Healing Center **Initial Intake Form**

Janette Votaw, L.Ac.
Master of Science in Traditional Chinese Medicine

Full Name:_____ Gender: □Female □Male

Address:_____City:_____

State: _____Zip:_____ Phone:_____hm/wk/cell (Circle one)

Alternate Phone: _____ hm/wk/cell (Circle one)

Email:_____

Emergency Contact: Phone:_____Name & Relation_____

Whom may I thank for your referral?_____

Date of Birth: _____ Height:_____Weight:_____

Are you currently taking any medication/drugs/herbs/supplements? □ Yes □ No (please specify below)

_____

Do you have a family history of any of the following conditions:
□Cancer □Allergies □Heart Disease □High blood Pressure □Stroke
□Diabetes □Other: _____

Have you ever had or do you currently suffer from any of the following conditions:
□Cancer □Allergies □Heart Disease □High blood Pressure □Stroke □AIDS
□Hepatitis □Asthma □High Cholesterol □Thyroid Disorder □Immune Disorder
□Other:_____

Are you pregnant: □ Yes □ No **Are you trying to conceive:** □ Yes □ No

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<u>What is your Main Complaint?</u>

_____

_____

How long have you had this condition: _____Have you had this in the past: □ Yes □ No

Is this condition: □*Improving* □*Constant* □*Getting Worse*

Is the pain*:* □*Mild* □*Moderate* □*Severe* On a scale from 1 (best) to 10 (worse), the pain is:_____

What makes it feel better: □*Heat* □*Cold* □*Movement* □*Rest* □*Don't know* □*Other:*_____

What makes it feel worse: □*Heat* □*Cold* □*Movement* □*Rest* □*Don't know* □*Other:*_____

Supplemental Information
Check ALL that Applies

Energy Level
□ High (time of day_____)
□ Low (time of day_____)
□ Feel sleepy after eating

Temperature
□ Feel cold easily □ Cold feet am/pm
□ Cold hands am/pm □ Chills
□ Feel hot easily □ Hot flashes am/pm
□ Burning sensation in □palms □feet □chest
□Fever (how high_____)
□ Low grade fever (for how long_____)
□Alternating hot and cold (temperature swings)

General
□Weight gain □Weight loss
□Edema □Hair loss
□Excess thirst □Lack of thirst
Crave: □ sweet □ salty □ sour □ spicy foods

Sleep
□Restful □Dream-disturbed
□Insomnia: □difficult falling asleep, or
□staying asleep
How many hours do you sleep at night:_____

Digestion/Gastrointestinal
□Belching □Gas □Bloating
□Nausea □Vomiting □Diarrhea
□Loose stools □Constipation □Heart burn
□Ulcers □Indigestion □Reflux

□Excess Hunger
□Low appetite □No appetite
□Abdominal Pain
(worsens: □ After or □Before eating)
□Rectal Pain □Hemorrhoids
□Rectal Bleeding: □Red □Brown □Black
□Mucus in Stool

How often do you have a bowel movement: _____
Stool is: □Dry □Hard □Loose □Pebble-like □Watery
□Other_____

Head & Neck
□Headaches (where)_____
□Neck Pain (where)_____

How often: _____
Cause:_____
□Dizziness □Vertigo □Blurred Vision
□Eye Pain □Floaters □Memory Loss
□Seizures □Poor Circulation
□Tingling □Numbness □Tremors

Ear/Nose/Throat/Mouth
□Sinus congestion □Runny nose □Sneezing
□Frequent colds □Sore throat □Infections
□Nose bleeding □Ringing in ears: □Low □High
□Loss of hearing □Blocked ear □Ear pain
□Bleeding gums □Grinding teeth

Chest/Respiration
□Shortness of Breath □Weezing
□Dry Cough: □Day □Night □Persistant
□Productive Cough (phlegm) □Thin □Thick
Color:_____
□Chest pain □Rib side pain □Palpitations

