Jordan Hoffman Acupuncture

2001 S. Barrington Ave. Ste 116 Los Angeles, CA 90025

Patient Confidential Information (All information is required)

Name_____Date_____

Address_____ City_____ State_____ Zip_____

Contact Phone (work/home/cell)_____ DOB_____ Age_____

Email_____ Marital Status S M D W Sex M F

□ Yes, please add me to your email list for newsletter and speaking engagement announcements

□ No, please do not add me to your email list.

Emergency Contact_____ Phone #_____

Referred By_____

Family Physician_____ Phone #_____ May we contact them? Y N

History (Please complete the following as accurately as possible)

What is your primary reason for seeking care at our office? _____

When did this condition begin? _____ What was the initial cause? _____

What treatments have you already received? _____

Rate the severity of pain: No Pain 0----1------2------3-------4-------5------6------7-------8------9-----10 Intolerable pain

What makes it better? _____ Worse? _____

How does this condition affect your daily life? _____

Medical History

What surgeries have you had and when? _____

List all serious injuries/medical conditions and when _____

_____

Do you have any allergies that you know of? _____

What medications/supplements are you taking, why, and for how long? _____

_____

Do you have any history of depression or anxiety? _____

Please circle any of the following conditions if you have had it or there is a history of it in your family:

Stroke Cancer Heart Disease Tuberculosis Bleeding Disorders Diabetes High Blood Pressure

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Menstrual History

Age of your first period _____ Are you or do you believe you are pregnant? Y N

Are you taking any Birth Control? Y N If Yes, which one? _____

Length of typical monthly cycle (Day 1 to Day 1) _____ Length of typical menstrual flow (days) _____

Date of your last period _____ Clots? _____ Vaginal Discharge? _____

Recreational Substance Usage

Do you smoke cigarettes? _____ For how long? _____ How many per day? _____

Do you drink alcohol? _____ How many drinks per week? _____

Do you use drugs? _____ What and how often? _____

How many cups of coffee per day? _____ Sodas? _____

Environment

Last plane flight and where: _____

Do you have carpeting? How old? _____ How old is your mattress? _____ Pillows? _____

Do you garden? _____ Do you have pets and what kind? _____ Chemical exposure? _____

Have you had any history of water damage or mold exposure? _____

Last dental cleaning: _____ Do you or did you have metal dental amalgams? _____

Diet

Describe your typical breakfast _____

Describe your typical lunch _____

Describe your typical dinner _____

What cravings do you have? _____

Exercise

Describe your weekly exercise routines _____

Treatment Goals

What are your short-term treatment goals? _____

What are your long-term treatment goals? _____

Payment Information

Credit Card _____ Credit Card Number _____

Exp Date _____ Authorizing Signature _____ Date _____

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Name: _____Date: _____

Place a check next to any current conditions and a "P" next to any conditions you have had in the past.

HEAD & NECK
__ Dizziness
__ Fainting
__ Neck stiffness
__ Enlarged lymph glands
__ Headaches
__ Migraines
_____ Other

EARS
__ Infection
__ Ringing
__ Decreased hearing
_____ Other

EYES
__ Blurred vision
__ Visual changes
__ Poor night vision
__ Spots/Floaters
__ Eye inflammation/Styes
_____ Other

NOSE, THROAT, MOUTH
__ Bleeding
__ Sinus Infection
__ Hay fever or allergies
__ Sore throat
__ Hoarseness
__ Changes in taste
__ Difficulty swallowing
__ Changes in smell
__ Oral ulcers/Canker sores
__ Metal Dental Amalgams
_____ Other

SKIN
__ Hives
__ Rashes
__ Eczema
__ Psoriasis
__ Seborrhea
__ Night sweating
__ Excess sweating
__ Dryness
__ Easy bruising
__ Changes in moles/lumps
_____ Other

NEUROLOGICAL
__ Numbness/tingling of limbs
__ Seizures
__ Tremors
__ Pain
__ Paralysis
__ Epilepsy/Convulsions
__ Poor memory
__ Difficulty concentrating
_____ Other

RESPIRATORY
__ Chronic cough
__ Coughing up blood
__ Coughing up phlegm frequently
__ Difficulty breathing
__ Wheezing/Asthma
__ Frequent colds/flu
__ Emphysema
__ Pneumonia repeatedly
__ Mold exposure
__ Frequent plane flights
_____ Other

CARDIOVASCULAR
__ Palpitations
__ Chest pain/tightness
__ Rapid heart beat
__ Irregular heart beat
__ Heart Disease
__ Poor circulation
__ Swelling of ankles
__ Phlebitis
__ Cold hands/feet
__ Cardiac pacemaker
__ High blood pressure
__ Stroke
_____ Other

GASTRO-INTESTINAL
__ Indigestion
__ Nausea
__ Stomach pain
__ Irritable Bowel Disease
__ Ulcerative Colitis
__ Crohn's Disease
__ Pancreatitis
__ Celiac Disease
__ Recent change in bowel habits
__ Diarrhea (__stools/day)
__ Constipation (__ stools/week)
__ Dry, hard stools
__ Soft, difficult, sticky stools
__ Irregularly/poorly formed stools
__ Poor appetite
__ Excessive hunger
__ Blood in stool/black stools
__ Hemorrhoids
__ with pain or blood
__ Gall Bladder disorder
__ Vomiting blood
__ Peptic Ulcer
__ Recent change in weight
__ Food cravings
_____ Other

