erin battison • integrative medicine, llc

an acupuncture and herbal practice

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please fill this health history out carefully and completely. For more room or anything not included, please use the space at the bottom of the form. All information is absolutely confidential.

Name: _____ Date: _____

Address:_____ City:_____ State:_____ Zip:_____

Home phone: _____ Cell phone: _____

Email:_____

Sex: □ Male □ Female □ Trans □ MTF □ FTM Height: _____ Weight: _____ Age:_____

Date of Birth ____/____/_____ Marital status: □ Single □ Married □ Partnered □ Divorced □ Widowed

Occupation: _____

Primary physician:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

Who can we thank for referring you? _____

In emergency notify: _____Phone: _____

Have you received acupuncture before? □ Yes □ No
When? _____ With Whom? _____

HISTORY OF:

□ HIV □ Hepatitis (A, B, C) □ Gonorrhea □ Syphilis □ HPV □ Herpes □ MRSA □ Hyper/Hypotension

Please list your major complaint (symptoms, duration, etc.). Rate the severity of the complaint on a 1-10 scale, 1 being very low and 10 being very high.

1._____1 2 3 4 5 6 7 8 9 10

2._____1 2 3 4 5 6 7 8 9 10

3._____1 2 3 4 5 6 7 8 9 10

4._____1 2 3 4 5 6 7 8 9 10

5. _____1 2 3 4 5 6 7 8 9 10

How have these complaints impacted your daily activities?

_____

_____

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MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays.

Prescription	Purpose	Duration	Dose	Last Dose

SUPPLIMENTS – Please list all supplements you use. Include those which you may only use occasionally.

Prescription	Purpose	Duration	Dose	Last Dose

NUTRITION

Please list any allergies: _____

Do you follow any type (Vegan, Vegetarian, etc.): _____

Reason for diet choices: _____

BREAKFAST_____

AVERAGE TIME_____

LUNCH _____

AVERAGE TIME_____

DINNER _____

AVERAGE TIME_____

SNACKS _____

TIME(S) _____

Form(s) of Exercise: _____

□ 1-2 x per week □ 2-4 x per week □ 4-6 x per week □ 6+ x per week

Describe type and weekly use (# per) of:

□ Caffeinated drinks_____ □ Alcohol_____ □ Cigarettes _____ □ Recreational drugs _____

HEALTH HISTORY

Please check any condition or symptoms that you have now:

- □ Alcoholism
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Cancer
- □ Chronic fatigue
- □ Chronic pain condition
- □ Diabetes
- □ Diverticulitis/IBS
- □ Elevated Cholesterol
- □ Emphysema or COPD
- □ Food Allergies
- □ Gastritis/Pancreatitis
- □ Heart Disease
- □ Hepatitis (A, B, C)
- □ High/Low B.P.
- □ Hypo/Hyperglycemia
- □ Impotence
- □ Infertility
- □ Kidney Disease
- □ Liver/Gall Disease
- □ Lyme Disease
- □ Multiple Sclerosis
- □ Pacemaker
- □ Raynaud's
- □ Thyroid Imbalance
- □ Ulcer

*Please fill this out carefully, even if some of the symptoms don't seem connected to your current issue. Place **a check** next to a symptom you have experienced, **please circle** a frequently occurring symptom and **star** a symptom that is particularly distressing to you.*

GENERAL SYMPTOMS

- □ Bleed/bruise easily
- □ Chills/fever
- □ Cravings
- □ Fatigue
- □ Localized weakness
- □ Night sweats
- □ Poor appetite
- □ Peculiar taste/smell
- □ Poor sleep/insomnia
- □ Strong thirst (for hot or cold drinks)
- □ Sweats easily
- □ Tremors
- □ Weight loss/gain
- □ Other _____

SKIN AND HAIR

- □ Acne
- □ Change in skin/hair texture
- □ Dandruff
- □ Dermatitis
- □ Eczema/Psoriasis
- □ Fungal infection
- □ Hives or itching
- □ Loss of hair
- □ Rashes
- □ Warts
- □ Weak or ridged nails
- □ Other _____

