# New Patient Health History Form

Patient Name ________________________________________ Date ______________________ __ Sex: M / F

Height __________ Weight __________ DOB ______________ Age _____ Marital Status S / M / P / W / D

Street ________________________________________ City _________________ State _______ Zip _____________

Best Phone # To Reach You ________________________________________________ HOME / WORK / CELL

If unable to reach you, is it okay to leave a message with voicemail/person who answers phone? YES / NO

Email ____________________________________________ May we include you on our mailing list? YES / NO

Occupation ________________________________________________ Hours worked per week _________________

Emergency Contact Name and # ________________________________________ Relationship _______________

Are you presently under a doctor's care? Y / N If yes, for what? ________________________________________

Primary Care Provider Name and # ____________________________________________________________________

How did you hear about us? __________________________________________________________________________

Have you had acupuncture before? YES / NO Do you bruise easily? YES / NO

Are you currently on blood thinners? YES / NO Do you have any allergies to nuts? YES / NO

CIRCLE if any of the following apply to you: Pacemaker Insulin Pump Pain Analgesic Pump

Seizure Disorder Bleeding Disorder Pregnant Other ________________________________

**CONDITIONS**
Please list the reasons for coming in order of order of importance.

1. ________________________________________
2. ________________________________________
3. ________________________________________
4. ________________________________________
5. ________________________________________

**INTENSITY**
On a scale of 1 to 10, please rate intensity the of your symptom/pain. (1 = mild, 10 = worst possible pain)

1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10

**ONSET OF SYMPTOMS**
For each condition listed above, please list when the condition started.

1. ________________________________________
2. ________________________________________
3. ________________________________________
4. ________________________________________
5. ________________________________________

**FREQUENCY OF SYMPTOMS**
How often do you experience this condition or symptom?

Constant / Sometimes / Other __________
Constant / Sometimes / Other __________
Constant / Sometimes / Other __________
Constant / Sometimes / Other __________
Constant / Sometimes / Other __________

MEDICAL HISTORY

| Chronic illnesses (past and present) | TYPE | DATE | AGE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

MEDICAL HISTORY (continued)

Past or future surgeries/ hospitalizations

| TYPE | DATE | AGE |
| --- | --- | --- |
| | | |
| | | |
| | | |

Trauma (Auto-accidents, falls, emotional, sexual):

| TYPE | DATE | AGE |
| --- | --- | --- |
| | | |
| | | |
| | | |

Allergies:

| ALLERGY | AGE @ ONSET | SYMPTOMS/TIME OF YEAR |
| --- | --- | --- |
| | | |
| | | |
| | | |

Prescription/OTC Drugs:

| NAME | WHAT'S IT FOR? | DOSAGE (# per day) | HOW LONG TAKEN? |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |

Nutritional Supplements:

| NAME | WHAT'S IT FOR? | DOSAGE (# per day) | HOW LONG TAKEN? |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |

Tests:

| TYPE | DATE(s)/RESULT(s) |
| --- | --- |
| X-Ray(s) | |
| MRI(s) | |
| CT (CAT) Scan(s) | |
| Ultrasound(s) | |
| Cholesterol | |
| Blood Sugar | |
| Thyroid | |
| Mammogram | |
| PAP Smear | |
| Other | |

Immediate Family Health History (Mother, Father, Siblings):

| FAMILY MEMBER | CONDITION/DISEASE |
| --- | --- |
| | |
| | |
| | |
| | |
| | |
| | |

EXERCISE, DIET, AND SUBSTANCE USE

Do you have a regular exercise routine? YES / NO If yes, please describe ______________________

Describe what you typically eat in a day: BREAKFAST ____________________

LUNCH ____________________

DINNER ____________________

SNACKS/DESSERT ____________________

Do you use (circle all that apply): Cigarettes/Tobacco Alcohol Coffee/Caffeine Soda

Marijuana Heroin Other ____________________

If so, do you what do you use in a typical day? ____________________

Have you ever been concerned about your smoking? YES / NO Would you like to try to quit? YES / NO

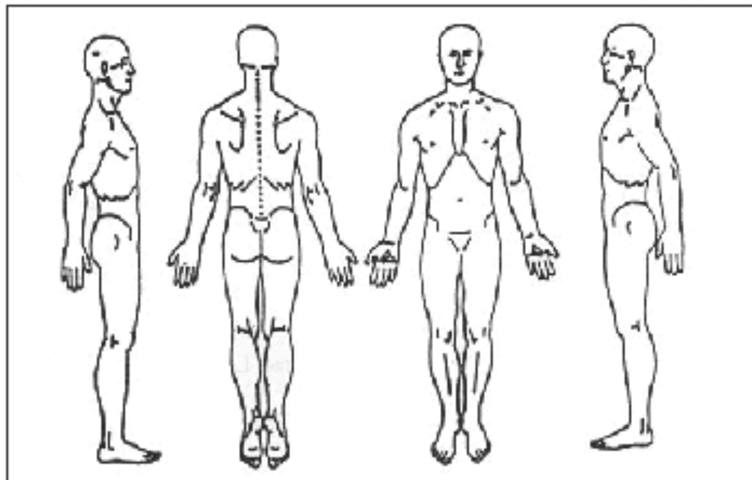
If you are a former smoker, how long ago did you quit? ____________________

