Kremer Acupuncture, LLC
New Patient Medical Health Intake Form

Today's Date _____

1. First Name _____
2. Last Name _____
3. Date of Birth (DD, MM,YY) _____
4. Gender (circle one): Male, Female, Transgender
5. Marital Status (circle one): Single, Married, Other
6. Employment Status (circle one)
   Employed, Student, Unemployed, Retired, Other
7. How did you hear about Carol Kremer, L.Ac.?

   _____

   _____

8. Name of referring medical provider if applicable
   Name _____
   Address _____
   Address _____
   Phone _____

9. Caregiver/Legal Guardian Details (If applicable)
   Name _____
   Relationship to Patient: _____
   Phone _____
   Email _____

10. Patient's E-mail Addresss and Phone Number(s):

Email Address_____

Cell Phone_____
- May we leave a voice mail message? Yes No

Home Phone:_____
- May we leave a voice mail message? Yes No

Work Phone: _____
- May we leave a voice mail message? Yes No

11. Patient's Address:

Address _____

Address _____

City _____

State _____

Zip _____

11. Emergency Contact Details
    Name _____
    Relationship _____
    Phone _____

12. Cardiac Pacemaker or other electronic implanted device? Yes No
13. Epilepsy or seizure disorder? Yes No
14. What was your last blood pressure reading and when was it last taken (month/year)?
    BP_____/_____ Date:_____
15. Women only: Currently pregnant? Yes No
16. Travel outside the U.S. in the past year? Yes No
    If yes, where?_____
17. Any major contagious diseases at this time? Yes No
    if yes, describe:_____
18. Smoking _____ cigarettes per day
19. Surgeries, major procedures, major illnesses, and/or hospitalizations and dates

    _____

    _____

    _____

    _____

    _____

    _____

    (Use other side if you run out of room)

20. Major diseases that run in your family:

    _____

    _____

21. Allergies (food, drugs, or environmental)

    _____

    _____

    _____

    (Use other side if you run out of room)

1. Medications and/or supplements, why you take it, dose, and how long you've taken it:

Medication or supplement	Reason	Dose	How long
(Use other side if you run out of room)			

2. Describe your reason for today's visit:

3. When did your symptoms start?

4. What makes it better (e.g. heat, cold, activity)?

5. What makes it worse?

6. What other therapies have you tried for this this condition?

PAIN LEVEL SCALE: 1= very little pain, 10 = worst pain

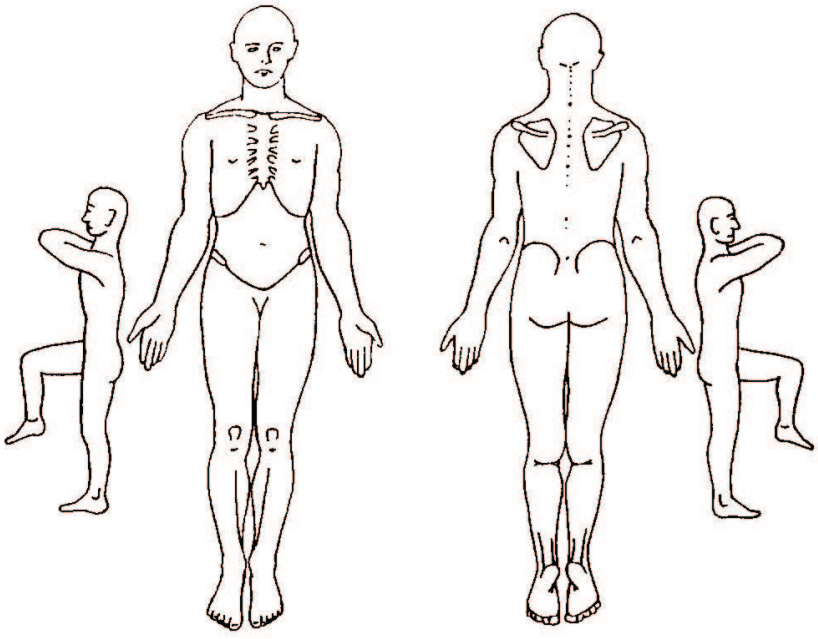
1. Pain level ***right now*** on a scale of 1 to 10? _____

2. ***Average*** pain level on a scale of 1 to 10?_____

3. ***Circle*** areas of pain on the diagram

4. ***Type*** of pain (circle all that apply):
   Stabbing
   Burning
   Throbbing
   Shooting
   Prickling
   Tingling
   Dull
   Aching
   Heavy

5. ***When*** do you have pain?
   Constant
   Intermittent (better at times)
   Daily
   Weekly
   Monthly
   Rarely



Almost all acupuncture **points** have **more than one function**. Even if you're seeking treatment for pain or stress we choose points to **support** other issues you may have.

An example:

- *Patient #1 has elbow pain and also tends to be **hot,** has sinusitus, acid reflux and restlessness. We use a point on the elbow to **relieve the local pain**, and **release general heat** from the body.*
- *Patient #2 has elbow pain but always tends to be **cold**, is more frail, and has grief. We choose **different points** because the point to release general heat may help with elbow pain, but may worsen patient #2's overall condition.*

The answers you provide below will guide our treatment strategy and help ensure you get the best result.

1. Overall Temperature

Tend to be cold, tend to be warm,
like warm beverages, like cold beverages,
thirst, night sweats, hot flashes, abnormal sweating

2. Overall Energy and Stress Levels

Energy on scale of 1 to 10 (1= low, 10=high) _____
Stress on scale of 1 to 10 (1=low, 10=high) _____

3. Heart Meridian Patterns

Palpitations, chest pain, insomnia, blood clots,
poor circulation, neuropathy
Emotions: anxiety, restlessness

4. Lung Meridian Patterns

(In TCM, controls spreading and decending of energy and fluids.)
Sinus issues, asthma, allergies, cough, congestion
Dry mouth, throat, nose, shortness of breath
Skin conditions
Emotions: sadness or grief

5. Liver and Gallbladder Meridian Patterns

(In TCM, ensures smooth flow of energy throughout the body.)
Dizziness, tremors, feels like something stuck in throat,
Dry eyes, gallstones, alternating diarrhea and constipation
Emotions: anger, frustration, irritability, depression

6. Stomach and Spleen Meridian Patterns

(In TCM, controls transportation and transformation of fluids.)
Appetite: low or high
Recent weight gain/weight loss
Bloating, burping, gurgling in stomach, acid reflux/GERD,
ulcers, hiccups, nausea
Gums: Bleeding, swollen, painful,
Bruise easily, fatigue
Loose stools, dry stool, constipation
Alternating diarrhea and constipation
Emotions: over-thinking, worry, difficulty focusing

7. Kidney and Bladder Meridian Patterns

(In TCM, controls growth, reproduction and aging.)
Hearing issues, kidney stones, hair loss,
Memory problems
Sore or weak knees, low back soreness
Urinary issues (painful, frequent, waking to urinate)
Emotions: fear

8. Musculo-skeletal

Muscle spasms, twiching, cramps, weakness, atrophy
Joint pain, instability, swollen, arthritis, overall pain,
General aches, injuries from accidents

9. Headaches

1. Headaches or migraines? Yes No
2. If yes, where? (circle all that apply)
   Top of head, side of head/face, frontal headaches,
   feels like a band wrapped around your head
3. If yes, how often?_____

10. Women's Health

1. Currently pregnant? Yes No
2. Date of last menses_____
3. Please circle all that apply: PMS, menstrual issues,
   fibroids, breast cancer, endometriosis, ovarian cysts
   Other (please describe)_____

CONSENT TO TREATMENT and POTENTIAL SIDE EFFECTS

1. General

- By initialing and signing below I voluntarily consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Carol Kremer, a nationally certfied and Ohio licensed acupuncturist.
- I understand that no guarantees concerning the use and effects of acupuncture and other treatment modalities offered in this clinic are given.
- I understand I am free to refuse or stop treatment at anytime.
- I understand I am encouraged ask questions at any time regarding treatment.

2. Acupuncture Scope of Practice

- I understand that licensed acupuncturists in Ohio are ***not*** primary care providers.
- I understand that other treatment modalities, which are outside of the scope of practice for this acupuncturist, may be better suited to the condition for which I am seeking treatment.

3. Diagnostic Exam Recommendation - Ohio Law

This acupuncturist recommends that you receive a diagnostic exam from a physician or chiropractor regarding the condition for which you are seeking treatment. (Choose one)

☐ ***I have*** received a diagnostic exam by a physician or chiropractor within the last six (6) months regarding the condition for which I am seeking treatment

☐ ***I have NOT*** received a diagnostic exam by a physician or chiropractor within the last six (6) months regarding the condition for which I am seeking treatment

4. Potential Side Effects

Below is a brief description of modalities that may or may not be utilized by this acupuncturist depending on the patient's condition and treatment plan. I understand that **the list of side effects may include, but is not limited to, those listed below.**

4.1 Acupuncture

I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. ***Potential Side Effects: local bruising, minor bleeding, fainting or dizziness, pain or discomfort, numbness or tingling near the needling sides that may last a few days, possible aggravation of symptoms existing prior to acupuncture treatment. Unusual risks: spontaneous miscarriage, nerve damage, or organ puncture. Another possible side effect is infection although the clinic uses sterile disposable needles and maintains a clean and safe environment.***

4.2 Heat Therapy (TDP Lamp, Moxibustion)

I understand that heat may be applied either alone or in combination with acupuncture at certain points on or near the surface of the body. ***Potential Side Effects: local burning or scarring.***

4.3 Electrical Stimulation

I understand that electro-stimulation may be applied either alone or in combination with acupuncture at certain points on or near the surface of the body. ***Potential Side Effects: electrical shock, pain or discomfort, possible aggravation of symptoms existing prior to treatment.***

4.4 Acupressure, Tuina, Guasha, Cupping

I understand that I may be given acupressure (aka tuin-na or guasha), or cupping as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***Potential Side Effects: bruising, sore muscles or aches, possible aggravation of symptoms existing prior to treatment.***

I understand I may be given lifestyle education according to traditional Chinese Medicine principles; which may include information about nutritional principles, breath awareness and movement. I have carefully read (or have had read to me) the Consent to Treatment form. I understand all of the above information including potential adverse side effects listed above and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I understand that I am free to refuse or stop treatment at anytime.

I give my permission and consent to treatment.

_____ _____

Patient Signature or Legal Guardian **Date**

KREMER ACUPUNCTURE, LLC
NOTICE OF PRIVACY PRACTICES

Effective 2_29_16

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. If you have any questions about this notice, please contact our office.

WHO WILL FOLLOW THIS NOTICE: This notice describes the personal health information (hereafter referred to as PHI) privacy practices followed by this office.

YOUR HEALTH INFORMATION: This notice applies to the information and records about your health, health status, mental health care, mental health status, alcohol and other drug treatment, and services you receive from this office. We are required by law to give you this notice describing your rights and our obligations regarding the use of this information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: *For treatment:* We may use PHI about you to provide you with treatment or services. A staff member may obtain PHI about you and create a record of this information, which may then be used to determine the course of treatment that should work best for you. A staff member may call you to remind you of an appointment. *For Payment:* We may use and disclose PHI about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you. *For Health Care Operations*: We may use and disclose PHI about you in order to run the office and to ensure that you and our other patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff in caring for you. We may also use PHI about all or many of our patients to help us decide what additional services we should offer, how we can be more efficient, or whether certain new treatments are effective.

OTHER USES AND DISCLOSURE OF HEALTH INFORMATION: We may use or disclose PHI about you without your permission for the following purposes, subject to all applicable legal requirements and limitations: *To Avert a Serious Threat to Health or Safety*: We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. *As Required By Law*: We will disclose PHI about you when required to do so by federal, state, or local law. *Public Health Risk*: We may disclose PHI about you for public health reasons to report suspected abuse or neglect of minors or the elderly. *Information Not Personally Identifiable*: We may use or disclose PHI about in a way that does not personally identify you or reveal who you are. *Family and Friends*: We may disclose PHI about you to your family members or friends if we obtain your written agreement to do so, or if we infer from the circumstances that you would not object. For example we may assume you agree to our disclosure of your PHI to your spouse when you bring your spouse with you into a treatment room while the treatment is discussed. *For Worker's Compensation*: We may share your PHI with W.C. agencies if needed for a benefit determination. *Other Uses and Disclosures of Health Information*: We will not use or disclose your PHI for any purpose other than those identified in the previous sections without your specific written authorization. You may revoke that authorization in writing at any time, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU*: Right to inspect and copy*: You have the right to inspect and copy your PHI, such as treatment records. You must submit a written request to the office in order to inspect and/or copy your PHI. If you request a copy, we may charge a fee for the costs of copying, mailing, or other associated supplies. *Right to Amend*: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, submit a letter to the office stating what information in your medical record you would like amended. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

A. We did not create
B. Is not part of the PHI that we keep
C. You would not be permitted to inspect and copy
D. Is accurate and complete

Right to an Accounting of Disclosure: You have the right to request an "accounting of disclosures", a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. This request must be submitted to the office, and it must state a time period no longer than six (6) years and may not include dates prior to March 1, 2009. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (e.g. at work or by mail). To request confidential communications, submit a letter stating your request to restrict the use/disclosure of medical/mental health information and/or confidential information. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to a paper copy of this notice: You may ask for a copy of this at any time.

Changes to this Notice: We are required to abide by the terms of this notice. However, we reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Carol Kremer, 2251 Robinwood Ave., Toledo, OH 43620.

My signature below indicates that I have been provided with a copy of the NOTICE OF PRIVACY PRACTICES from the above stated office.

Patient Signature (or legal guardian)_____ Date _____