Daniel Martin Acupuncture

Daniel Martin, L.Ac., CMT

Patient Information Sheet

CONFIDENTIAL

Today's Date	First Name		Last Name	
Gender	Date of Birth	Age	Marital Status *circle one* Single Married Separated Divorced Domestic Partner	
Street Address	City		State	Zip
Phone (Daytime) – Home Work Cell *Circle one*			Alternate Phone # - Home Work Cell *Circle one*	
Email			Place of Employment / Occupation	
Name of Primary Care Physician			Last time seen	
Emergency Contact Name Phone #				
How did you hear about us?				
Have you received acupuncture or herbal therapy before? ☐Yes ☐No				

Major Complaint(s), **in order of importance to you:**	Severe	Moderate	Slight
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐

How do these conditions impair your daily activities?

When and how did this condition occur?

Treatments you have received for these conditions?

Weight:	Height:	Blood Pressure:

Major Medical Conditions – Please list conditions and/or surgeries and year of occurrence	
Date	Condition/Surgery

Allergies- Please list seasonal, environmental, food or drug allergies.

Medications / Supplements – Please list all medications, supplements, vitamins and herbs you use. Include those which you may only use occasionally.

Name	Purpose	How long	Dose

Occupational Concerns - Please check (√) if your work exposes you to the following:	Exercise – Please check (√) all that apply:
□ Stress □ Heavy Lifting □ Typing Other_____	□ Regular Exercise □ Infrequent Exercise □ None Type _____ Frequency _____

Diet - Please check (√) all that apply

□ Vegetarian/Vegan
□ Coffee _____ cups per day/week *circle one*
□ Alcohol _____ cups per day/week *circle one*
□ Cigarettes _____ cigarettes/packs per day/week *circle one*
□ Other _____
□ High protein/low carbohydrate

Review of Systems – Please check (√) if the symptom has occurred within the last year. Indicate with a 'P' if the symptom occurred prior to one year ago.

General	____ Night sweats	____ Fever/chills	____ Significant weight loss or gain
	____ History of dieting	____ Chronic fatigue	____ Sick more than 2x per year
	____ Weakness	____ Excessive thirst	____ Spontaneous sweating
	____ Cold hands/feet	____ Intolerance to heat	____ Other_____
	____ Intolerance to cold	____ Fatigue in the afternoon	

Skin	____ Dry skin ____ Moist skin ____ Eczema ____ Changes to nails ____ Nail fungus ____ Ringworm ____ Moles	____ Rashes ____ Bruising easily ____ Psoriasis ____ Changes to skin color ____ Shingles ____ Nail ridges ____ Varicose veins	____ Hives ____ Acne ____ Athletes foot ____ Changes to moles ____ Other _____
Head	____ Headaches ____ Trauma ____ Vertigo	____ Migraines ____ Hair loss	____ Dizziness ____ Other _____
Eyes	____ Dry eyes ____ Blurred vision ____ Eye pain ____ Sties ____ Cataracts ____ Farsighted	____ Watery eyes ____ Discharge from eyes ____ Impaired vision ____ Poor night vision ____ Vision loss ____ Nearsighted	____ Itchy eyes ____ Floaters/halos/flashes ____ Sensitivity to light ____ Contacts ____ Glasses ____ Laser correction surgery ____ Other _____

Ears	_____ Ear pain _____ Ringing in ears _____ Ear infections as a child	_____ Itchy ears _____ Waxy ears	_____ Discharge from ears _____ Hearing loss _____ Other _____
Nose & Sinuses	_____ Itchy nose _____ Nosebleeds _____ Snoring	_____ Discharge from nose _____ Post-nasal drip _____ Breathe through mouth	_____ Congested nose/sinuses _____ Loss of smell _____ Other _____
Mouth & Throat	_____ Dry mouth _____ Bad breath _____ Persistent cough _____ Loss of taste _____ Dentures _____ Jaw clicks _____ Braces	_____ Itchy mouth/throat _____ Frequent sore throat _____ Hay fever/allergies _____ Hoarseness _____ Cavities _____ TMJ	_____ Sores on mouth/lips/tongue _____ Coughing up blood _____ Difficulty swallowing _____ Inflamed/bleeding gums _____ Teeth sensitivity _____ Treatment for strep. as child _____ Other_____
Neck	_____ Swollen glands	_____ Neck pain or stiffness	_____ Trauma
Respiratory	_____ Wheezing _____ Chronic cough _____ Bronchitis/pneumonia _____ Asthma _____ Allergies _____ Exposure to second hand smoke	_____ Shortness of breath _____ Coughing up blood _____ History of smoking _____ Exposure to chemicals	_____ Pain with breathing _____ Sleep Apnea _____ Positive TB test _____ Exposure to particulates _____ Other _____
Cardiovascular	_____ Chest pain _____ High glucose _____ Heart murmur _____ Palpitations _____ Calf pain at night _____ Heart fluttering _____ Varicose veins _____ Spider veins	_____ High blood pressure _____ High cholesterol _____ Heaviness in legs _____ Feel heart racing _____ Swelling in ankles _____ Purple fingers/lips _____ Irregular heartbeat _____ Calf pain - walking	_____ Low blood pressure _____ Heaviness in legs _____ Cold hands/feet _____ Difficulty breathing at night _____ Exhaustion with minor exertion _____ Dizziness upon standing _____ Other _____

Gastrointestinal	_____ Poor appetite _____ Excessive appetite _____ Changes in appetite _____ Excessive thirst _____ Trouble swallowing _____ Heartburn/antacid use _____ Vomiting blood _____ Nausea/vomiting _____ Burping/belching _____ Indigestion _____ Abdominal pain _____ Abdominal bloating _____ Hemorrhoids _____ Gas/flatulence _____ Constipation (<1 stool/day) _____ Diarrhea _____ Foul-smelling stool _____ Stools that are hard to pass _____ Blood in stool _____ Black tar in stool _____ Undigested food in stool _____ Mucous in stool _____ Loose stool (breaks up) _____ Intolerance to specific foods _____ Food sensitivity _____ Fatigue after eating _____ Gallbladder disease _____ Anal itching _____ Liver disease _____ Other _____ _____ Ulcers _____ Treated for parasites Stool shape: _____ One piece _____ Hard little pellets _____ Breaks up when in water _____ Other _____ Stool color: _____ Yellow _____ Green _____ Light Brown _____ Dark brown
Neurological	_____ Fainting _____ Dizziness/vertigo _____ Numbness/tingling _____ Head trauma _____ Trembling hands _____ Poor concentration _____ Memory loss _____ Lack of mental alertness _____ Loss of grip strength _____ Heavy head _____ Loss of muscle tone _____ Heavy extremities _____ Muscle weakness _____ Other _____
Urinary	_____ Can't hold urine _____ Painful burning urination _____ Frequent urination (>5 times/ day) _____ Bed wetting _____ Urination at night _____ Urination with cough or sneeze _____ Cloudy urine _____ Dripping after urination _____ Kidney or bladder infections _____ Strong smelling urine _____ Other _____ Color: _____ Light yellow _____ Yellow _____ Dark yellow _____ Red
Musculoskeletal	Pain in: _____ Shoulders _____ Arms _____ Upper back _____ Lower back _____ Legs _____ Hips _____ Neck _____ Hands _____ Feet _____ Knees _____ Elbows _____ Painful bones _____ Tight shoulder muscles _____ Swollen knees/elbows _____ Numbness _____ Spasms/cramps _____ Morning stiffness _____ Burning _____ Chronic pain _____ Loss of height _____ Tingling _____ Herniated disc _____ Unable to sit straight _____ Arthritis _____ Tendonitis _____ Activities limited due to pain _____ Osteoporosis _____ Broken bone _____ Other _____
Men only	_____ Sore penis _____ Difficulty urinating _____ Sense of full bladder _____ Infertile _____ Wake to urinate _____ Burning pain with urination _____ Hernias _____ Dripping after urination _____ Increased straining with urination _____ Breast lump _____ Discharge from penis _____ Painful ejaculation _____ Testicular pain _____ Premature ejaculation _____ Erectile dysfunction _____ Testicular lump _____ Lack of sexual drive _____ Pain/cold in genital area _____ Tested for STD's _____ Enlarged prostate _____ Have had a prostate exam _____ History of STD's _____ Have had a PSA _____ Monthly testicular/ breast exam _____ Prostate cancer _____ History of prostatitis _____ Other _____

Personal Medical and Family Health History

Please indicate those that are current health problems for yourself and your family members with a '**C**' under the appropriate persons column. Indicate a past problem with a '**P**'. Leave blank those that do not apply.

* If any of the above family members are deceased, please list their age at death and cause.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children	
Alcohol										
Anxiety										
Arthritis										
Asthma										
Hayfever/Allergies										
Back Problems										
Bursitis										
Cancer (specify type)										
Constipation										
Depression										
Diabetes										
Digestive Problems										
Headaches										
Heart Problems										
Hepatitis										
High Blood Pressure										
HIV/AIDS										
Immune Disorder										
Insomnia										
Kidney Problems										
Liver Problems										
Migraines										
Neck Pain										
Thyroid Disorder										
Tobacco										
Weight Problems										
Emotional Problems										
Other_____										

If any of the above family members are deceased, please list their age at death and

Women's Health History

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Please provide the following information:

1. Age at which menses began _____
2. Date of the first day of your last period _____
3. Number days bleeding lasts _____
4. Number of days in your cycle _____
5. Have your cycles changed since they first began? □ Yes □ No
   How? _____
7. Are you currently pregnant? □ Yes □ No
8. Menstrual Flow:
   □ Heavy □ Moderate □ Light □ None
9. Color of Menstrual Flow:
   □ Light Red □ Red/Purple □ Dark Red □ Brown
10. Cramping:
    □ Severe □ Moderate □ Mild □ None
    □ Before period □ During □ After period
11. Clotting:
    □ Large □ Medium □ Small □ None
    □ Bright in color □ Dark in color
12. Birth Control:
    □ None □ IUD
    □ Barriers □ Spermicides
    □ Rhythm method □ Condoms
    □ Birth control pills
13. How many pregnancies have you had? Number_____ Year _____
14. How many children do you have?
15. How many abortions have you had?
16. How many miscarriages have you had?
17. Have you ever had an abnormal pap smear? □ Yes □ No Date _____
18. Have you ever had a cervical biopsy, operation, cauterization, or conization? □ Yes □ No Date _____
19. Have you ever been diagnosed with Chlamydia? □ Yes □ No
20. Do you have chronic vaginal discharge? □ Yes □ No If yes, what color? _____
21. Have you gone, or are you currently going through menopause? □ Yes □ No Age of menopause _____
    If yes, are you currently taking any medications or hormone replacement therapy? □ Yes □ No Type _____

Please check any of the premenstrual syndrome symptoms that apply:

□ Fluid retention/Bloating	□ Cravings	□ Acne/Break outs	□ Fatigue
□ Mood swings	□ Irritability	□ Back pain	□ Depression
□ Breast tenderness	□ Other _____		

Please check any that apply:

□ Hysterectomy	□ Infertility	□ Ovaries removed	□ Mastitis
□ Breast cysts	□ Brain fog	□ Pelvic Inflam. Disease	□ Frequent UTI
□ Vaginal discharge	□ PCOS	□ Fibroids/cysts	□ Irregular periods
□ Abnormal pap smear	□ Endometriosis	□ Post-menopausal bleeding	□ Abnormal mammogram
□ Pain/Itching of the genitalia	□ Bleeding between periods	□ Recurrent yeast infection	□ Nipple discharge
□ Hot flashes	□ Vaginal dryness	□ Moodines	

Daniel Martin Acupuncture
Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to our office.

Legal Responsibilities of Daniel Martin, L.Ac.: As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

Contact Person's Name: Daniel Martin, L.Ac
Telephone: (415) 290-2239
City, State, Zip: San Francisco, CA 94110

I have read and understood the HIPAA privacy policies of Daniel Martin's acupuncture clinic

_____ _____ _____
Name Date Relationship to patient (if applicable)

Daniel Martin Acupuncture - Informed Consent

Voluntary Consent For Treatment

I, the undersigned, consent to acupuncture treatments and other procedures associated with Traditional Asian Medicine. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal medicine, and nutritional counseling. I understand that some possible side effects of acupuncture can include dizziness, local bruising, slight bleeding, temporary discomfort, headaches or fainting. I also understand that some possible side effects of medicinal herbs include nausea, gas, stomachache, vomiting and diarrhea. I will notify my practitioner of any such side effects or if I am or become pregnant. I understand that sterile, disposable needles will be used on me to protect me from communicable diseases. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

Agreement to Pay All Balances Due

I, the undersigned, agree to pay all balances due at the time of service. If I have insurance coverage I will pay all co-pays at the time of services and if my insurance for whatever reason does not cover a particular service I will pay the balance due for those unpaid services.

Cancellation Policy:

We ask that you honor our strict 24-hour notice of cancellation or appointment change in the event another client may need that time. A fee equal to half the amount of your scheduled treatment is required for all cancellations that do not meet the 24-hour policy. Please note that if your treatments are covered under insurance, you must pay this amount out of pocket – we cannot bill insurance for missed treatments. We understand that emergencies may arise, but please know that your session time is reserved exclusively for you.

I have read and understand the above and I agree to be treated.

Name: _____

Signature: _____ Date:_____