Natural Life Therapy Clinic

Family Healthcare Through Oriental Medicine

443 North New Ballas Rd. Suite 224 - St. Louis, MO 63141 - Phone: 314-991-6035 - www.nltclinic.com

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Patient Intake Form

Date: _____

Name_____

Date of Birth _____ Age _____ ☐ Male ☐ Female Marital Status _____

Address_____ City_____ State_____ Zip_____

Home Telephone_____ Work Telephone _____ Cell # _____

Email Address_____

Employer_____ Occupation _____

Emergency Contact_____Relationship_____Telephone_____

How did you learn of Natural Life Therapy Clinic? _____

Responsible Party (if dependent) _____ Relationship_____ Telephone_____

Purpose of Visit:

_____

_____

_____

Location of Pain/Discomfort:

_____

_____

Date current problem began: _____ Have you had problem in the past? ☐ Yes ☐ No
If so, when? _____
Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and goes
Is the pain ☐ Slight ☐ Moderate ☐ Severe
What makes it better? _____
What makes it worse? _____
How does it interfere with your daily activities (work, sleep, sex, etc.)?

_____

_____

Have you been given a diagnosis for this problem? If so, what was the diagnosis?

_____

_____

What kinds of treatment have you tried?

_____

_____

Any other complaints/pre-existing conditions?

_____

_____

Presently, do you have any known infection? Have you had a staph infection in the past year?

_____

What medications/drugs/herbs/supplements are you presently taking?

_____

_____

_____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom and for what condition(s)?

_____

_____

Date of your last physical exam _____ by whom? _____

Do you have, or have you had, any of the following?

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Seizures
☐ Asthma	☐ Stroke	☐ Gallstones	☐ Ulcers
☐ Anemia	☐ Hepatitis	☐ Thyroid Disease	☐ Venereal Disease
☐ Heart Disease	☐ Chronic Fatigue	☐ Immune Deficiency	☐ High Blood Pressure

☐ Other: _____

Is there any history in your family of any of the above conditions? Who? What did they have?

_____

_____

List all surgeries/operations you have had and dates:

_____

_____

_____

List any traumas you had and dates (accidents, injuries, etc.)

_____

_____

_____

List any allergies (food, medications, pollens):

_____

_____

Is your energy level: ☐ Good ☐ Insufficient ☐ Erratic
☐ Low (time of day)_____ ☐ High (time of day)_____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep
☐ Restful ☐ Other_____

Stress: ☐ None ☐ Moderate ☐ Severe
What causes it? _____

How much alcohol do you consume per week? _____
Do you smoke? How much per day? How many years? _____
How much coffee/tea/cola do you consume per week? _____
Do you have a regular exercise program? Please describe _____
_____

GENERAL: Please check all that apply.

☐ Sweating easily	☐ Cravings	☐ Tremors	☐ Strong thirst
☐ Night sweats	☐ Bleeding or bruising	☐ Fever	☐ Lack of thirst
☐ Cold	☐ Hot	☐ Poor coordination	☐ Breast Fed

☐ Other _____

DIGESTION: Please check all that apply.

☐ Nausea	☐ Abdominal Pain	☐ Heartburn	☐ Belching
☐ Vomiting	☐ Bad Breath	☐ Abdominal Bloating	☐ Gas
☐ Constipation	☐ Diarrhea	☐ Blood Stools	☐ Hemorrhoids
☐ Stomach Aches	☐ Poor Appetite	☐ Excessive Appetite	
☐ Changing Appetite	☐ Feel tired or weak if a meal is missed		☐ Excessive Thirst

☐ Other_____

What are some of your favorite foods? _____
What foods do you dislike? _____

Do you:
☐ Eat frequently between meals? ☐ Eat when you're not hungry?
☐ Eat until you feel full? ☐ Occasionally go on crash diets?
☐ Binge? ☐ Eat sweets every day?
☐ Follow any restricted diet?

Please describe your <u>average</u> daily diet:
Breakfast_____

Lunch_____

Dinner_____

Snacks/Time of day eaten_____

MUSCULOSKELETAL: Please check all that apply

Pain, weakness, and/or numbness in:

- ☐ Neck ☐ Shoulders ☐ Arms/Hands ☐ Feet/Legs
- ☐ Hips ☐ Knees ☐ Upper Back ☐ Mid-Back
- ☐ Lower Back

Are you experiencing cramps/spasms, stiffness, swelling? If so, where? _____

_____

Do you have a feeling of heaviness in your body? _____

CARDIOVASCULAR/RESPIRATORY: Please check all that apply

- ☐ Palpitations ☐ Difficulty breathing ☐ Wheezing ☐ Shortness of breath
- ☐ Chest pain/pressure ☐ Persistent coughing Coughing phlegm
- ☐ Coughing blood ☐ Cold hands/feet Dizziness/lightheaded
- ☐ Fainting ☐ Irregular heartbeat Other

_____

HEAD: Please check all that apply.