MUSCLE & JOINTS
__ Osteoarthritis
__ Rheumatoid Arthritis
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Spinal curvature
__ Back pain
__ Fibromyalgia
_____ Other

MALE
__ Pain/itching of genitalia
__ Genital lesions/discharge
__ Impotence
__ Low libido
__ Premature ejaculation
__ Prostate problems
__ Infertility (e.g. abnormal sperm)
_____ Other

FEMALE
__ Frequent vaginal infections
__ Infertility
__ Pain/itching of genitalia
__ Genital lesions/discharge
__ Pelvic Inflammatory Disease
__ Abnormal Pap smear
__ Human Papilloma Virus
__ Irregular periods
__ Emotional changes with menses
__ Clots with menses
__ Painful menstrual periods/cramps
__ Premenstrual Syndrome
__ Abnormal bleeding
__ Menopausal symptoms (e.g. hot flashes)
__ Osteoporosis/Osteopenia
__ Breast lumps/cysts
__ Breast swelling/pain
_____ Other

URINARY
__ Frequent urinary/bladder infections
__ Frequent night urination (__x)
__ Frequent day urination (__x)
__ Weak urinary stream
__ Recent change in bladder habits
__ Kidney Disease
_____ Other

GENERAL
__ Fatigue
__ Thirst
__ Aversion to cold
__ Insomnia
__ Frequent dreams/nightmares
__ Depression
__ Agitation
__ Irritability
__ History of psychiatric treatment
__ Sores that don't heal
__ Congenital abnormalities
__ Surgical implants
__ Unusual bleeding/discharge
__ Jaundice
__ Hernia
__ Epstein-Barr virus (EBV)
__ Rheumatic Fever
__ Diabetes Type 1
__ Diabetes Type 2
__ Thyroid disorder
__ Cancer
__ Anemia or other blood disorder
__ Systemic Lupus Erythematosis (SLE)
_____ Other

INFECTIONS
__ HIV/AIDS: self or partner
__ Tuberculosis: self or household
__ Hepatitis A, B, or C
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital Warts
__ Herpes Type 1 (oral)
__ Herpes Type 2 (genital)
_____ Other

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Office Terms and Conditions of Service

24-Hour Cancellation Policy: In order to provide you and patients like you with the highest standards of care, all cancellations must be made within a minimum of 24 hours notice. Failure to do so or failure to show for your scheduled appointment will result in your credit card account being charged the full appointment fee.

Admissions and Medical Services Agreement: The patient or the patient's representative consents to the admission of the patient to Jordan Hoffman Acupuncture if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

Release of Information: Jordan Hoffman Acupuncture is authorized to furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

Medical Records: The patient or patient's representative hereby authorizes Jordan Hoffman Acupuncture to obtain his/her medical records from previous medical histories rendered by other physicians or medical centers.

Financial Agreement: The patient or patient's representative shall pay Jordan Hoffman for all services rendered in accordance with the regular rates and terms of Jordan Hoffman Acupuncture. When this agreement is executed by the patient or the patient's representative or a financial guarantor, all shall be jointly and individually liable for the patient, whether or not the patient's insurance company pays. Should accounts be referred to an attorney or collection agency, I agree to pay all collection costs, court costs, and attorney's fees in addition to the fees for services rendered.

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of the acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), massage, Chinese Herbal Medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses single-use sterile disposable needles as per California State law, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and supplements (which are entirely from plant sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate in during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be releases without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and Terms and conditions of Service, have been told about the risks and benefits of acupuncture and other procedures, and have had an 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.

Patient's or Patient's Representative Signature _____ Date_____

Clinic Signature_____ Date_____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Jordan Hoffman Acupuncture may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Jordan Hoffman Acupuncture's Health Information and Privacy Policy (HIPP) for a more complete description of such uses and disclosures.

I have reviewed and received a copy of the HIPP prior to signing this consent. Jordan Hoffman Acupuncture reserves the right to revise its HIPP at anytime without notice to me. A revised HIPP may be obtained by submitting a written request to Jordan Hoffman Acupuncture.

With my consent, Jordan Hoffman Acupuncture may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any information pertaining to my clinical care.

With my consent, Jordan Hoffman Acupuncture may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Jordan Hoffman Acupuncture may email to me appointment reminder cards and patient statements. I have the right to request that Jordan Hoffman Acupuncture restrict how it uses or discloses my PHI to carry out TPO. However, Jordan Hoffman Acupuncture is not required to agree to my requested restrictions.

By signing this form, I am consenting to Jordan Hoffman Acupuncture's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Jordan Hoffman Acupuncture may decline to provide treatment to me.

Health Information and Privacy Policy (HIPP)

This notice describes Jordan Hoffman Acupuncture's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share personal medical and financial information with your insurance company, with worker's compensation (and your employer as well in this instance), or with other medical practitioners or others that you authorize.

Safeguards in place at Jordan Hoffman Acupuncture include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records are kept on permanent file

In administering your health care, we gather and maintain information that may include non-public personal information

- About your financial transactions with us (billing transactions)
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners concerning your healthcare
- From healthcare providers, insurance companies, workers' compensation and your employer, and other third party administrators (e.g. request for medical records, claim payment information).

We here, at Jordan Hoffman Acupuncture, value our relationship with you and respect your privacy. If you have any questions about our privacy guidelines, please call us during regular business hours.

Thank you for placing your trust in us.

By voluntarily signing below, I show that I have reviewed and received a copy of Jordan Hoffman Acupuncture's HIPP.

Patient's Name_____

Signature of Patient/Representative_____ Date_____

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**** PATIENT COPY****

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