HEAD, EARS, EYES, THROAT

- □ Blurred vision, floaters
- □ Dental problems
- □ Difficulty swallowing
- □ Dizziness
- □ Earaches
- □ Eye pain, eye twitch
- □ Frequent colds
- □ Grinding teeth/TMD
- □ Headaches
- □ Migraines
- □ Nosebleeds
- □ Poor hearing
- □ Poor vision
- □ Ringing in the ears
- □ Sore throat
- □ Sinus problems
- □ Sore throat
- □ Other _____

CARDIOVASCULAR

- □ Blood clots
- □ Chest pain/tightness
- □ Cold hands/feet
- □ Dizziness
- □ Fainting
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Palpitations at rest
- □ Shortness of breath
- □ Spontaneous sweating
- □ Swelling of hands/feet
- □ Varicose veins
- □ Other_____

RESPRITORY

- □ Asthma
- □ Bronchitis
- □ Difficulty breathing when laying down
- □ Cough/wheeze
- □ Difficult inhale/exhale
- □ Persistent cough
- □ Shortness of breath
- □ Phlegm, what color? _____
- □ Pneumonia
- □ Other _____

GASTROINTESTINAL

- □ Abdominal cramps
- □ Bad breath
- □ Belching
- □ Black stool
- □ Bloating
- □ Blood in stool
- □ Changes in appetite
- □ Constipation
- □ Diarrhea
- □ GERD/acid reflux
- □ Hemorrhoids
- □ Hernia
- □ IBS/Crohn's Disease
- □ Indigestion
- □ Gas
- □ Nausea
- □ Rectal pain
- □ Significant thirst
- □ Vomiting
- □ Other _____

GENITO-URINARY

□ Blood in urine □ Dribbling urination □ Unable to hold urine □ Scanty flow
□ Burning urination □ Frequent urination □ Urinary tract infection □ Other _____
□ Copious flow □ Painful urination □ Nighttime urination, # times per night? _____

MUSCULOSKELETAL

□ Bursitis □ Hip pain □ Rotator cuff injury □ Tendonitis
□ Carpal Tunnel □ Knee pain □ Sciatica □ Other _____
□ Foot/ankle pain □ Muscle pain/weak □ Shoulder pain
□ Hand/wrist pain □ Neck pain □ Back pain: Low ___ Middle___ Upper ___

NEUROPSYCHOLOGICAL

□ ADD/ADHD □ Concussion □ Nervousness □ Dizziness
□ Anxiety/panic attacks □ Depression □ Poor memory □ Other _____
□ Areas of numbness □ Easily susceptible to stress □ Seizures
□ Bad temper/irritable □ Manic depression □ Seasonal Affective Disorder

MALE

Date of last prostate checkup? _____ Results? _____

□ BPH/enlarged prostate □ Impotence □ Lumps in testicles □ Retention of urine
□ Back pain □ Incontinence □ Discharge □ Decreased stream
□ Genital/testicular pain □ Increased libido □ Erectile dysfunction □ Other _____
□ Genital sores □ Decreased libido □ Premature ejaculation

FEMALE

Are you pregnant?
YES NO

Date of last gynecological exam: _____
Results: _____

□ Decreased libido □ Infertility □ Painful intercourse □ Uterine fibroids
□ Endometriosis □ Irregular menstruation □ PCOS □ PID
□ Fibrocystic breast □ Ovarian cysts □ Vaginal discharge □ PMS
□ Increased libido □ Painful menstruation □ Vaginal dryness □ Other _____

Age of first menses: _____ Age of menopause, if applicable: _____
Number of pregnancies _____ Births _____ Abortions_____ Miscarriages _____

What form of birth control do you use? _____

Number of days between periods: _____

Number of days of flow: _____ Color of flow: _____ Clots? Y N

Average number of pads used per day: 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____ 6th ____ 7th ____ 8th ____

Pain related to menses:

□ Cramping □ Stabbing
□ Burning □ Aching
□ Dull □ Bloating
□ Consistent □ Intermittent

Other symptoms related to menses:

□ Constipation/Diarrhea □ Mood swings
□ Discharge □ Nausea
□ Headache □ Night sweats
□ Hot flashes □ Ravenous appetite
□ Insomnia □ Swollen breasts

PERSONAL ASSESMENTS

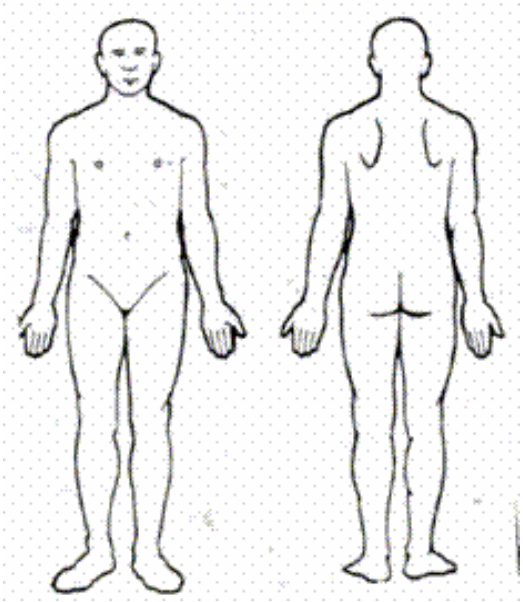
How do you FEEL about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments:
Partner	□	□	□	□	□	
Family	□	□	□	□	□	
Diet/Exercise	□	□	□	□	□	
Sex	□	□	□	□	□	
Self	□	□	□	□	□	
Work	□	□	□	□	□	
Spirituality	□	□	□	□	□	

PAIN MAP

Use the following key to indicate areas of pain or sensation in your body by drawing the symbols on the diagram below.

+: sharp pain *****: dull ache **#**: burning pain **@**: itching **^**: cramping



Patient OR GuardianSignature:_____Date:_____

Office Signature:_____ Date:_____

Cancellation Policy: Appointments must be canceled or changed within 24 hours of scheduled time. Without 24 hour notice, full payment for treatment will be incurred. If less than 24 hours notice is given, ***but the appointment is rescheduled and kept within the same week of original booking***, the fee will be waived.
I understand the above policy (please initial) :_____

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Informed Consent for Acupuncture Treatment

I herby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I'm legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as back-up for the acupuncturist Erin Battison, L.A.c., including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, breathing techniques, exercise therapy, Tui-Na, Herbal Medicine, and Eastern nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including; bruising, numbness and tingling that can last for a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of needles and adjunctive techniques and in many forms, is not seen as pathological in TCM. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, or organ puncture. Infection is another possible risk, although the acupuncturist below is certified in clean needle techniques and uses sterile, one time use needles and maintains a regulated, clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are plant, mineral and animal sources) that have been recommended are traditionally considered safe and effective in the practice of Chinese Medicine, although in large doses, some may have toxic side effects. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, digestive upset, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue.

I understand that herbs need to be consumed according to the instructions provided orally and/or in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with treatment or the consumption of herbs. I will notify the acupuncturist who is caring for me if I become pregnant, change, omit or add medications, or obtain a new Western medical diagnosis. I do not expect the acupuncturists to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based on facts known then, is in my best interest. I understand results are not guaranteed.

By voluntarily signing below I show I have read, or have had read to me, this consent to treatment, have been told of the risks and benefits of acupuncture and other procedures and, have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name_____

Signature of Patient or Representative_____

Relation to Patient_____ Date_____

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HIPPA Privacy Notice

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. Legal responsibilities of Erin Battison Integrative Medicine, LLC: 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 polices, 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 polices 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 provider 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 Process: We may use and disclose your protected health 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 practitioners, 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 used 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 health information will prevent a serious threat to your health or safety or the health and 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 health information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.
Appointment Reminders and Communication: Your protected health information may be used to assist you with appointment reminders or to answer questions directed by you in the form of voicemail messages, postcards, emails or letters. We may also write a thank you card or email to a person who referred you to our practice.
Patient Rights Access: At all times, you have the right to review your protected healthcare 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 on the appropriate Consent Form sent to you by our office. We may need to charge you a reasonable cost-based fee per IL law. Fees and explanations can be made available at your request.
Disclosure Accounting: Your rights include the choice to receive a review of every time we, or our business associates disclose your protected healthcare 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.
Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your requests 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 of why information should be amended. Certain conditions may exist where we may reject your request.
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 alternative means or at alternative locations, you have the right to bring this issue forward. You may make a 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. We are available at any time to assist you with questions, concerns, or complaints.

By signing below, I acknowledge that I understand the Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in this office and have been informed on how I may gain access to and control this medical information.

Print Name_____

Signature of Patient or Representative_____

Relation to Patient_____ Date_____