☐ Headaches (what area and how often?) _____

_____

- ☐ Dizziness ☐ Neck Pain ☐ Grinding teeth ☐ Jaw clicks
- ☐ Tooth problems ☐ Migraines ☐ Facial pain ☐ Other _____

EYES: Please check all that apply.

- ☐ Glasses/contacts ☐ Dryness ☐ Pain/burning ☐ Itching
- ☐ Redness ☐ Blurred vision ☐ Other_____

EARS: Please check all that apply.

- ☐ Poor hearing ☐ Earaches ☐ Ear infections ☐ Poor balance
- ☐ Ringing or buzzing in ears ☐ Other _____

NOSE: Please check all that apply.

- ☐ Excessive mucus ☐ Blocked sinuses ☐ Sinus pressure/pain ☐ Allergies/hayfever
- ☐ Nose bleeds ☐ Other _____

THROAT/MOUTH: Please check all that apply.

- ☐ Reoccurring sore throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Bleeding gums
- ☐ Sores on lips/tongue ☐ Other _____

URINE: Please check all that apply.

- ☐ Up at night to urinate ☐ Unable to hold urine ☐ Hard to urinate ☐ Pain/burning
- ☐ Blood in urine ☐ Urinary infections ☐ Water retention ☐ Kidney stones
- ☐ Other _____

FEMALE:

Are you pregnant? _____ Date of last period: _____

Number of days between periods: _____ Age started: _____ Age stopped: _____

Form of birth control: _____

Number of pregnancies: _____ Number of deliveries: _____ Number of miscarriages: _____

Number of abortions: _____ Number of Cesareans: _____

Operations: ☐ Cervix ☐ Uterus ☐ Ovaries

Other:

☐ Menstrual pain/cramps	☐ Low back pain	☐ Leg cramps	☐ Painful breasts
☐ Clotting	☐ Heavy bleeding	☐ Light bleeding	☐ Dark color
☐ Water retention	☐ Irregular periods	☐ Missed periods	☐ Little/no sex drive
☐ Mood swings	☐ Hot flashes	☐ Food cravings	☐ Vaginal sores
☐ Infections	☐ Discharge - Color	☐ Other _____	

MALE: Please check all that apply.

☐ Low sex drive	☐ Impotence	☐ Painful ejaculation	☐ Discharges
☐ Sores	☐ Painful urination	☐ Premature ejaculation	☐ Prostrate problems
☐ Nocturnal emissions		☐ Other _____	

NEUROPSYCHOLOGICAL: Please check all that apply.

☐ Nervousness	☐ Depressed	☐ Easily angered/irritated	☐ Frequent crying
☐ Worry/anxiety	☐ Mood swings	☐ Memory confusion	☐ Poor concentration
☐ Suicidal	☐ Dizzy	☐ Seizures	☐ Neuralgia

☐ Numbness/tingling (Where?)

☐ Other _____

Is there anything else that you would like for us to know?

_____

_____

_____

_____

_____

_____

_____

Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation and/or electrical impulse near the needle. Patients usually report little or no pain during an acupuncture treatment. On occasion, there may be slight bruising where a needle was inserted. The duration of a treatment is usually 30-45 minutes. Although, no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient. I UNDERSTAND THAT I HAVE THE RIGHT TO CONSENT TO, OR REFUSE, TREATMENT.

PATIENT CONSENT:

I consent to treatment by Oriental medicine therapies, including acupuncture.

SIGNED: _____ DATE: _____

PARENT OR GUARDIAN CONSENT:

I, _____, as parent or guardian of _____, authorize treatment of this minor by physicians at Natural Life Therapy Clinic, Inc.

SIGNED: _____ DATE: _____

CANCELLATION POLICY:

I understand that Natural Life Therapy Clinic reserves the right to charge for appointments canceled or missed without *24 hours advance notice.*

SIGNED: _____ DATE: _____

PAYMENT POLICY:

I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Natural Life Therapy Clinic. I understand that Natural Life Therapy Clinic does not submit insurance claims; however, the staff of the clinic can assist me in my submission claims.

SIGNED: _____ DATE: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

Natural Life Therapy Clinic, Inc.

To Our Valued Patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patient inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of the PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any questions/concerns about any part of that notice, please contact our HIPAA Compliance Officer in person, by mail or by phone at our main phone number: 314-991-6035.

Your signature below is only acknowledgement that you have received a copy of the Notice of our Privacy Practices:

Sign Here _____

HIPAA Notice of Privacy Practices

Natural Life Therapy Clinic, Inc.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician, to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.