

OAKLAND ACUPUNCTURE & INTEGRATIVE MEDICINE CLINIC
AUGUST-G VARLACK L.AC., CMT, MSTCM

Patient Information

Patient's Name _____ Today's Date _____

Street Address Apt. # _____

City _____ State _____ Zip _____

Home Phone () _____ Office () _____

Other Phone () _____ Email _____

Birth Date _____ Age _____ Gender _____

single married divorced widowed domestic partnership other

Referred by _____

Emergency Contact and Relationship _____

Emergency Contact Phone # home () _____ Office or Cell _____

Physician's Name _____ Phone _____

Date of last visit _____

Employment - Please check all that apply

full-time part-time self-employed student unemployed retired

Occupation Number of hours of work/study per week _____

Employer's Name _____ Phone () _____

Billing and Insurance

Note on Insurance

Payment in full is due at the time services are rendered. Upon request a Superbill will be provided. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance Phone () _____

Primary Insurance Address _____

Policy Holder's Name Relationship _____

Policy # / ID # Group # _____

Superbill requests No, thanks! Once a month At the end of each treatment

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Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Health History

Patient Name _____ Date _____

Have you had acupuncture treatment before? If so, for what reason? _____

Pain

Circle: l, r, b = left, right, or both sides

past current	past current	past current	past current
___ __ head	___ __ forearm l r b	___ __ upper back	___ __ shin l r b
___ __ jaw	___ __ wrist l r b	___ __ mid-back	___ __ ankle l r b
___ __ neck	___ __ hand l r b	___ __ low back	___ __ foot l r b
___ __ throat	___ __ fingers l r b	___ __ hip l r b	___ __ heel l r b
___ __ shoulder l r b	___ __ chest	___ __ thigh l r b	___ __ toes l r b
___ __ upper arm l r b	___ __ rib / flank	___ __ knee l r b	
___ __ elbow l r b	___ __ abdomen	___ __ calf l r b	

other current related symptoms _____

ST

past current

___ __ nausea / vomiting

___ __ belching

___ __ heartburn

___ __ bad breath

___ __ bleeding gums

___ __ ulcers

___ __ excessive appetite

___ __ change in appetite

___ __ nose bleeds

___ __ difficulty swallowing

___ __ recurring sore throat

___ __ laryngitis / hoarse voice

Sp

past current

___ __ gas

___ __ abdominal bloating

___ __ abdominal pain

___ __ decreased appetite

___ __ indigestion

___ __ low energy / fatigue

___ __ crave sweets

___ __ decreased sense of taste/ smell

___ __ sweet taste in mouth

___ __ often feel pensive / thoughtful

___ __ edema

past current

___ __ diarrhea

___ __ constipation

___ __ blood in stools / black

___ __ pus in stools

___ __ hemorrhoids

___ __ anal fissures

___ __ rectal pain

other current related symptoms _____

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Lu

past current

- frequent colds
- sinus infection
- cough
- cough with blood
- production of phlegm
- hay fever or allergies

past current

- asthma
- bronchitis
- pneumonia
- COPD
- acne
- rashes, hives, eczema or psoriasis

past current

- often feel sad
- crave pungent foods
- dry skin
- itching

other current related symptoms _____

K

past current

- frequent urination
- urgency to urinate
- pain on urination
- urine/bowel incontinence
- weak urine stream
- blood in urine
- kidney stones
- low back pain
- sore / weak knees
- crave salty foods
- often feel afraid

past current

- frequent urinary tract infections
- frequent vaginal infections
- pelvic inflammatory disease
- abnormal PAP smear
- irregular periods
- premenstrual syndrome
- painful menstrual periods
- abnormal bleeding
- menopause symptoms
- breast lumps
- ear infections

past current

- impotence
- premature ejaculation
- testicular lumps
- prostatitis
- genital itching /pain
- genital lesions/discharge
- decreased libido
- ear ringing –low pitch
- ear ringing –high pitch
- decreased hearing

Total Pregnancies _____ Living _____ Ectopic _____ Miscarriages _____
 Induced Abortions _____

other current related symptoms _____

LV.

past current)

- dry eyes
- red eyes
- eye inflammation
- blurred vision
- poor night vision
- irritability
- treated for emotional / psychological problems
- cataracts
- crave sour foods
- tendonitis

X

past current

- insomnia
- excessive / vivid dreams
- grinding teeth
- depression
- anxiety / stress
- floaters (spots in the visual field)
- numbness or tingling of limbs
- poor concentration
- indecisiveness
- often feel angry
- gallstones

past current

- migraine
- dizziness
- fainting
- seizures
- localized weakness
- visual changes
- glasses / contact lenses
- tremors
- paralysis
- aversion to wind

other current related symptoms _____

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Ht

past current

- high blood pressure
- low blood pressure
- palpitations
- irregular heart beat

past current

- chest pain or pressure
- jaw, neck, shoulder or arm pain
- nausea
- swollen hands or feet

past current

- blood clotting disorders
- phlebitis
- poor memory
- crave bitter foods

other current related symptoms _____

YM

past current

- fevers
- frequent or strong thirst
- tend to feel warmer than others
- night sweats
- sweat easily
- prefer cold food and drink

past current

- chills
- hands / feet
- tend to feel colder than others
- cold sweats
- prefer warm food and drink

past current

- headache
- neck stiffness
- concussion
- enlarged lymph

tumors or lumps

past current

- HIV
- TB
- chicken pox
- meningitis
- hepatitis

past current

- gonorrhea
- chlamydia
- syphilis
- genital warts
- herpes oral / genitals

past current

- SARS
- west Nile

other current related symptoms _____

Recent Tests and indicate results

cholesterol _____ blood pressure _____ mammography _____ prostate _____

blood work _____ STD Check _____

other tests and results _____

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FAMILY HISTORY Complete for each family member, placing an X in the appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

