# American College of Traditional Chinese Medicine Community Clinic
# Initial Health History Form

**PATIENT INFORMATION (Please Print and complete in full)** **New Patient ☐ Established Patient ☐**

Name: _____ Today's Date:_____

Address:_____

_____ ZIP: _____

Home Telephone # : _____Work Telephone #: _____Cell #: _____

May we leave a message at these phone numbers? _____

Would you like to be contacted by email with informational newsletters and special clinic offers?

If Yes ☐ Email Address: _____ No ☐

**Patient Status:**

Birth Date:_____ Age: _____ Social Security # (optional) : _____

Gender: M___ F___ Transgender___ Other_____How would you like to be addressed? _____

Married ___ Single ___ Divorced ___ Widowed ____ Partnered ____ Other _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone #: _____

Referred to our Clinic By: _____

**Employment Status:**

Full Time ___ Part Time___ Retired ___ Unemployed ___ Student ___

Occupation: _____

Employer's Name: _____Telephone #: _____

Employer's Address: _____

**Primary Health care source**

Physician's Name:_____ Telephone #: _____

Physician's Address: _____ Date of last visit: _____

What are you being treated for? _____

Date of Injury or Onset of Illness: _____

**Medical Insurance status (only some insurance companies cover acupuncture):**

Self ___ Private Insurance ___ Medi –Cal___ Workmen's Comp___ Other _____

Primary Insurance: _____ Telephone #: _____

Insurance Billing Address: _____

Policy Holder's Name: _____Relationship: _____

**American College of Traditional Chinese Medicine Community Clinic**
**Initial Health History Form**

Policy # / ID #: _____Group #: _____

Secondary Insurance: _____ Telephone #: _____

Insurance Billing Address: _____

Policy Holder's Name: _____ Relationship: _____

Policy #/ ID #: _____Group #: _____

**Medi-Cal Information:**

Identification Number: _____Issue Date:_____

**Insurance Responsibility Statement:**
Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

**Assignment and Release:**
I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Signature: _____ Date: _____

The ACTCM Community Clinic exists for the benefit of the community in our area and to support clinical instruction. To help maintain our small operating budget we ask that payment for services are made at the time of treatment. If your insurance covers acupuncture, we will bill them for you. We also accept Medi-Cal.
.

We would like our patients to understand that this clinic provides treatments exclusive to traditional Chinese medicine and patients who seek other modalities of diagnosis and treatment must arrange to see other appropriate practitioners. We have no Medical Doctors on staff. As this is a teaching clinic, our students participate in both the diagnosis and treatment of patients under the supervision of licensed acupuncturists.

I understand the above statements and will comply with the stated needs and requests of the clinical personnel in order to retain this unique health care service in the city of San Francisco.

Patient Signature: _____ Date: _____

Parent or Guardian Signature:_____ Date: _____

---

**To allow us to see as many patients as possible as well as maintain our operating costs, we ask patients to provide us with 24 HOURS NOTICE WHEN CANCELLING or rescheduling appointments. When shorter notice or a no-show occurs, the patient will be subject to a $20 SERVICE CHARGE, and may be put on a same day appointment basis or lose their sliding scale privileges.**
**Fees for treatment do not include the cost of herbs. If you do not have insurance, or if your insurance does not cover acupuncture, do you wish to be considered for the sliding scale rate?**
**YES ____ NO ____ If yes, what is your gross monthly income? $_____**

Have you ever had an acupuncture treatment? When and for what reason?

---

Are you presently being treated for a medical condition? Please describe

---

Date of Injury or Onset of Illness:

---

Please briefly describe any chronic pain:

---

What health issue do you want treated? Please describe as fully as possible.

---

What treatment have you been using for relief of this issue?

---

Do you have other health concerns?

