LA Herbs & Acupuncture

Wellness through ancient wisdom

Yvonne R. Farrell, DAOM, LAc.

Patient Confidential Information **Date:**_____

Patient Name_____

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Cell Phone**_____

Email Address_____

Age_____ **Date of Birth**___/___/___ **Place of Birth**_____

Gender _____ **Marital Status** **S/M/D/W/Cohab**

Occupation/Profession _____ **Employer** _____

Referred by_____

Emergency Contact _____ **Phone Number** _____

Relation _____

Medical History Questionnaire

Present Illness:

What is your chief complaint and when did this condition begin?

What treatment have you already received?

Past Medical History:

Do you smoke? Yes/No
If yes, how many?____ How long?_____

Do you drink? Yes/ No
If yes, how many per week?

Surgery: Please list all previous operations and the approximate dates

Fractures or other serious injuries:

Allergies:

Medications:

Women:
Age of start of menses_____
Date of last menstrual cycle _____
Are you currently pregnant? Yes/No

Please indicate if you have (had) any of the following:

HIV Virus	Yes	No
Herpes simplex	Yes	No
Epstein Barr Virus	Yes	No
Heart disease or heart attack	Yes	No
Rheumatic fever	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Epilepsy or convulsions	Yes	No
Kidney or bladder problems	Yes	No
Diabetes	Yes	No
Tumor or Cancer	Yes	No
Respiratory diseases	Yes	No
Pneumonia or Emphysema	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Hepatitis	Yes	No
Peptic ulcer or pancreatitis	Yes	No
Anemia or blood disorders	Yes	No
Bleeding disorders	Yes	No
Jaundice	Yes	No
Hernia	Yes	No
Hemorrhoids	Yes	No
Thyroid disease	Yes	No
Venereal disease	Yes	No
Genital disorders	Yes	No
Gynecological disorders	Yes	No
Congenital abnormalities	Yes	No
Skin diseases	Yes	No
Do you have a pacemaker?	Yes	No
Any surgical implants?	Yes	No
Change in bowel or bladder?	Yes	No
Sores that will not heal?	Yes	No
Unusual bleeding or discharge?	Yes	No
Indigestion/difficulty swallowing?	Yes	No
Obvious change in a wart or mole?	Yes	No
Nagging cough or hoarseness?	Yes	No
Do you have pain anywhere?	Yes	No

Family History:

Has any blood relative had any of the following:

Stroke	**Yes/No**	**Cancer**	**Yes/No**
Heart Disease	**Yes/No**	**Tuberculosis**	**Yes/No**
Bleeding tendency	**Yes/No**	**Diabetes**	**Yes/No**
High blood pressure	**Yes/No**	**Mental Illness**	**Yes/No**

Please mark any symptom you currently have and place a "P" near a symptom from the past.

— **Chest pains**
— **Palpitations**
— **Difficulty falling asleep**
— **Restless sleep**
— **Nightmares**
— **Night sweating**
— **Hot hands & feet**
— **Unusual or excessive sweating**

— **Cough**
— **Skin problems**
— **Difficulty breathing**
— **Sore Throat**
— **Stiff neck**
— **Depression**
— **Pale face**
— **Nasal Problems**
— **Asthma**
— **Intolerance to weather changes**
— **Fever and/or chills**
— **Loss of voice**
— **Red eyes**
— **Eye problems**
— **Sinus problems**
— **Phlegm**

— **Excessive worry**
— **Bitter taste in mouth**
— **Easily angry or irritable**
— **Headaches**
— **Twitching or muscle spasms**
— **Facial redness**
— **Brittle nails**
— **Pain in the rib area**
— **Hernia**
— **Dizziness**

— **Stomach problems**
— **Gas**
— **Belching or hiccups**
— **Heartburn**
— **Bloating after meals**
— **Nausea**
— **Vomiting**
— **Mouth sores**
— **Diarrhea**
— **Loose stool**
— **Constipation**
— **Hemorrhoids**
— **Lack of appetite**
— **Excessive appetite**
— **Cravings**
— **Thirst**

— **Cold limbs**
— **Edema (water retention)**
— **Ear ringing (tinnitus)**
— **Deafness, difficulty hearing**
— **Back pain**
— **Knee pain**
— **Easily frightened**
— **Urinary problems**
— **Night urination**
— **Decreased sex drive**
— **Poor memory**
— **Joint pain**
— **Hair loss**

FOR WOMEN ONLY

— **Discharge between periods**
— **Menstrual cramps**
— **Excessive bleeding**
— **Clots**
— **Breast tenderness/swelling**
— **Irregular menses**
— **Pregnant**

FOR MEN ONLY

— **Sexual dysfunction**
— **Impotence**

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Financial Agreement

Please remember that insurance is considered a method of reimbursement to our healthcare facility, but it is not a substitute for the patient's responsibility. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance payments, or any other balance that is not paid by the insurance. When the patient or the patient's representative or a financial guarantor executes this agreement, all shall be jointly and individually liable for payment. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to other amounts due.

I authorize disclosure of portions of the patient's records to the extent necessary to determine liability for the payment and to obtain reimbursement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance and other health plans, to L.A. Herbs & Acupuncture, An Integrative Medical Corp./ Yvonne R. Farrell, DAOM, LAc.

L.A. Herbs & Acupuncture, an Integrative Medical Corp., Yvonne R. Farrell, DAOM, LAc. and the patient or the patient's representative hereby enter into this agreement. The patient or patient's representative certifies that he/she has read and accepted the "Terms and Conditions of Service".

I understand the 24-hour cancellation policy, and I agree to pay the standard fee if cancellation occurs within 24 hours of the date of my scheduled appointment.

Signed_____ Date_____

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Yvonne R. Farrell, DAOM, LAc
Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Yvonne R. Farrell, DAOM, LAc may use and disclosure protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to LA Herbs & Acupuncture, An Integrative Medical Corp.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. LA Herbs & Acupuncture and Yvonne R. Farrell, DAOM, LAc reserves the right to revise their Notice of Privacy Practices at any time.

With my consent, Yvonne R. Farrell, DAOM, LAc or LA Herbs & Acupuncture, An Integrative Medical Corp. may call my home or any other designated location and leave a message on voice mail or in person in reference to any times that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Yvonne R. Farrell, DAOM, LAc or LA Herbs & Acupuncture may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, Yvonne R. Farrell, DAOM, LAc or LA Herbs & Acupuncture may e-mail to me appointment reminders and patient statements. I have the right to request the Yvonne R. Farrell, DAOM, LAc or LA Herbs & Acupuncture restrict how it uses or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Yvonne R. Farrell, DAOM, LAc or LA Herbs & Acupuncture's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If I do not sign this consent Yvonne R. Farrell, DAOM, LAc. and LA Herbs & Acupuncture may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print name of the Patient or Legal Guardian

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Informed Consent to Acupuncture Treatment and Care

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 the patient named below for whom I am legally responsible) by the licensed acupuncturist(s) 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, included those working at L.A. Herbs & Acupuncture, An Integrative Medical Corp., 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 (Oriental Massage), Chinese herbal medicine and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herb.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 only sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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.

Patient Signature_____ **Date**_____

Patient Representative_____ **Date**_____

LAc_____ **Date**_____