PATIENT CONFIDENTIAL INFORMATION

Name: ____
First | Middle | Last

Mailing Address: ____
Street | City | State | Zip

Home Phone: ____________________ Business Phone: ____________________

Cellular Phone: ____________________ Email: ____________________

Can we leave a message? Y/N At what number? Home Phone/Cell Phone

In case of emergency, call:
Name Phone

FOR MINORS: List both parents' names and addresses:

NEW PATIENT HEALTH HISTORY

Date of Birth: Age: Gender: M/F Height: Weight:

Successful health care and preventative medicine are only possible when the practitioner has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

1. When and where did you last receive health care?

   For what reason?

2. Has your case been referred to an attorney? Y N
3. Please identify the health concerns that have brought you to New Leaf, **in order of importance:**

Condition	**Past Treatment**
a. ______________________	______________________
b. ______________________	______________________
c. ______________________	______________________
d. ______________________	______________________

4. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?
7. Do you have any infectious diseases? Y N If yes, please identify:

8. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

9. **X-rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

10. **Family History:**

(√check if applicable)	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good, P=Poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay Fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

11. **Childhood Illness** (circle if you have had)**:**

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (circle if you have had)**:**

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B Others:

Directions: circle if you experience now and underline if you have experienced in the past.

13. **Overwhelming Emotions**

Mood Swings Nervousness Mental Tension Anger/Frustration/Irritability Sadness Other:

Please Note: *Emotional symptoms help with Traditional Chinese Medicine pattern diagnosis and point determination. New Leaf Acupuncture does not provide counseling services.*

14. **Energy and Immunity**

Fatigue Slow Wound Healing Chronic Infection Frequent Cold/Flu Chronic Fatigue Syndrome Seasonal Allergies

15. **Head, Eye, Ear, Nose, and Throat**

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

16. **Respiratory**

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Other Respiratory Problems:

New Leaf
Acupuncture & Herbal Medicine

17. **Cardiovascular**

Heart Disease
Chest Pain
Swelling of Ankles
High Blood Pressure
High Cholesterol
Palpitations/Fluttering
Stroke
Heart Murmurs
Rheumatic Fever
Varicose Veins

18. **Gastrointestinal**

Ulcers
Change in Appetite
Nausea/Vomiting
Epigastric Pain
Excessive Gas
Heartburn
Belching
Gall Bladder Disease
Liver Disease
Hepatitis B or C
Hemorrhoids
Abdominal Pain

19. **Genito-Urinary Tract**

Kidney Disease
Painful Urination
Frequent UTI
Frequent Urination
Excessive Urination
Kidney Stones
Difficulty Urinating
Blood in Urine
Frequent Urination at Night
Scanty Urination

20. **Female Reproductive/Breasts**

Irregular Cycles
Breast Lumps/Tenderness
Nipple Discharge
Heavy Flow
Long Flow (>7 days)
Vaginal Discharge
Premenstrual Problems (PMS)
Clotting
Bleeding Between Cycles
Menopausal Symptoms
Difficulty Conceiving
Painful Periods
Scanty Flow
Short Flow (<3 days)

21. **Male Reproductive**

Sexual Difficulties
Prostate Problems
Testicular Pain/Swelling
Penile Discharge

22. **Musculoskeletal**

Neck/Shoulder Pain
Muscle Spasms/Cramps
Arm Pain
Upper Back Pain
Mid Back Pain
Low Back Pain
Leg Pain
Joint Pain (if so, where?):

23. **Neurologic**

Vertigo/Dizziness
Paralysis
Numbness/Tingling
Loss of Balance
Seizures/Epilepsy
Concussion

24. **Endocrine**

Hypothyroid
Hyperthyroid
Hypoglycemia
Diabetes Mellitus
Night Sweats
Feeling Hot or Cold

25. **Other**

Anemia
Cancer
Rashes
Eczema/Hives
Cold Hands/Feet

Is there anything else that should/could be mentioned?