---

**Diet:**

Please describe the type of foods you eat regularly:

Breakfast _____

Morning Snack_____

Lunch_____

Afternoon Snack_____

Dinner_____

Evening Snack_____

**Exercise:**
Do you exercise regularly? Yes ____ How often? ____ No ____
What type of exercise do you do?
_____

# American College of Traditional Chinese Medicine Community Clinic
# Initial Health History Form

**American College of Traditional Chinese Medicine Community Clinic- Initial Health History Form**

Patient Name:_____ Date:_____

**Family History:** Complete for each family member, placing an X in the appropriate box:

| | Self | Mother | Father | Sister | Brother | Spouse | Child |
|---|---|---|---|---|---|---|---|
| Allergies | | | | | | | |
| Blood Disorder | | | | | | | |
| Diabetes | | | | | | | |
| Cancers or Tumors | | | | | | | |
| Seizures | | | | | | | |
| High Blood Pressure | | | | | | | |
| Kidney or Bladder disorder | | | | | | | |
| Stomach or intestinal disorder | | | | | | | |
| Drug Abuse | | | | | | | |
| Tuberculosis | | | | | | | |
| Heart Disease | | | | | | | |
| Stroke | | | | | | | |
| Depression/Mental Illness | | | | | | | |
| Other | | | | | | | |
| Age at Death | | | | | | | |

**Major Hospitalizations (If you have ever been hospitalized for any serious medical illness or operation):**
Write in your most recent hospitalizations below.

| Operation/Illness/Procedure | Year | Name of Hospital | City & State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Pregnancy History:**
Currently Pregnant? ____ If yes, for how long? _____
Total Pregnancies____Living____Ectopic___Misscariages___Induced Abortions____

**Medicines** - Mark an X in the box next to any of the following that you are now taking:

| | | | |
|---|---|---|---|
| ☐ aspirin | ☐ ibuprofen | ☐ acetaminophen(Tylenol) | ☐ OTHER: |
| ☐ antacids | ☐ laxatives | ☐ cold tablets | _____ |
| ☐ oral contraceptives | ☐ diet pills | ☐ tranquilizers | _____ |
| ☐ fiber supplements | ☐ sleeping pills | ☐ hay fever tablets | _____ |
| ☐ blood pressure pills | ☐ blood thinning pills | ☐ insulin, diabetic pills | _____ |

Vitamins (please list)_____
Supplements (please list) _____
Herbs (please list)_____

**Drug Allergies** _____Latex Allergy?_____

HABITS: Please check any of the habits listed below which apply to you now or in the past.

| | | | | | |
|---|---|---|---|---|---|
| Coffee | ☐ yes | ☐ no | cups per day/week_____ | age started: ____ | age quit: ____ |
| Tobacco | ☐ yes | ☐ no | # cigarettes per day____ | age started: ____ | age quit: ____ |
| Marijuana | ☐ yes | ☐ no | use per day/week _____ | age started: ____ | age quit: ____ |
| Alcohol | ☐ yes | ☐ no | use per day/week _____ | age started: ____ | age quit: ____ |
| Crack/Cocaine | ☐ yes | ☐ no | use per day/week _____ | age started: ____ | age quit: ____ |
| Heroin | ☐ yes | ☐ no | use per day/week _____ | age started: ____ | age quit: ____ |

Other _____

# American College of Traditional Chinese Medicine Community Clinic
# Initial Health History Form

Patient Name: _____ Date: _____

**Mark an X in the box next to all of the symptoms you currently have or have had in the past.**

### GENERAL

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Poor appetite |
| ☐ | ☐ | Excessive appetite |
| ☐ | ☐ | Insomnia |
| ☐ | ☐ | Fatigue |
| ☐ | ☐ | Fevers |
| ☐ | ☐ | Night sweats |
| ☐ | ☐ | Sweat easily |
| ☐ | ☐ | Chills |
| ☐ | ☐ | Localized weakness |
| ☐ | ☐ | Poor coordination |
| ☐ | ☐ | Change in appetite |
| ☐ | ☐ | Strong thirst |
| ☐ | ☐ | Other _____ |

### SKIN AND HAIR

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Rashes |
| ☐ | ☐ | Hives |
| ☐ | ☐ | Itching |
| ☐ | ☐ | Eczema |
| ☐ | ☐ | Pimples |
| ☐ | ☐ | Dryness |
| ☐ | ☐ | Tumors/lumps |
| ☐ | ☐ | Other _____ |

### HEAD AND NECK

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Neck stiffness |
| ☐ | ☐ | Enlarged lymph glands |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Concussions |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Other _____ |

### EARS

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Infection |
| ☐ | ☐ | Ringing |
| ☐ | ☐ | Decreased hearing |
| ☐ | ☐ | Discharge |
| ☐ | ☐ | Other_____ |

### EYES

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Blurred vision |
| ☐ | ☐ | Visual changes |
| ☐ | ☐ | Poor night vision |
| ☐ | ☐ | Spots |
| ☐ | ☐ | Cataracts |
| ☐ | ☐ | Glasses/Contacts |
| ☐ | ☐ | Eye inflammation |
| ☐ | ☐ | Other _____ |

