Traditional Chinese Medicine and Acupuncture Intake Form

Robert Alexander Elvir, DOM, LPN

INFORMED CONSENT

Please read the following information carefully, and ask your practitioner if you have any questions: while the traditional Chinese medicine practices of acupuncture, acupuncture injection therapy, cupping, electro-acupuncture, holistic counseling, and tui-na (meridian physical therapy) are considered to be safe treatments, you should be aware that the following side effects may occur:

Residual needle sensation – sometimes there is a residual sensation at the point of insertion that may last for a period of time after treatment, please advise your practitioner if this does not dissipate in 1 to 2 days

Drowsiness or dizziness – please ensure that you eat and drink before treatment, as these effects may be more common if you are hungry or dehydrated. It is also recommended that you do not drive or operate equipment after treatment.

Fainting- more likely again if he's hungry or dehydrated, and it is your first acupuncture treatment

Bruising or bleeding – may occur at the site of insertion, please advise if physician if it seems to be a temporary

Aggravation of symptoms – with many types of healing symptoms may worsen before improving, please advise your practitioner if symptoms worsen for more than a few days.

The herbs used in traditional Chinese medicine (which can be from plant, animal, or mineral source) that have been recommended for use are considered safe. Some of the herbs may be inappropriate during pregnancy, or while taking other medications. It is important to inform your practitioner of all these situations and conditions. Possible side effects to herbal therapy include such things as gastrointestinal upset or skin rash. It is important to see cease use immediately, and inform your practitioner, in the case of adverse reaction to a real therapy.

CONSENT TO TREATMENT

As a patient of Robert Alexander Elvir, I have read the information and understand that this form of medical care is based on traditional Chinese medicine principles and practices. As, Intuitive Wellness, is an integrated health clinic; I recognize that the practitioner working with me may have access to my file and will ensure all information is private and confidential. I also recognize that even practitioners potentially have their complications, and hence the information provided must be complete and then inclusive of all health concerns including pregnancy, significant medical history, and all medications (including over-the-counter drugs and supplements).

Robert Alexander Elvir (DOM, LPN), utilizes therapies as outlined by the theories of Traditional Chinese Medicine and acupuncture; however, I do not expect, Robert Alexander Elvir, to be able to anticipate all the risks and complications associated with this treatment. I have been informed that certain side effects reactions to treatment may occur, including such reactions as residual needle sensations, dizziness, fainting, bruising, bleeding injury, temporary aggravation of symptoms, or other related reactions. I also fully understand that there are possible side effects to herbal therapy and will cease use and inform my practitioner immediately if these occurred. I will also inform my practitioner immediately if I am pregnant. I understand that it is my responsibility to fully disclose all medications and supplements I may be taking, and refrain from mixing these medications with any prescribed herbal formulas.

I hereby consent to acupuncture treatment, herbal treatments, and other practices within the scope of Traditional Chinese medicine on me by, Robert Alexander Elvir. I also confirm that I have the ability to accept or reject this care and treatment of my own free will and choice, and that I am not an agent of any private, local, provincial, or federal agency attempting together information without so stating.

CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a ninety-dollar ($90) fee; this will be nonrefundable. I accept full responsibility for fees incurred during this care and treatment and agree to the cancellation policy requiring a 24-hour notice for all canceled appointments.

Name (please print): _____

Signature:_____ Date:_____

HIPAA Consent Agreement
Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, **Intuitive Wellness, LLC,** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Intuitive Wellness, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Intuitive Wellness, LLC has already taken action in reliance thereon.

I request **the following restrictions** to the use or disclosure of my health information:

_____

_____

Patient Name (print):_____ Date :_____

Patient Signature:_____ Intuitive Wellness Rep/Date:_____

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To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information provided will be kept confidential in your patient's file.

PATIENT INFORMATION

NAME:		TODAY'S DATE:
DATE OF BIRTH:	AGE:	SEX:
HOME ADDRESS:		POSTAL CODE:
HOME PHONE:		MOBILE PHONE:
EMAIL:		OCCUPATION:

EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:
FAMILY PHYSICIAN:	PHONE:	NAME OF CLINIC:
Are you currently under a physician's care? ☐ ☐	If YES, for what?	
List all prescription medications currently taking (with dosage if possible):		
List all non-prescription medications or supplements currently taking:		

REASONS FOR TODAY'S VISIT

CONCERNS	ABOUT HOW LONG HAS THIS BEEN AN ISSUE?
1.	
2.	
3.	

How did you hear about Dr. Robert Elvir?

WOMEN'S HEALTH:

Is there any chance you are currently pregnant? ☐ ☐ **(If YES, at _____ weeks)**	Are you trying to conceive?

Do you use birth control?	If so, what form of birth control do you use?	
Have you been pregnant before?	If so, have you had serious problems with pregnancy?	
Age when you had your first period?	Age when you underwent menopause (if applicable):	
Is your period regular?	Length of menstrual cycle:	Any bleeding between cycles?
Any current menstrual symptoms (e.g. PMS, cramps, breast distension, water retention, headaches, nausea, etc.)?		
Any current menopausal symptoms (e.g. hot flashes, night sweats, etc)?		
Any history of sexually transmitted infections? If so, please indicate what and when:		
Date of last PAP smear, and if any, abnormal findings:		
Do you have any other women's health concerns? Please specify:		

MEN'S HEALTH:

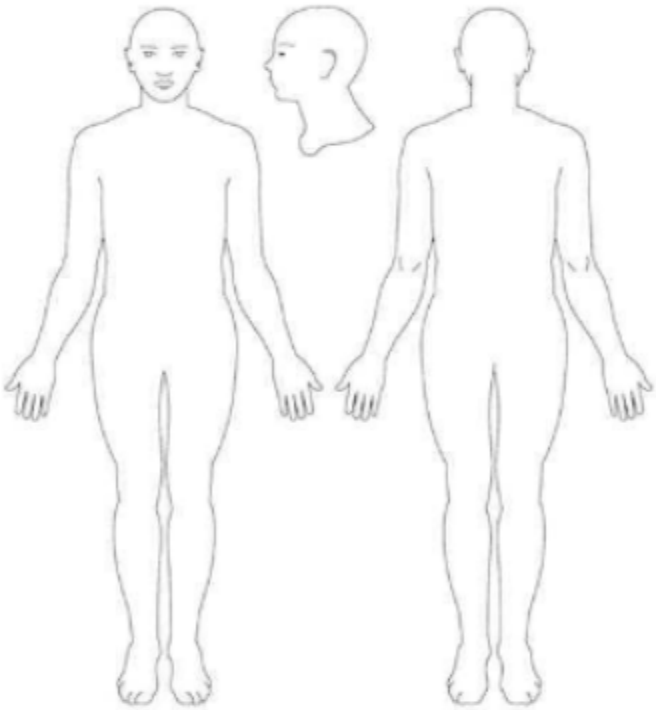
Do you have any problems with (please circle):

Decreased libido ☐	Ejaculation disorders ☐	Difficulty urinating ☐
Infertility ☐	Testicular pain ☐	Urinary incontinence ☐
Erectile dysfunction ☐		Prostate enlargement ☐

Any history of sexually transmitted infections? If so, please indicate what and when:
Date of last prostate exam, and if any, abnormal findings:
Do you have any other men's health concerns? Please specify:

Thank you for taking the time to fill out this form thoroughly and to the best of your knowledge.

On the figures below, please indicate your areas of pain/concern:



GENERAL

HEIGHT:	WEIGHT:

Are you physically active?	How many times do you exercise a week?

PERSONAL MEDICAL HISTORY

Past and current medical diagnosis (given by a certified medical professional), include date diagnosed:	
List all allergies and sensitivities:	
History of hospitalizations, surgeries, significant illnesses, or injuries (what for, include date):	
Are you scheduled for an upcoming surgery? If so, for what?	
Do you have a pacemaker?	Do you have any metal implants?

Please check any of the following **conditions** that you currently suffer from, or have a medical history of:

- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ bone fractures
- ☐ cancer
- ☐ chronic fatigue
- ☐ COPD
- ☐ deep vein thrombosis
- ☐ emotional problems
- ☐ epilepsy
- ☐ fibromyalgia
- ☐ gall stones
- ☐ glaucoma
- ☐ hayfever
- ☐ heart disease
- ☐ hemophilia
- ☐ hepatitis a
- ☐ hepatitis b
- ☐ hepatitis c
- ☐ high blood pressure
- ☐ HIV/AIDS
- ☐ kidney disease
- ☐ kidney stones
- ☐ liver disease
- ☐ low blood pressure
- ☐ mental illness
- ☐ migraines
- ☐ multiple sclerosis
- ☐ osteoporosis
- ☐ pacemaker
- ☐ respiratory disease
- ☐ sinus problems
- ☐ skin conditions
- ☐ spinal injury
- ☐ stress/anxiety
- ☐ stroke
- ☐ thyroid problem
- ☐ tuberculosis
- ☐ ulcers
- ☐ varicose veins

Other (please specify):

Symptoms Checklist (please check all that apply):

- ☐ abnormal feeling of cold
- ☐ abnormal feelings of heat
- ☐ abnormal sweating
- ☐ addictions
- ☐ allergies
- ☐ anxiety
- ☐ apathy
- ☐ asthma
- ☐ bad breath
- ☐ bad taste in moth
- ☐ bleeding gums
- ☐ blood in stool
- ☐ blood in urine
- ☐ brittle hair/nails
- ☐ bruise easily
- ☐ chest pain
- ☐ chronic cough
- ☐ chronic runny nose
- ☐ cloudy urine
- ☐ constant thirst
- ☐ constipation
- ☐ depression
- ☐ diarrhea
- ☐ difficulty concentrating
- ☐ dizziness
- ☐ dry mouth/throat
- ☐ dry skin
- ☐ easily angered
- ☐ edema
- ☐ fatigue
- ☐ fevers
- ☐ floaters in eyes
- ☐ foggy thinking
- ☐ frequent urination
- ☐ gas/bloating
- ☐ hair loss
- ☐ headaches
- ☐ hearing problems
- ☐ heartburn/acid reflux
- ☐ heat in palms/soles
- ☐ hemorrhoids
- ☐ high libido
- ☐ infertility
- ☐ insomnia
- ☐ irritability
- ☐ loose stools
- ☐ low appetite
- ☐ low back pain
- ☐ low immune system
- ☐ low libido
- ☐ mouth/tongue sores
- ☐ mucous in stool
- ☐ muscle tension/spasm
- ☐ nausea/vomiting
- ☐ neck pain
- ☐ night sweats
- ☐ mouth/tongue sores
- ☐ mucous in stool
- ☐ muscle tension/spasm
- ☐ nausea/vomiting
- ☐ problems with weight
- ☐ redness in eyes
- ☐ restless leg
- ☐ ringing in ears
- ☐ shortness of breath
- ☐ skin discolorations/moles
- ☐ swollen lymph nodes
- ☐ tightness in chest
- ☐ urinary incontinence
- ☐ urinary tract infection
- ☐ vision problems
- ☐ water retention

Other (please specify):

_____