Welcome to the Alternative Therapy Center

Confidential Patient Intake Form (**Acupuncture**)

Name: _____Hm #:_____ Wk #: _____ Cel # _____
Street: _____ City: _____ State _____ Zip _____
Date of Birth _____ Age: ____ M __ F __ Ht: ____Wt:_____ Occupation _____
Social Security # _____ How did you hear about us _____
Primary Reason for your visit today _____
Other concurrent therapies _____

Name of Doctor: _____ Phone # _____Fax #_____
Address: _____ City _____ St _____ Zip_____
Doctors Diagnosis _____
How are you responding to your present course of treatment? Better _____Worse _____ Same _____
Date of last appointment with regular Physician: _____
Reason for that appointment _____

INSURANCE INFORMATION
Insurance Company _____ Phone Number _____
Address: _____City _____ ST _____ Zip _____
Name & Ext of Adjuster _____ Date of Accident _____
Policy # _____ Claim# _____PIP ___ WC___ Deductible _____ % of coverage

***YOUR* PAST MEDICAL HISTORY** (include dates)
( ) Cancer ( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) Sexually Transmitted Disease
( ) Seizure ( ) Hepatitis ( ) Thyroid Disease ( ) Alcoholism ( ) High Blood Pressure
( ) Other (explain) _____

***FAMILY* PAST MEDICAL HISTORY**
( ) Cancer ( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) Sexually Transmitted Disease
( ) Seizure ( ) Hepatitis ( ) Thyroid Disease ( ) Alcoholism ( ) High Blood Pressure
( ) Other (explain) _____

Surgeries_____

Significant Trauma: _____

Birth History: _____

Allergies (drug, food, chemical, environmental) _____

Medicine taken in the past 2 months (medications, vitamins, and food supplements)

Name _____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____

Occupational Stresses (chemical, physical, psychological, etc)_____

Exercise (type duration, frequency)_____

Habits: ( ) Cigarettes ( ) Coffee ( ) Soda ( ) Tea ( )Alcohol ( )Drugs ( ) Sugar

Avg Daily Diet Morning _____
Afternoon _____
Evening _____

General:
( ) Poor Appetite ( ) Fevers ( ) Poor Sleep ( ) Heavy Sleep ( ) Insomnia ( ) Fatigue
( ) Sweat Easily ( ) Tremors ( ) Cold Hands ( ) Cold Feet ( ) Cold Back ( ) Heavy Appetite
( ) Cold Abdomen ( ) Chills ( ) Vertigo ( ) Night Sweats ( ) Localized Weakness
( ) Poor Coordination ( ) Cravings_____( ) Sudden Energy Drop At _____(time)
( ) Peculiar Tastes or Smells _____ ( ) Strong Thirst (cold/hot drinks) _____
( ) Bleeds/ Bruises Easily (where) _____ ( ) Varicose/Spider Veins

SKIN/HAIR
( ) Rashes ( ) Pimples ( ) Ulcerations ( ) Dandruff ( ) Loss of Hair ( ) Change in Texture
( ) Hives ( ) Itching ( ) Purpura ( ) Eczema ( ) Other hair/skin problems_____

HEAD, EYES, EARS, NOSE AND THROAT:
( ) Dizziness ( ) Eye Pain ( ) Sinus Problems ( ) Poor Hearing ( ) Jaw Clicks ( ) Ringing in Ears
( ) Concussion ( ) Mucus ( ) Poor vision ( ) Copious Saliva ( ) Earaches ( ) Nose Bleeds
( ) Eye Strain ( ) Floaters ( ) Facial Pain ( ) Color Blindness ( ) Glasses ( ) Night Blindness
( ) Migraines ( ) Cataracts ( ) Dry Mouth ( ) Grinding Teeth ( ) Dry Throat ( ) Teeth Problems
( ) Headaches (where) _____

CARDIOVASCULAR:
( ) High Blood Pressure ( ) Chest Pain ( ) Fainting ( ) Irregular Heart Beat ( ) Cold Hands/Feet
( ) Low Blood Pressure ( ) Blood Clots ( ) Dizziness ( ) Swollen Hands/Feet ( ) Difficulty Breathing

