SOURCE INTEGRATIVE MEDICINE, LLC
4424 NE Glisan St.
Portland, OR 97213
503.928.6728

NEW PATIENT INTAKE FORM

Personal Information

Date: ________________

Legal Name: ____ Birth Gender: _______

Preferred Name and Gender Identity, if different from above: ________________________

Date of Birth: ____________________________________ Age: _______

Home Address: ____

Home Phone: (   ) ______________ Cell Phone: (   ) _______________

May we leave a message on your home phone? Yes ___ No ___

E-mail Address: ___________________________________

Would you like to receive our clinic newsletter? Yes___ No ___

Marital Status: single: ___ married: ___ partnership: ___ divorced: ___ widowed: ___

Partner's Name: ___________________________________ # of Children: _______

Employer: ____________________________

Occupation: ____

Emergency Contact

Name:____

Relationship to You: ________________________________

Home Phone: (   ) ______________ Cell Phone: (   ) ________________

Referral Information

Who may we thank for referring you to this clinic? _____________________________________

Health History

What conditions would you like to address with acupuncture and Chinese Medicine, in order of priority?

What therapies have you received for these concerns?

History of major medical events, including illnesses, injuries, and surgeries:

Family history of significant illness (include who and type):

Please list all medications, herbs, supplements and home remedies that you are taking (please include amount, frequency, and duration, and include a separate page if needed):

Please explain any allergies (to drugs, chemicals, foods, etc.):

Do you smoke or chew tobacco products? Yes: ___ No: ___
If yes, what type and how much/day? ____
If you are a former tobacco user, what was your former usage and when did you quit?
____

Are you routinely exposed to second-hand smoke? Yes: ___ No: ___
If yes, how and how much per day? ____

Do you drink alcohol? Yes: ___ No: ___ If yes, what and how much/day?
____

Do you drink caffeinated beverages? Yes: ___ No: ___
If yes, what and how much/day? ____

Do you use recreational drugs? Yes: ___ No: ___
If yes, what and how much/day?
____

Please describe your typical daily diet, including time of meals and portion size:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Any foods you specifically avoid or minimize: ____

Women Only

Length of cycles (from day 1 of one period to day 1 of the next period): _______
Number of days of menstruation: _________________________________
Is your typical flow light, medium or heavy? _________________________
Do you see clots in your menstrual flow? Yes: ___ No: ___
Any unusual symptoms or difficulties with menstruation? Yes: ___ No: ___
If yes, please explain:
____
____
____
Have you completed menopause? Yes: ___ No: ___ If so, when? ____________________
Please list all contraception methods ever used, including length of use:
____
____
Please list:

Number of pregnancies: ___ Number of miscarriages: ___ Number of Cesareans: ___
Number of live births: ___ Number of abortions: ___

Please CHECK the box next to any conditions you are currently experiencing, and UNDERLINE any conditions you have experienced in the past:

Emotional

- □ Mood Swings
- □ Stress
- □ Anxiety
- □ Frequent or Excessive Anger
- □ Frequent Fearfulness
- □ Frequent Sadness
- □ Feelings of Depression

Energy and Immunity

- □ Fatigue
- □ Difficulty Waking
- □ Energy Crashes
- □ Slow Wound Healing
- □ Chronic Infections
- □ Frequent Colds/Flus

Head, Eye, Ear, Nose, & Throat

- □ Impaired Vision
- □ Eye Pain/Strain
- □ Tearing/Dryness
- □ Glaucoma
- □ Impaired Hearing
- □ Ear Ringing (Tinnitis)
- □ Earaches
- □ Headaches
- □ Sinus Problems
- □ Seasonal Allergies
- □ Frequent Nose Bleeds
- □ Frequent Sore Throats
- □ Teeth Grinding
- □ TMD/Jaw Problems

Respiratory

- □ Shortness of Breath
- □ Frequent Colds
- □ EnvironmentalAllergies
- □ Asthma
- □ Persistent Cough
- □ Emphysema
- □ Tuberculosis
- □ Pneumonia
- □ History of Smoking
- □ Other Respiratory Problems

Cardiovascular

- □ Chest Pain
- □ Palpitations/Fluttering
- □ Heart Murmur
- □ Arrhythmia
- □ High Blood Pressure
- □ Swelling of Ankles/Legs
- □ Stroke
- □ Heart Disease
- □ Varicose Veins

Gastrointestinal

- □ Low Appetite
- □ Excessive Appetite
- □ Nausea/Vomiting
- □ Epigastric Pain
- □ Abdominal Pain
- □ Ulcers
- □ Frequent Gas
- □ Frequent Belching
- □ Heartburn
- □ Gall Bladder Disease
- □ Liver Disease
- □ Hepatitis B or C
- □ Hemorrhoids

Genito-Urinary Tract

- □ Painful Urination
- □ Frequent Urination
- □ Impaired Urination
- □ Incontinence
- □ Frequent UTIs
- □ Blood in Urine
- □ Kidney Stones
- □ Kidney Disease

Female Reproductive

- □ Irregular Cycles
- □ Painful Periods
- □ Heavy Flow
- □ Clotting
- □ Premenstrual Symptoms
- □ Bleeding between Cycles
- □ Breast Lumps/Tenderness
- □ Nipple Discharge
- □ Excess Vaginal Discharge
- □ Menopausal Symptoms
- □ Chronic Yeast or BV
- □ Difficulty Conceiving

Male Reproductive

- □ Sexual Difficulties
- □ Prostate Problems
- □ Testicular Pain/Swelling
- □ Penile Discharge

Musculoskeletal

- □ Neck/Shoulder Pain
- □ Muscle Spasms/Cramps
- □ Muscle Pain
- □ Joint Pain
- □ Tendonitis
- □ Osteoarthritis