26. **Menstrual/Birthing History:**

Age of First Menses:
Date of Last Menses:
Birth Control Type:
# of Days of Menses:
# of Days Between Menses:
Total Length of Cycle:
# of Pregnancies:
# of Live Births:
# of Miscarriages:
# of Abortions:

27. **Lifestyle:**

Do you typically eat at least three meals per day? Y N
If no, how many?
Typical daily diet:
How many glasses of non-caffeinated, non-alcoholic, non-carbonated beverages do you drink per day?
Exercise routine:
How many hours per night do you sleep?
Do you wake rested? Y N
Occupation:
Employer:
Hours/Week:
Do you enjoy work? Y N Why/Why not?
Nicotine/Alcohol/Caffeine/Illicit Substance Use:
Have you experienced any major traumas? Y N Describe:
Do you feel safe and content in your home?
Interests and hobbies:

New Leaf Acupuncture & Herbal Medicine

28. Oriental Medicine (OM) Pattern Diagnosis Questions:

Your OM diagnosis and treatment is based on your symptoms *plus* ***your body's constitution and current state (pattern). The following questions are important to help determine your pattern and treatment within the framework of OM. These questions will typically be reviewed during each visit in order to assess your body's most current status and custom-tailor a treatment specifically to suit you each step along the way towards balance and health.***

Circle **all** answers that apply **currently** (today or within the last few days).

Energy Level:	1 worst	2	3	4	5	6	7	8	9	10 best
Stress Level:	1 worst	2	3	4	5	6	7	8	9	10 best

Sleep:
Difficulty falling asleep | Wake frequently at night | Wake early and can't go back to sleep
Frequent dreaming | Nightmares | Other:
Don't feel rested in the morning | Feel rested in the morning

Sweating:
Night sweating | Sweating without activity/anxiety | Normal sweating with activity only

Appetite:
Always feeling hungry | Appetite seems normal | Rarely feel hungry | Aversion to food
I eat more than I should | I eat the right amount for me | I eat less than I should
I prefer: Hot food | Cold food | Spicy | Salty | Sweet | Bitter | Sour | Bland

Thirst:
Always feeling thirsty | Thirst seems normal | Rarely feel thirsty | Aversion to drinks
I drink more than others | I drink the right amount for me | I drink less than others
I prefer: Hot drinks | Room temperature | Cold drinks

Bowel Movements:
Regular | Irregular | Mostly regular | Laxative use:
1-2 week | Every other day | <1/day | 1/day | 2-3/day | >3/day
Dry/Hard | Sticky | Loose/Soft | Watery | Undigested food bits
Black/Tarry | Brown | Green | Yellow | Gray/Silver | Blood | Mucus | Other:

Urination:
More than fluid intake | Proportional to fluid intake | Less than fluid intake
Clear | Light Yellow | Dark Yellow | Brown | Pink/Red | Cloudy
Pain with urination | Frequent urination | Urgency | Difficulty stopping/starting

How did you find out about New Leaf ***?***
Referral (who?)
Friend (who?)
Other:

FINANCIAL POLICIES

Oriental Medicine Evaluation & Acupuncture Treatment (45-75 min)	$60
Extended OM Evaluation & Acupuncture Treatment (75-90)	$80
New Patient Comprehensive Health History	$60
Herbal Prescription with Herb/Drub Database Check	$15
Missed Appointment / Cancellation of 24 hours or less	$25
Clerical Requests (per 15 minutes)	$15
Cosmetic Acupuncture Treatment	$135
"Trying Out Acupuncture" Treatment	$75

Please initial the following:

______ All payments are due in full at the time of service.

______ Insurance is not accepted, however if your policy covers acupuncture, we can provide paperwork for you to submit to your insurance company yourself.

______ In the event of a missed appointment or an appointment cancelled with notice of 24 hours or less, a $25 fee will be charged.

Please indicate your understanding and acceptance of these policies by signing below.

Signature **Printed Name** **Date**

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many 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.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

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

____

____

X____ ________________

Patient Signature **Date**