RESPIRATORY:
( ) Coughing Blood ( ) Cough ( ) Asthma ( ) Bronchitis ( ) Pneumonia ( ) Tight Chest
( ) Production of Phlegm ( ) Difficulty Breathing When Lying Down

GASTROINTESTINAL:
( )Nausea ( )Vomiting ( )Diarrhea ( )Hemorrhoids ( )Belching ( )Black Stools ( )Gas
( )Bad Breath ( )Rectal Pain ( )Pain/Cramps ( )Constipation ( )Bloody Stool ( )Sensitive Abdomen
BOWEL MOVEMENT: Frequency _____ Color_____

GENITO-URINARY
( )Pain on Urination ( )Wake up to Urinate ( )Kidney Stones ( )Urgency to Urinate ( )Impotency
( )Incontinence ( )Frequent Urination ( )Blood in Urine ( )Venereal Disease ( )Other _____

PREGNANCY & GYNECOLOGY
( ) Irregular Periods ( ) Clots ( ) Discharge ( ) Sores ( ) Breast Lumps ( ) Menopause
# of pregnancies____ #of Births ____ # Premature____ # Miscarriages ____ Age at first Menses_____
Period Duration _____ Last Menses _____ Birth Control _____

MUSCULOSKELETAL:
( ) Neck Pain (where) _____ ( ) Muscle Pain (where) _____
( ) Back Pain (where) _____ ( ) Joint Pain (where) _____

NEUROPSYCHOLOGICAL:
( ) Poor Memory ( ) Seizures ( ) Areas of Numbness ( ) Concussion ( ) Depression
( ) Anxiety ( ) Anger Easily ( ) Easily Stressed ( ) Considered/Attempted Suicide
( ) Other Neurological or Emotional (specify) _____

Most & Least Favorite Climate: _____
Season: _____ Taste: _____
Time of Day _____ Temperature _____

ACUPUNTURE TREATMENT AGREEMENT & CONSENT
JoAnne Lehrfeld, AP

VOLUNTARY TREATMENT

I voluntarily consent to receive acupuncture treatment. The procedures involved in treatment have been explained to me and I have felt free to ask questions. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

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 AND HEALING REACTIONS

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

MEDICAL REFERRAL

I understand that if there is a worsening of my ailment or condition, or if a new ailment or condition arises that I should consult my medical doctor.

Acupuncture treatment is a complement to and not a substitute for Western medical care. Certain conditions may best be addressed in partnership with my medical doctor or other health care provider.

INFECTIOUS DISEASE AND CLEAN NEEDLE PROCEDURES

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that my acupuncture practitioner follows universally prescribed precautions to guard against the spread of infection. My practitioner uses only sterilized, prepackaged, disposable needles. Needles that are used for my treatment are used only on me and are inserted according to clean procedures based on nationally prescribed standards.

PAYMENT AND CANCELLATIONS

I understand that payment is due at the time of treatment. In order to prevent being charged a $60 cancellation fee I agree to give at least 24hrs notice of cancellation.

_____ _____

Name (Please Print) Date

_____ _____

Patient Signature Physician Signature

Alternative Therapy Center MM 15975
2525 4th Street N. Saint Petersburg, FL 33704
727-822-9220
JoAnne Lehrfeld, M.Ac, L.Ac., Acupuncture Physician

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation.
   _____
   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition IN AN EMERGENCY:
   _____
   _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.
   _____
   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”:
   YES _____ NO _____

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number _____

6. Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?
   YES _____ NO _____

PATIENT NAME _____ (Guardian if under 18 years)

_____ _____
Patient/Guardian Signature Date

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Authorization for *other uses* of Protected Health Information (PHI)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose: Office promotions, holiday & or birthday cards, newsletters, change of address

Individuals who may use or disclose this information: JoAnne Lehrfeld, AP and the staff of Alternative Therapy Center

Expiration date of this Authorization: Ongoing until patient indicates in writing otherwise

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and my no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: _____ _____
Printed name- Patient or Representative Date

Relationship to Patient (if other than patient):_____

_____ _____
Patient/Guardian Signature Date

Witness: _____ _____
Name Date

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Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the lay. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is uses or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by: _____ _____
Patient or Representative Date

_____
Printed name of person signing this form

Relationship to Patient (if other than patient):_____

Witness: _____ _____
Name Date