

SERENE CARE CLINIC PATIENT INTAKE FORM

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____ Cell _____

Age _____ Date of Birth _____ Sex M ___ F ___ SS# _____

Married ___ Separated ___ Divorced ___ Widowed ___ Partnership ___ Single ___

Occupation _____ Hours per week _____

Employer Name _____

Employer Address _____

Emergency Contact _____

Phone _____ Relationship _____

Address _____

How did you hear about or who referred you to our clinic _____

GENERAL MEDICAL INFORMATION

Chief Problem(s) _____

Objective _____

How long have you had this problem? _____

Does any family member have this problem? _____

Have you had this problem before? _____

Where is the problem? _____

Have you traveled recently? _____

Height _____ Weight _____ Exercise Y___ N___

If so, what kind and how often? _____

PLEASE LIST ALL YOUR MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS OR OTHER SUPPLEMENTS.

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

ALLERGIES

Are you allergic or hypersensitive to:

Any drugs? _____

Any foods? _____

Any chemicals? _____

HOSPITALIZATIONS

Please bring copies of any reports for lab work, x-ray, EKGs, etc. that you have had done recently.

REASON FOR HOSPITALIZATION	YEAR	REASON FOR HOSPITALIZATION	YEAR
1		6	
2		7	
3		8	
4		9	
5		10	

Have you ever had a blood transfusion? Yes ___ No ___

If yes list approximate dates _____

DATE	SERIOUS ILLNESS/INJURY	OUTCOME

PREGNANCIES

YEAR OF BIRTH	SEX OF BIRTH	COMPLICATIONS IF ANY

HEALTH HABITS

CHECK WHICH YOU USE AND AMOUNT OF USE.		
Alcohol		
Tobacco		
Street Drug		
Other		

FAMILY HISTORY

RELATIONSHIP TO YOU	AGE	STATE OF HEALTH	CAUSE OF DEATH	DISEASE	YES	RELATIONSHIP TO YOU
Father				Arthritis		
Mother				Asthma, Hay Fever		
Paternal Grandfather				Cancer		
Paternal Grandmother				Chemical Dependency		
Maternal Grandfather				Diabetes		
Maternal Grandmother				Heart Disease Or Stroke		
Brothers				High Blood Pressure		
				Kidney Disease		
Sisters				Tuberculosis		
				Other		

GENERAL	CARDIOVASCULAR	MEN ONLY	CONDITIONS cont.
<input type="checkbox"/> Chills	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Erection difficulties	<input type="checkbox"/> Bulimia
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Lump in Testicles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Fainting	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Penis discharge	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Sore on penis	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Headache	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Other	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Swelling of ankles		<input type="checkbox"/> Diabetes
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Varicose veins		<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Nervousness			<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Numbness			<input type="checkbox"/> Heart Disease
			<input type="checkbox"/> Hepatitis
			<input type="checkbox"/> Gonorrhea
			<input type="checkbox"/> Gout
			<input type="checkbox"/> Heart Disease
			<input type="checkbox"/> HIV Positive
			<input type="checkbox"/> Hernia
			<input type="checkbox"/> Herpes
			<input type="checkbox"/> Measles
			<input type="checkbox"/> Migraine Headaches
			<input type="checkbox"/> Miscarriage
			<input type="checkbox"/> Mononucleosis
			<input type="checkbox"/> Multiple Sclerosis
			<input type="checkbox"/> Mumps
			<input type="checkbox"/> Pacemaker
			<input type="checkbox"/> Pneumonia
			<input type="checkbox"/> Polio
			<input type="checkbox"/> Prostate Problem
			<input type="checkbox"/> Pacemaker
			<input type="checkbox"/> Rheumatic Fever
			<input type="checkbox"/> Polio
			<input type="checkbox"/> Prostate Problem
			<input type="checkbox"/> Psychiatric Care
			<input type="checkbox"/> Rheumatic Fever
			<input type="checkbox"/> Scarlet Fever
			<input type="checkbox"/> Stroke
			<input type="checkbox"/> Suicide Attempt
			<input type="checkbox"/> Thyroid Problems
			<input type="checkbox"/> Tonsillitis
			<input type="checkbox"/> Tuberculosis
			<input type="checkbox"/> Typhoid Fever
			<input type="checkbox"/> Ulcers
			<input type="checkbox"/> Vaginal Infections