### CARDIOVASCULAR

| Past | Current | |
|---|---|---|
| ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Low blood pressure |
| ☐ | ☐ | Blood clots |
| ☐ | ☐ | Palpitations |
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Phlebitis |
| ☐ | ☐ | Chest pain/Angina |
| ☐ | ☐ | Irregular heart beat |
| ☐ | ☐ | Cold hands/feet |
| ☐ | ☐ | Swelling of hands/feet |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Other _____ |

### RESPIRATORY

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Bronchitis |
| ☐ | ☐ | Frequent colds |
| ☐ | ☐ | Pneumonia |
| ☐ | ☐ | Cough |
| ☐ | ☐ | Coughing blood |
| ☐ | ☐ | Production of phlegm |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Shortness of breath |
| ☐ | ☐ | Chronic obstructive pulmonary disease |
| ☐ | ☐ | Other _____ |

### GASTRO-INTESTINAL

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Nausea |
| ☐ | ☐ | Vomiting |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Belching |
| ☐ | ☐ | Blood in stools/black stools |
| ☐ | ☐ | Bad breath |
| ☐ | ☐ | Rectal pain |
| ☐ | ☐ | Hemorrhoids |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Pain or cramps |
| ☐ | ☐ | Indigestion |
| ☐ | ☐ | Gall bladder disorder |
| ☐ | ☐ | Gas |
| ☐ | ☐ | IBS |
| ☐ | ☐ | Heartburn |
| ☐ | ☐ | Other _____ |

### GENITO-URINARY

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Kidney stones |
| ☐ | ☐ | Pain on urination |
| ☐ | ☐ | Frequent urination |
| ☐ | ☐ | Blood in urine |
| ☐ | ☐ | Urgency to urinate |
| ☐ | ☐ | Unable to hold urine |
| ☐ | ☐ | Other _____ |

### FEMALE

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Frequent urinary tract infections |
| ☐ | ☐ | Frequent vaginal infections |
| ☐ | ☐ | Pain/itching of genitalia |
| ☐ | ☐ | Genital lesions/discharge |
| ☐ | ☐ | Pelvic inflammatory disease |
| ☐ | ☐ | Abnormal pap smear |
| ☐ | ☐ | Irregular periods |
| ☐ | ☐ | Painful menstrual periods |
| ☐ | ☐ | Premenstrual syndrome |
| ☐ | ☐ | Abnormal bleeding |
| ☐ | ☐ | Menopausal syndrome |
| ☐ | ☐ | Breast lumps |
| ☐ | ☐ | Other _____ |

### NEUROLOGICAL

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Tremors |
| ☐ | ☐ | Numbness or tingling of limbs |
| ☐ | ☐ | Concussion |
| ☐ | ☐ | Pain |
| ☐ | ☐ | Paralysis |
| ☐ | ☐ | Other _____ |

### PSYCHOLOGICAL

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Depression |
| ☐ | ☐ | Anxiety/Stress |
| ☐ | ☐ | Irritability |
| ☐ | ☐ | Emotional/Psychological issues |
| ☐ | ☐ | Mania/bipolar |
| ☐ | ☐ | PTSD |
| ☐ | ☐ | Other _____ |

### MALE

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Pain/itching of genitalia |
| ☐ | ☐ | Genital lesions/discharge |
| ☐ | ☐ | Impotence |
| ☐ | ☐ | Weak urinary stream |
| ☐ | ☐ | Lumps in testicles |
| ☐ | ☐ | Prostatitis |
| ☐ | ☐ | Other _____ |

### NOSE, THROAT, AND MOUTH

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Nose bleeds |
| ☐ | ☐ | Sinus infection |
| ☐ | ☐ | Hay fever or allergies |
| ☐ | ☐ | Recurring sore throats |
| ☐ | ☐ | Grinding teeth |
| ☐ | ☐ | Difficulty swallowing |

# American College of Traditional Chinese Medicine Community Clinic
# Initial Health History Form

## Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by the member of the Clinic Medical Staff (Licensed Acupuncturist. Guest Acupuncturist, Student Intern, or Trainee) named below and/ or other member of the Clinic Medical Staff. I have discussed the nature and purpose of my treatment with the member of the Clinic Medical Staff named below.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion. cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have 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 the clinic uses sterile needles and maintains a 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 from plant, animal and mineral 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 during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **Herbal formulas and acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy.**

I understand that the herbs 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 Clinic Medical Staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the Clinic Medical Staff member who is caring for me if I am or become pregnant.