Have you ever been concerned about your drinking? YES / NO

What concerns do you have, if any, about your past or current drug use? ____________________

PAIN

Circle or use lines to indicate where you have pain or other symptoms:



PREVIOUS PHYSCIAN EVALUATION AND/OR REFERRAL

I, (patient's name) ____________________, am notifiying the Acupuncturist, Melissa Mulvaney, of the following:

YES / NO I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed.

YES / NO I have been referred to see my Acupuncturist, Melissa Mulvaney, by a physician or dentist for the condition being treated.

Name of referring physician/dentist ____________________

Signature of the patient/guardian ____________________ Date ____________________

YOUR TREATMENT GOALS

What goals do you want to achieve with Acupuncture treatments?
______________________________________________________________________

On a scale of 1 – 10, 10 as your body's Optimal Health, how would you rate your present health right now?

1 2 3 4 5 6 7 8 9 10

On a scale of 1 – 10, 10 being 100% commitment, how would you rate your commitment to feeling better/getting rid of symptoms/building your health?

1 2 3 4 5 6 7 8 9 10

## COMPANY POLICIES

Our clients may expect:

1. To be treated with respect and dignity and without regard for gender, marital status, family status, age, disability, sexual orientation, race, religious beliefs, political affiliation, state of health, personal habits, or body type.
2. To be provided with a competent and professional session, addressing his/her specific needs for that session, each time the client comes for an appointment.
3. To receive immediate assistance during clinic hours; OR to be able to leave a voicemail and have their call returned within 24 hours on weekdays and at the first possible opportunity on weekends.
4. To be given at least one week's notice of scheduled clinic closings (i.e. vacations, holidays, etc.).
5. To be informed with as much time in advance as possible of unscheduled clinic closings (i.e. sick days, inclement weather, etc.).
6. To have accurate records kept of their sessions including (but not limited to) notes on diagnosis, treatment strategies, treatment outcomes, future treatment plans, etc.
7. To have their privacy and confidentiality maintained at all times, per HIPAA law.
8. To be referred to appropriate specialists when what a client is presenting is outside our scope of practice or not in the client's best interest.
9. To have personal and professional boundaries observed at all times.
10. To return any unused products in saleable condition for a full refund within 10 days of purchase.

*(Please initial after each policy as an indication that you have read and understand each policy. )*

We expect our clients:

1. If new clients, to arrive *at least fifteen minutes* prior to appointment time to allow for paperwork and processing. Sessions begin and end at scheduled times. Sessions that begin late because the client arrived late end at the appointed time and are full price. Clients arriving more than 15 minutes late may be asked to reschedule. _____
2. To not be under the influence of alcohol or illegal drugs. _____
3. To provide a thorough and accurate health history and update information when necessary. _____
4. To have eaten within at least two hours of the appointment. Acupuncture and other modalities cannot be received on an empty stomach. Sessions that begin late because the client failed to eat prior are full price. _____
5. To wear comfortable clothing that allows easy access to the head, torso, and limbs. In the event that clothing does not allow access to the body areas necessary for treatment, the practitioner will offer either a gown, a sheet to drape the body, or another suitable item to provide for patient modesty. _____

6. To be considerate of other patients and avoid bringing small children to the clinic. Exceptions may be made for infants or small children in car seats or strollers who can remain quiet or for older children both of whom may remain with their parent/guardian inside the treatment room. Children who are well-behaved may be allowed to wait for their parents in the waiting room or any other area of the clinic on a case by case basis. _____
7. To provide at least 24-hour notice in the event of client cancellation, or the client is charged the FULL AMOUNT of the treatment missed. First-time failure to give 24-hour notice payment is waived. We are aware that sometimes emergencies occur. Should this happen, please contact our staff immediately in order to avoid the fee. _____
8. To pay their bill in full at the time of service unless other arrangements have been made prior to treatment. Remedy Healing Arts, LLC accepts cash, checks, and Visa/Mastercard/Discover. We do not bill insurance, but we can provide a superbill for you to submit for reimbursement. However, the client is still expected to make a full payment at time of service. _____
9. To refrain from smoking within the clinic or within 25 feet of any entrance to the clinic. _____
10. To refrain from using any electronic device, including cell phones, anywhere inside the clinic. _____
11. To refrain from any behavior, verbal or otherwise, that would cross personal or professional boundaries. Sexual harassment is not tolerated. If the practitioner's safety feels compromised, the session is ended immediately. _____

FINANCIAL POLICY

I understand that I am financially responsible for all charges and all services rendered on my behalf or my dependents. I agree to pay in full for charges when services are rendered unless other arrangements are made in advance. I clearly understand that services and products rendered to me are charged directly to me and that I am personally responsible for payment and any fees for collection of past due accounts. I also understand that if I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable. Remedy Healing Arts, LLC accepts cash, personal checks, Visa, Mastercard, Discover, and American Express. Returned checks are subject to a $35 service charge.

Signature of the patient/guardian ________________________________________ Date __________________

INSURANCE POLICY

I understand and agree that health/accident insurance policies are an agreement between an insurance carrier and myself. I understand that Remedy Healing Arts, LLC not bill insurance on my behalf for services rendered or products purchased and that I am responsible for paying for services and products at the time they are rendered or purchased. I understand that I may request a superbill for services rendered to me by RHA so that I can submit for payment from my insurance company on my own behalf.

Signature of the patient/guardian ________________________________________ Date __________________

NOTICE OF TREATMENT TIME LIMIT

I, (patient's name) ________________________________________, understand that South Carolina state law governing acupuncture requires that my Acupuncturist, Melissa Mulvaney, must provide me with written notice, on or before the expiration of the third month of treatment after receiving at least one treatment per month, if I have not demonstrated clinical improvement. Further, I understand that if I have not demonstrated clinical improvement within three months, my Acupuncturist, Melissa Mulvaney, must recommend that I seek a Western medical diagnosis from a physician or dentist before continuing with acupuncture treatment unless I was referred to see my Acupuncturist by my physician or dentist for the same condition prior to receiving acupuncture treatment. Whether I choose to follow this advice and seek a Western medical diagnosis is my responsibility and choice.

Signature of the patient/guardian ________________________________________ Date __________________

Signature of the Acupuncturist ________________________________________ Date __________________

NOTICE OF PRIVACY PRACTICES

Remedy Healing Arts, LLC (RHA) respects your right to privacy. In order to maintain the highest level of service that you expect from our office, we will gather personal health information (PHI) from you, from other healthcare providers that you authorize, with Worker's Compensation (and your employer as well in this instance) and from insurance companies or other third-party payers. Your PHI directly relates to your past and present physical or mental health, and either identifies you directly or provides ample identifiable indicators. During the course of our relationship, we will likely use and disclose health information about you for treatment, continued care, payment, and healthcare operations purposes.

SAFEGUARDS: RHA safeguards your PHI via established policies for handling PHI, controlling access to facilities where PHI is stored, requirements for third parties to contractually comply with privacy laws, and permanent files kept of all medical files and records (including email, regular mail, telephone, and faxes sent. **You may specifically authorize us to use protected health information (PHI) by submitting authorization in writing.** Such disclosures will be made to any personal representative you choose to have your PHI.

MARKETING: Remedy Healing Arts, LLC will communicate to you via appointment reminders, birthday cards, newsletters, announcements, calls, emails, postcards or letters. We may send you information to support your healthcare, information about alternative treatments, and health-related services of interest to you. **If you do not wish to receive these kinds of communication, you must advise RHA in writing below or via letter mailed to our office.**

DISCLOSURE: Remedy Healing Arts, LLC will safeguard your PHI in accordance with HIPAA regulations and may use or disclose your PHI when required by law without your consent or authorization. This notice will remain in effect until it is replaced or amended by law.

PATIENT RIGHTS:

1. You have the right to receive all notices in writing.
2. Upon written request, you have the right to request access, review, or receive copies of your healthcare records within 30 days. NOTE: There is a small fee per copy.
3. Upon written request, you have the right to receive a list of items RHA has disclosed about your healthcare information. NOTE: There is a maximum response time of 90 days by RHA.
4. You have the right to request that we amend your PHI; the request must be in writing. NOTE: There is a maximum response time of 90 days by RHA. RHA reserves the right to refuse any amendments.
5. You have the right to request that RHA place additional restrictions on disclosure of your PHI (see below). The request must be in writing below or via letter mailed to office.

I request the following restriction(s) as to how my PHI is used or disclosed:

_______________________________________________________________

If you have questions, complaints or want more information, contact Melissa Mulvaney (Privacy Officer) in writing at 8180 Regent Parkway, Suite 104, Fort Mill, SC 29715. If you are not satisfied with how RHA handles your complaint, you may contact in writing: DHHS (Office of Civil Rights), 200 Independence Avenue, S. W., Room 509F, HHH Building, Washington, D.C. 20201.

**HIPAA DOES NOT require that you give your healthcare provider written permission to share or discuss your health information with your family, friends, or others involved in your care or payment for your care.**

**If there is a family member, friend, or others involved in your care or payment for your care whom you DO NOT want us to share or discuss your health information, you MUST submit in writing to our office a list of those individuals below or via letter mailed to our office.**

DO NOT SHARE my PHI with the following individuals: ____________________________________

I have read, reviewed, understand, and agree to the Notice of Privacy Practices for healthcare in this office.

Signature of the patient/guardian ______________________________ Date ______________