Urination
□Frequent urination: □Day □Night
□Burning urination □Blood in the urine
□Difficult urination □Dribbling
□Urgent □Incontinence
□Frequent urinary tract infections

Emotions
□Nervous □Depressed
□Anxious □Easily angered
□Easily irritated □Moody
□Manic □Crying easily
□Fearful □Grieving

Lifestyle
Do you:
□Smoke □Drink: □Coffee □Tea (cups/day)_____
□Drink alcohol (glass/wk) _____
□Exercise (type & frequency)_____
_____

Female Health
Date of last menstrual period_____
Menses lasts _____ days
Duration of cycle lasts_____days
Do you menstruate regularly: □Yes □No
Color: □Pale Red □Bright Red □Dark □Brown
Consistency: □Thick □Watery
Clotting: □Yes □No
□Cramps (Better with) □Heat □Exercise □Rest

□Breast tenderness □Acne □Mood changes
□Food Cravings □Bearing down sensation
□Low back pain □Spotting between periods

□Menopause
□Hot Flashes
□Vaginal dryness
Libido: □Low □High

Fee Schedule-Payment is due at time of Service

Acupuncture

$100.00 1st appointment. Must be paid **out of pocket** at time of treatment. We do not bill insurance for the 1st treatment.

$50.00 follow up appointment.

Integrative/Functional Medicine Consultations (In Person or Video)

$50.00 for treatment and/or herbal consultation

Zyto Scan & Integrative/Functional Consultation (In Person)

$50.00 for scan and treatment consultation

I understand that I am financially responsible for all charges incurred at the Healing Center.

_____ Date: _____

Signature of Patient

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for the Healing Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Healing Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Janette Votaw, Healing Center, 574 Manzanita Ave. #4 , Chico, CA 95926.

With this consent, the Healing Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, the Healing Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements. By signing this form, I am consenting to allow the Healing Center to use and disclose 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 prior consent. If I do not sign this consent, or later revoke it, the Healing Center may decline to provide treatment to me.

_____ _____ Date:_____

Signature of Patient or Legal Guardian Print Name

_____ _____

Relationship to Patient Print Patient's name (if signed by Legal Guardian)

ACUPUNCTURE INFORMED CONSENT FORM

I, (print) _____ the undersigned understand that methods of treatment used in this practice may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, gua sha, tui na (Chinese massage) and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, gua sha and tui na are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and sores at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, organ puncture, including lung puncture (pneumothorax), spontaneous miscarriage and possible worsening symptoms. Infection is possible, although the practice uses alcohol and sterile disposable needles and maintains a safe and clean environment and clean needle technique is always employed. Potential risks of moxibustion heat therapy are burns, blistering or scarring, Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success of effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Policies document that has been provided to me, and of which I have acknowledged the receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred or carried out at this practice. 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 the consent form with my Acupuncturist. I understand that I can request more information at any time if desired.
- I consent to receive treatment that involves the above procedures.
- I understand that I have the right to refuse of discontinue any treatment at any time. I understand that refusal or discontinuation of treatment should be done in writing and will be kept in my medical file. I understand this refusal may effect the expected results.

_____

Signature of Patient or Parent/Guardian if minor

Date: _____

Appointment Cancellation Policy Agreement

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. The ways you can notify us of a cancellation are by text or call at (530) 892-1196 or by email at chico.healingcenter@gmail.com.

Our staff wants to be available for the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. We will begin enforcing the cancellation policy by charging a fee for no-show appointments. **As of October 1, 2022 there will be a full appointment charge if we do not receive a call to cancel an appointment.**

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will help us open otherwise unused appointments to better serve the needs of all patients.

--The staff of The Healing Center

Credit/Debit Card Information

Number on Card:_____

Name on Card:_____

Expiration Date:_____ 3-digit code:_____

Zip Code:_____

By signing this agreement you consent to the terms above and you agree to The Healing Center charging your card $20.00 for every missed appointment where 24 hours notice was not given.

Signature:_____

Date:_____