I do not expect the Clinic Medical Staff to be able to anticipate and explain all possible risks and complications of treatment, and 1 wish to rely on the Clinic Medical Staff to exercise judgment during the course of treatment which the Clinic Medical Staff thinks at the lime, based upon the facts then known, is in my best interests.

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

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, 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.

---

To be completed by patient (or by patient's representative if the patient is A minor or is physically or legally incapacitated)

_____
Print Name of Patient

_____
Signature of Patient (or Representative)

_____
(Print Name of Patient or Representative)

_____
Date Consent Completed

To be completed by the member of the Clinic Medical Staff providing information and obtaining consent.

_____
Print Name of Clinic Medical Staff

_____
Signature of Clinic Medical Staff

_____
(Print Name of Witness/Translator)

_____
(Signature of Witness/Translator)

## CONSENT TO USE AND PUBLICATION OF CLINICAL DATA AND CONTENTS OF PATIENT RECORDS FOR STATISTICAL PURPOSES, RESEARCH AND PUBLICATION

I, _____(print patient's name) authorize The American College of Traditional Chinese Medicine and members of its Clinic Medical Staff, faculty and students to review my records for the purpose of collecting statistical data or pertinent clinical information for the purposes of research, publication, education and case review. I give my permission and consent to the publication of statistical and/or clinical data obtained from by records. I understand that all patient records are protected by clinic protocols and confidentiality agreements. I also understand that I will never be identified as the source of this information and that if any particulars of my case are used for the purposes of publication all possible clues to my identity will be disguised or altered. I understand that there is the remote possibility of being accidentally identified as the source of the clinical data but that the way this information is handled makes the risk very small.

_____
Patient Signature

_____
Date Signed

# American College of Traditional Chinese Medicine Community Clinic
# Initial Health History Form

## Notice of Privacy Practices

**Our Pledge Regarding Medical Information:**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. This notice will remain in effect until it is replaced or amended by changes in law.

**Use and Disclosure of Your Medical Information**

We gather personal health information in several ways. This information comes from you, from other healthcare providers, and from third party payers. This section describes different ways that we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. We may use and disclose your medical information in the following ways:

- For treatment
- For payment
- For healthcare operations
- When required by law

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls or mail.

**Patient Rights**

1. Upon written request, you have the right to access, review or receive copies of your health care records. The copy fee is **$15** for onsite charts (an additional **$35** for ones that need to be retrieved offsite). Please allow up to 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4. You have the right to request that we amend your protected health information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office.
Contact: Tracy Tognetti
Telephone 415-282-9603, Ext. 232
Address: 455 Arkansas Street, San Francisco CA 94107
Send written complaints to the U.S. Department of Health and Human Services.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Practices for healthcare services in this office.
This practice has attempted to provide each patient with a statement of Privacy Practices.

Patient Signature _____ Date_____

**Patient's Consent for the Purposes of Treatment, Payment, and Healthcare Operations**

I, _____, give consent to ACTCM Community Clinic to use and disclose my individual identifiable health information or Protected Health Information for the specific purposes of: providing treatment to me, relating to the payment of services this office has rendered to me, and the general administrative operation this practice provides to me.

**Protected Health Information includes:**

- Demographic information
- Information gathered by this practice as it relates to my past, present and future physical or mental health or condition
- Information gathered by this office for past, present or future payments of healthcare services.
- Information used for healthcare operations purposes, including quality assessment activities, credentialing, business management and other general operations procedures or activities.

I understand I have the right to request a restriction on the use and disclosure of my protected health information for the purposes of treatment, payment, and healthcare operations of the clinic, but the clinic is not required to agree to these restrictions. However, if the clinic agrees to a restriction that I request, the restriction is binding to the clinic.

I understand I have the right to read and discuss the Notice of Privacy Practices form before I sign this consent form, regarding the use and disclosures of my protected health information.

I have the right to revoke this consent, in writing, at any time except to the extent that ACTCM Community Clinic has acted in reliance on this consent.

_____ _____

Patient Signature or Personal Representative Date

_____ _____

Description of Personal Representative's Authority Date