Major Hospitalizations – Please list any hospitalization or surgeries you have undergone

Year Operation or Illness Name of Hospital City and State

Medicines, Herbs, Supplements – Please check any that you are currently taking

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> antacids | <input type="checkbox"/> blood thinners | <input type="checkbox"/> sleeping pills |
| <input type="checkbox"/> ibuprofen | <input type="checkbox"/> fiber / laxatives | <input type="checkbox"/> blood pressure pills | <input type="checkbox"/> tranquilizers |
| <input type="checkbox"/> acetaminophen (Tylenol) | | <input type="checkbox"/> diet pills | <input type="checkbox"/> insulin |
| <input type="checkbox"/> oral contraceptives | <input type="checkbox"/> allergy medication | <input type="checkbox"/> antidepressants | |

other, please list _____

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Western Drugs

Herbs

Vitamins and Supplements

Medication Allergies _____

Food Allergies _____

Habits – Please check any habits which apply to you now or in the past

Coffee __ yes __ no	# per day _____	age started _____	age quit _____
Tobacco __ yes __ no	# per day _____	age started _____	age quit _____
Marijuana __ yes __ no	# per day _____	age started _____	age quit _____
Alcohol __ yes __ no	# per day _____	age started _____	age quit _____
Crack/Cocaine __ yes __ no	# per day _____	age started _____	age quit _____
Heroin __ yes __ no	# per day _____	age started _____	age quit _____

Please describe any restricted diet you follow(ed) now or in the past _____

Please describe you typical daily diet

Breakfast _____	Morning Snack _____
Lunch _____	Afternoon Snack _____
Dinner _____	Evening Snack _____

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Please list your health concerns in order of importance –

Please describe any regular program of exercise –

Do you have a religious or spiritual practice? If so, please describe –

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.

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Oakland Acupuncture & Integrative Medicine Clinic August-G Varlack L.Ac., CMT, MSTCM Notice of HIPPA Privacy Practice
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The attached Notice describes how health information about you may be used, and your rights, regarding the use of that information. **Please review this summary and the full Notice carefully.**

Oakland Acupuncture & Integrative Medicine Clinic Pledge: Staff and Employees of Oakland Acupuncture & Integrative Medicine Clinic and it's affiliates and contract providers understand that information about you and your health is personal. We are committed to protecting your health information.

Who will follow the rules in this notice: All Oakland Acupuncture & Integrative Medicine Clinic staff will follow these rules.

You have the right to:

- Ask to see, read, and or/obtain a copy of your health record (charges may be necessary)
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes.
- Ask that Oakland Acupuncture & Integrative Medicine Clinic send copies of your health records to whomever you wish (charges may be necessary).
- Be informed about who has read your record
- Specify where and how Oakland Acupuncture & Integrative Medicine Clinic employees may contact you.
- Receive a paper copy of the full Notice of Privacy Practices.

Who is authorized to see confidential Patient Health Information (PHI) at Oakland Acupuncture & Integrative Medicine Clinic?

The Acupuncturist and nurse may access the entire medical record. The "Notice of Privacy Practices" describes the ways in which we may use patient health information without obtaining patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted:

1. **Treatment** of patient, including appointment reminders
2. **Payments** of health care bills (insurance claim submissions, authorizations and payment posting)
3. **Healthcare operations** and business operations, including, teaching and medical staff quality activities, research (when approved by the IRB and with a patient's written permission); health care communications between patient and their health care practitioner.

Written Authorization

To use or disclose patient health information for almost any other reason, you will need to sign a written authorization prior to access of disclosure. Refer to the "Notice of Privacy Practices: for a list of covered exceptions to the authorization required related to public policy, certain health disease reporting requirements and law enforcement activities. (Available as of April 14, 2003 at <http://www.ucsf.edu/hippa>.) If you do not know or understand what you can do with Patient Health Information, please read the "Notice of Privacy Practices"

Exceptions to the Rules

Under HIPPA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices." Disclosures can be made without patient authorization: subject to profession judgment, for public health and safety purposes, for government functions, law enforcement and based on judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with August-G Varlack L.Ac. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretary, the address is US Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

- I acknowledge receipt of the "Notice of Practices: and "Patients Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
- I understand and acknowledge that it is the practice of Oakland Acupuncture & Integrative Medicine Clinic to place a reminder phone call to me the night before treatment, and I agree to received these calls.

Please Print Name: _____

Signature: _____

Date: _____

Staff signature: _____

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Oakland Acupuncture & Integrative Medicine Clinic
Missed Appointment Policy

In the event when you find it impossible to keep an appointment, please give us a call 24 hours in advance. A fee of \$25 will be added to your account if you cancel your appointment with less than 24 hours notice. A fee of \$50 will be added to your account if you miss your appointment without giving notice. If an emergency prevents you from keeping your appointment, special arrangements can be made. We maintain a timed appointment schedule and ask that you be here and ready for your appointment on time. If you know that you will be late, please call. We will make every effort to see you at a later time. Thank you for your support and understanding. It is our pleasure to provide you with the very best of treatment and service.

Patient Name (please print): _____

Patient Signature: _____