Neurological

- □ Vertigo/Dizziness
- □ Numbness/Tingling
- □ Poor Balance
- □ Paralysis
- □ Seizures/Epilepsy

Endocrine

- □ Hypothyroid
- □ Hyperthyroid
- □ Diabetes
- □ Hypoglycemia
- □ PCOS
- □ Cushings Syndrome
- □ Adrenal Fatigue
- □ Other Endocrine Problem

Skin

- □ Rashes
- □ Eczema
- □ Frequent Hives
- □ Dry Skin
- □ Oily Skin
- □ Acne

Other

- □ Feeling Excessively Cold/Hot
- □ Cold Hands/Feet
- □ Night Sweats
- □ Easy Bruising
- □ Anemia
- □ Cancer (if so, what kind?):

____

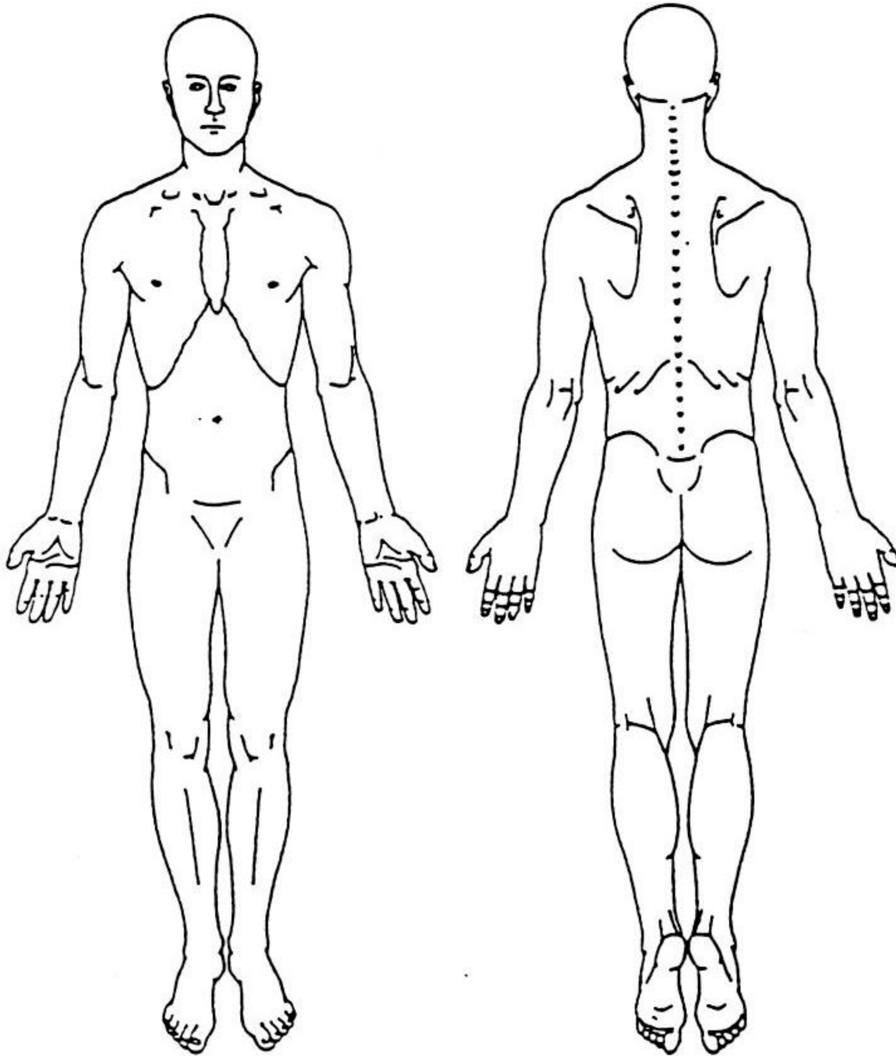
____

MUSCULOSKELETAL COMPLAINTS

Please circle the number that best corresponds to your level of pain:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Minor Pain			Moderate Pain			Severe Pain		Worst Possible Pain

Please mark the area(s) where you feel pain, using a <u>circle</u> to indicate dull pain, and an X to indicate sharp pain:



GENERAL COMMENTS

If you have any comments or additional information, please use this space:

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. **It is important that you understand that your information can be used and shared in the following ways**:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- Obtain payment from third party payers

In order to provide you with service that best meets your privacy needs, please tell us how to best contact you when needed. If you have no specific requests we will use your information provided on the intake form. Please check all that apply:

☐ Please do not phone me at _______________Use this alternate phone number:_______________

☐ Please do not leave messages at/on: Cell phone Work Home

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address:

____

____
Signature Date

____
Printed Name Date

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OFFICE POLICIES & FINANCIAL AGREEMENT

Please read the following statements:

- Payment for all services and medicinary items is due at the time of the your visit. In the event that your insurance company denies benefits or makes a partial payment, you are responsible for any balance due.
- We accept cash, check, or credit card. Returned checks will be subject to a $35.00 NSF fee.
- Most insurance companies do not cover medicinary items that may be prescribed and/or dispensed at SOURCE Integrative Medicine or elsewhere.
- Your appointment time is reserved especially for you. **In the event of a missed appointment or cancellation with less than 24 hours notice, you will be charged a Missed Appointment Fee of $80.00**. Insurance companies do not cover late cancellation fees.

I have read and understand the above stated policies of SOURCE Integrative Medicine LLC and will comply with them in all respects.

____

Patient Name (Please print. Parent or guardian if patient is a minor).

____________________________________ ____________

Patient signature (Parent or guardian if patient is a minor) Date

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For Patients with Insurance:

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to SOURCE Integrative Medicine, LLC.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature: ____________________________ Date: ____________