New Patient Intake Form

Today's Date____/____/____

Name

Email Address:

Marital Status

Birthdate / /

Age

Address

❑M ❑ F

Ht

Wt

City, State, Zip

Home Phone

Work Phone

Occupation

Emergency Contact Name & Phone

Referred by

Reason for visit today

Have you had acupuncture before? ❑ Yes ❑ No

Chinese herbal medicine? ❑ Yes ❑ No

How long have you had this condition?

Is it getting worse? Does it bother your: ❑ Sleep ❑ Work ❑ Other (what?)

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? ❑ Yes ❑ No If yes, for what?

Who is your physician? Physician's Phone

Other concurrent therapies

Family Medical History

❑ Allergies __________

❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism

❑ Cancer __________

❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure

❑ Seizures
❑ Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

❑ AIDs/HIV
❑ Alcholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox

❑ Diabetes
❑ Emphy sema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitus
❑ Herpes
❑ High Blood Pressure
❑ Measles

❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Stroke

❑ Surgery (list) __________
❑ Thyroid Disorders
❑ Major Trauma (Car, fall, etc--list) __________

❑ Tuberculosis
❑ Typhoid Fever
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough
❑ Other (Specify) __________

Your Diet

Appetite ❑ Low ❑ High

❑ Coffee
❑ Soft Drinks

❑ Artificial Sweetener

❑ Sugar
❑ Salty Food

Thirst for water:
glasses per day:______

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in last 2 months:

Vitamins/supplements taken in last 2 months:

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Drugs
- ☐ Stress
- ☐ Occupational Hazards

Regular Exercise
Type________________ Frequency________________
Type________________ Frequency________________

General Symptoms

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Recent weight loss/gain
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Shortness of breath
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Vertigo or dizziness
- ☐ Bleed or bruise easily
- ☐ Peculiar taste (describe)

____

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Excessive phlegm

Color of phlegm ________________

- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions

Other head or neck problems ________________

Respiratory

- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Cough

Wet or Dry?________________
Thick or thin?________________

Color of phlegm ________________

- ☐ Coughing blood
- ☐ Pneumonia

Cardiovascular

- ☐ High blood pressure
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Tachycardia
- ☐ Heart palpitations
- ☐ Phlebitis
- ☐ Irregular heartbeat

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Hiccup
- ☐ Bloating
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Intestinal pain or cramping
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Hemorrhoid
- ☐ Anal fissures

Bowel movements:
Frequency________________ Texture/form________________
Color________________ Odor________________

Musculoskeletal

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Rib pain
- ☐ Limited range of motion
- ☐ Limited use

Other (describe) ________________

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair loss
- ☐ Change in hair/skin texture
- ☐ Fungal infections

Other hair or skin problems ________________

Neuropsychological

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Abuse survivor
- ☐ Considered/attempted suicide
- ☐ Seeing a therapist

Other (specify) ________________

Genito-urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ Venereal disease
- ☐ Bedwetting
- ☐ Wake to urinate
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Kidney stone
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission

Gynecology

- ☐ Age menses began ________________

Length of cycle (day 1 to day 1) ________________

- ☐ Duration of flow ________________
- ☐ Irregular periods
- ☐ Painful periods
- ☐ PMS
- ☐ Vaginal discharge (color)________________
- ☐ Vaginal sores
- ☐ Vaginal odor
- ☐ Clots
- ☐ Breast lumps

\# Pregnancies________________
\# Live births________________
Premature births________________
Age at Menopause________________

Date of last PAP ________________

Date last period began ________________

Other

____

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services at The Morningside Clinic.

____   ____________

Patient's Signature   Date

____

Print Name

___________________________________   ____________

Clinic Administrator's Signature   Date

The Morningside Clinic
6023 Morningside Avenue
Dallas, TX 75206
Phone: (214) 828-4558

NOTICE TO THE PATIENT

(Pursuant to the requirements of section 183.6(e) of this title (relating to Denial of License; Discipline of Licensee) and TEX. OCC. CODE ANN., '205.351, governing the practice of acupuncture.)

I (patient's name) ______________________________, am notifying the acupuncturist

(practitioner's name), ________________________ 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. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist. _____ (initials of patient) Date: __________

___ Yes ___ No

I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Patient's signature ______________________________ Date ______________

Please Print Name______________________________

<u>Optional</u> Form to be Completed by Patient, Attesting that the Acupuncturist Has Referred Him/Her

(Pursuant to the requirement of section 183.6(e) of this title and TEX. OCC. CODE ANN. '205.351, governing the practice of acupuncture.)

The acupuncturist has referred me to see a physician. It is my responsibility and choice whether to follow his or her advice.

Patient's signature ______________________________ Date ______________

Acupuncturist's signature __________________________ Date ______________

[his sheet is for you to keep

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Morningside Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and how to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The Morningside Clinic."
>
> "It is our policy to provide a substitute health care provider, authorized by The Morningside Clinic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We expect payment at the time the services are rendered but in the event you file an insurance claim, we may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

> "Since you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to you which you can submit to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Worker's Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or translating organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below. (Example)

> "As a courtesy to our patients, it is our policy to call your home, usually the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership
In the event that The Morningside Clinic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that The Morningside Clinic is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information. We will charge you reasonable cost-based fee expenses such as copies and staff time. The fee is set as a base fee of $30.00 for 10 pages or less; additional fee of $1.00 per page for pages 11-60, $.50 per page for pages 61-400. The base fee must be paid at the time of the request and the balance paid at the time of pick-up.
- You have a right to request that The Morningside Clinic amend your protected health information. Please be advised, however, that The Morningside Clinic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by The Morningside Clinic.
- You have a right to a paper copy of this Notice of Practices at any time upon request.

Changes to this Notice of Privacy Practices
The Morningside Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that in maintains. Until such an amendment is made, The Morningside Clinic is required by law to comply with this Notice.

The Morningside Clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Sharon Kraus by calling the office at 214-828-4558. If Sharon is unavailable you may leave a message for an appointment to have a personal conference or a telephone conference.

Complaints
Complaints about your Privacy Rights, or how The Morningside Clinic has handled your health information should be directed to Sharon Kraus by call the office at 214-828-4558. If you are not satisfied with the manner in which this office handles your complaint you may submit a formal complaint to:

The Morningside Clinic
6023 Morningside Avenue
Dallas, TX 75206

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _______. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE	X	(Date)
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	X	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE