Anjali P. Desai, L.Ac Acupuncture Clinic

Patient Information: (Please Print) Date: ____/____/____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Birth Date: _____/_____/_____ Age: _____ Social Security# _____

Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Email: _____

Employment: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled ☐

Occupation: _____ Disability: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Alt. Contact _____ Relationship: _____ Phone # _____

Physician's Name: _____ Phone #: _____

Address: _____ Last Visit: _____

Date of Onset of Illness/Injury: _____ Medical Issues Being Seen For: _____

_____

Referred to the Clinic By: _____

Address: _____ Phone: _____

Have You Had Acupuncture Treatment Before? When? _____

What Health Issue Would You Like Treated? _____

What Treatment Have You Used? _____

Do You Have Other Health Concerns? _____

Anjali P. Desai, L.Ac. Acupuncture Health and History Form

Please describe the type of foods you eat daily, including snacks_____

_____

_____

What foods do you avoid? Food Allergies?_____

Do you exercise? How often? What type?_____

Major Hospitalizations

Year	Operation/Illness	Hospital	City and State

What medications are you taking, including non_prescription?_____

_____

Vitamins?_____

Herbs? Supplements?_____

Are you allergic to any medication or other allergens?_____

Which medical or psychological issues are present in your immediate family ?_____

_____

Have you contracted Tuberculosis, HIV (Optional), Hepatitis, or any sexually contracted diseases?_____

_____

Habits: Please check any that apply to you now or in the past (This is Protected Health Information!)
This information helps provide you with the best treatment possible.

☐ Coffee	Cups per DAY_____	Age Started_____	Age Quit_____	
☐ Tobacco	Use per DAY_____	Age Started_____	Age Quit_____	
☐ Marijuana	Use per week_____	Age Started_____	Age Quit_____	
☐ Alcohol	Drinks per week_____	Age Started_____	Age Quit_____	
☐ Crack or Cocaine	Use per week_____	Age Started_____	Age Quit_____	
☐ Heroin	Use per week_____	Age Started_____	Age Quit_____	
☐ Ecstacy	Use per week_____	Age Started_____	Age Quit_____	
☐ Methamphetamine	Use per week_____	Age Started_____	Age Quit_____	
☐ Ketamine	Use per week_____	Age Started_____	Age Quit_____	
☐ Sedatives/Pain Killers	Use per week_____	Age Started_____	Age Quit_____	
☐ GHB	Use per week_____	Age Started_____	Age Quit_____	
☐ Hallucinagens	Use per week_____	Age Started_____	Age Quit_____	
☐ Other _____	Use per week_____	Age Started_____	Age Quit_____	

Medical History (Do you have or ever had):
Arthritis Asthma Anemia Dermatitis/Eczema/Rash Hepatitis
HIV/AIDS Heart trouble Cancer Tuberculosis
High Blood Pressure Kidney or Bladder Trouble

Family History (Has any member had any of the above)? Yes No
If yes, which member and what did they have?
_____

Energy Level: _____High (Time of Day)_____
_____Low (Time of Day)_____

Stress None Moderate High

Sweating: Night Sweats Rarely Sweats Excessive

Circulation: Feelings of Hot Cold Bleeds Easily Cold Limbs

Skin: Dry Itchy Acne Hair loss/thinning Bruises easily
Other_____

Sleep Problems: Trouble falling asleep Trouble Staying Asleep
Restful Excessive Dreaming
Other_____

Head: Headaches (What area)?_____
Dizziness Memory Loss Loss of Balance
Other_____

Ears: Poor Hearing Ringing in Ears

Eyes: Dry Eyes Blurry Vision

Nose: Frequent Nose Bleeds Sinus Trouble Frequent Colds

Throat: Sore Throat Jaw Problems Teeth Problems
Dry Throat Lump in Throat

Chest: Hard to Breathe in / out Wheezing Shortness of Breath
Palpitations Coughing Phlegm Persistent Cough Pain/Pressure in Chest

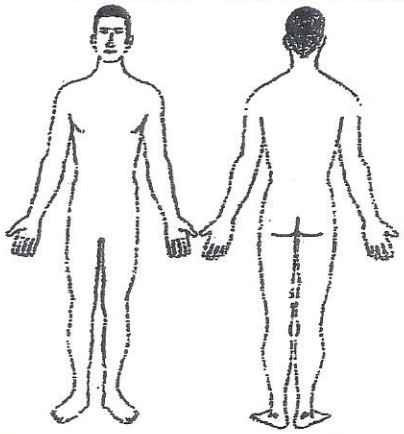
Blood Pressure: High Low Spikes

Bowels: Diarrhea Constipation Bloody Stools Hemorrhoids
Gas _____ Number of Bowel Movements per Day

Urine: Frequent Urination Burning Urination Water Retention
Incontinence Night time
Other_____

Musculoskeletal: Pain Numbness Tingling

Please indicate with an X the area(s) below:



Neurological: Depressed Easily Angered Frequent Crying
Anxiety Mood Swings Poor Concentration Tremors Seizures
Numbness/Tingling

Females: Pregnant? _____ First Day of Last Monthly Period
Menstrual Cycle: Irregular Clotting Heavy Bleeding
Light/Scanty
Mood Changes Low or no Sex Drive Painful Breasts Hot
Flashes
Discharges: Yellow Thick White Itching

Males: Low Sex Drive Impotence Premature ejaculation

Appetite: Excessive appetite Poor Appetite Excessive thirst

Digestion: Stomach Gas Heartburn Belching Stomach pain Bitter taste
in mouth Abdominal bloating Acid regurgitation
Food allergies? If yes, to what?_____

Additional Health Information:

_____
_____
_____
_____
_____
_____

Please date and sign below attesting to the fact that all information given above is true to the best of your knowledge.

_____
Signature of Patient or Guardian Date

Anjali P. Desai, L.Ac Acupuncture Clinic
Notice of Privacy Policies

This office is dedicated to providing services for your health and protecting your privacy. This notice will remain in effect until it is replaced or amended by changes in law.

Personal Information is gathered from you in the following ways:

- Information received from you
- Information received from other healthcare providers

This information is used for the purposes of treatment, payment and healthcare operations. This office will use and disclose information about you for those purposes.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, email, or mail. Please inform us if you do not want us to contact you for one of the above reasons. We do NOT sell your information or share with unrelated companies.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of $0.25 per page and this office will need 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; this request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact me. Send written complaints to the U.S. Department of Health and Human Services.

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 in this acupuncture office, Anjali P. Desai, L.Ac Acupuncture.

This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature_____

Date:_____

If you do not wish to be contacted in a specific manner, please notify us in the space provided below.

_____

_____

_____

Patient Signature_____

Date_____

Patient's Consent For The Purposes of Treatment, Payment, And Healthcare Operations

I_____ give

Consent to Anjali P. Desai, L.Ac. Acupuncture Clinic to use and disclose my individual identifiable health information or Protected Health Information for the purposes:

A. Providing treatment to me
B. Relating to the payment of the services this office has rendered to me
C. The general administrative operation this practice provides to me.

The purpose of this consent:
Protected Health Information is any information that includes:

A. Demographic information
B. Information gathered by this practice as it relates to my past, present and future physical or mental health condition.
C. Information gathered by this office for past, present, and future payments for providing healthcare services.
D. Healthcare operations purposes will include quality assessment activities, business management and other general operations, procedures, or activities.

I understand I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the Practice has acted in reliance on this consent.

_____Date_____
Signature of Patient or Personal Representative

_____Date_____
Description of Person Representative's Authority

Anjali P. Desai, L.Ac. Acupuncture

There is a 24 Hour Cancellation Policy in effect. If an appointment must be cancelled after the 24 hour period, a cancellation fee of $ 50 will be charged to the credit card on file.

Fees for treatment do not include the costs of herbs, which are additional. Payment for ordered herbs is due at pickup. If herbs are ordered and not picked up after 14 days, the credit card on file will be charged.

If we bill your insurance and acupuncture coverage is denied, we will notify you of the amount due. If we are unable to contact you regarding fees for services due, your credit card will be charged after 14 days.

I understand the policies of this office as stated.

_____ Date_____

Signature

_____ [ ] MC [ ] VISA [ ] AMEX

Credit Card Number

_____ _____

Expiration Date 3 Digit code on back

Assignment of Benefits (Complete if you have insurance other than Blue Cross)

With this signature I give permission for my insurance company to assign benefits and send payment directly to Anjali P. Desai, L.Ac at for acupuncture services that have been provided to me.

_____ _____

Signature Date