MUSCLE, JOINT, BONE	EYE, EAR, NOSE, THROAT	WOMEN ONLY	
<input type="checkbox"/>	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Abnormal Pap Smear	
<input type="checkbox"/> Arms <input type="checkbox"/> Hips	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Bleeding between	
<input type="checkbox"/> Back <input type="checkbox"/> Legs	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Breast lump	
<input type="checkbox"/> Feet <input type="checkbox"/> Neck	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Extreme Menstrual	
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> Double vision	<input type="checkbox"/> Pain	
	<input type="checkbox"/> Earache	<input type="checkbox"/> Hot flashes	
	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Nipple discharge	
	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Painful intercourse	
	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Vaginal discharge	
	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Other	
	<input type="checkbox"/> Nosebleeds	Date of last menstrual	
	<input type="checkbox"/> Persistent cough	Period _____	
	<input type="checkbox"/> Ringing in ears	Date of Last Pap	
	<input type="checkbox"/> Sinus problems	Smear _____	
	<input type="checkbox"/> Vision – Flashes	Have you had a	
	<input type="checkbox"/> Vision – Halos	Mammogram _____	
		Are you pregnant _____	
		Number of Children _____	

GENITAL-URINARY	SKIN	CONDITIONS
<input type="checkbox"/>	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> AIDS
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Hives	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Itching	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Change in moles	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Rash	<input type="checkbox"/> Appendicitis
	<input type="checkbox"/> Scars	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Sore that won't heal	<input type="checkbox"/> Asthma
		<input type="checkbox"/> Bleeding Disorders

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative	Date
---	------

Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient
---	-------------------------

SERENE CARE CLINIC

INFORMED CONSENT FOR NATUROPATHIC MEDICINE, ORIENTAL MEDICINE AND ACUPUNCTURE

I hereby voluntarily consent to receive Naturopathic Medicine, Oriental Medicine and Acupuncture treatment for my present and future health condition.

Naturopathy: Naturopathic philosophy focuses on treating the whole person and strives to find the underlying cause of the patient's condition rather than focusing solely on symptomatic treatment. A naturopathic approach to healthcare focuses on taking the time to understand each patient's individual needs. With "the patient comes first" approach in a health care system the ND is able to recommend the most appropriate and comprehensive therapies the first time. Where the situation calls for, Naturopathic physicians also work with all other branches of medical science to provide the most thorough patient care.

Acupuncture: This is a safe treatment involving the insertion of tiny sterile disposable needles, through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding and will rarely leave a bruise (not painful). Other possible risks from acupuncture include dizziness and fainting. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection however these have an extremely low incidence rate, especially when acupuncture is administered properly.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently one may experience digestive upset or other reactions to the herbs. If you experience any discomforts related to the use of herbs you should stop the herbs and inform the LAc of your symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. Please inform the LAc of suspected or confirmed pregnancy, or if you are a nursing mother.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising at the treated area. The bruising, which is not painful, virtually resolves in three to seven days.

Electro-acupuncture: A mild electric micro current similar to a TENS treatment, is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

PRP Injection: To aid in healing tendon or ligament injuries by injecting Platelet Rich Plasma into the injured area.

Prolotherapy: A non-surgical ligament reconstruction by injecting a sugar based solution at the site of tendon to bone attachment.

By signing below I show that:

- I have read or had read to me, the information on this consent form.
- I understand the possible risks and complications involved.
- I have had the opportunity to discuss this consent form with my licensed acupuncturist.
- I understand that I can request more information at any time if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse any treatment at any time.
- I understand that this refusal may affect the expected results.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

SERENE CARE CLINIC

HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public’s health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

- Please do not phone me at home. Use this alternate phone number: _____
- Please do not phone me at work. Use this alternate phone number: _____
- Please do not leave messages on my answering machine.
- Please do not contact me by email.
- Please send mail, including my bills, to this alternate address:

- Other request (please describe):

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient