Print Name of Patient Date

_____

Lucía G. Perillán, M.Ac., L.Ac., RCST (NCCAOM)