



PATIENT INTAKE FORM

Personal Information:

Date Completed: ___/___/_____

Name: _____ Social Security #: ___ - ___ - _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: () _____ Cell Phone: () _____

May we leave messages on your home phone? __Yes __No

E-Mail Address: _____

Marital Status: __Single __Married __Divorced __Partnership __Widowed

Gender: __Male __Female

Date of Birth: _____

Age (years completed): _____

Parent/Partner's Name: _____

of children: _____

Employer: _____

[___ Retired]

Occupation: _____

Work Phone: () _____

Emergency Contact Information:

Name: _____

Relationship to you: _____

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Referral Information:

Who referred you to the Invisible Grace Acupuncture Clinic?

Please Note:

* Payment is expected at the time of service.

* You are responsible for billing your primary insurance company.



POLICIES AND REQUESTS

- We require payment in full for all services rendered and medicinal items purchased at the time of visit.
- If you are unable to keep your appointment, **PLEASE GIVE US AT LEAST 48 HOURS NOTICE.** If you fail to keep your appointment or cancel without 48 hours prior notice, you will be billed at the discretion of your practitioner.

Initial here to acknowledge that you have read and understand the Invisible Grace Acupuncture Clinic cancellation and payment policies.

- Many of our patients are extremely sensitive to perfumes and scents. Please refrain from wearing them during your office visits.

Thank you.

Statement of Financial Responsibility and Consent for Treatment

I, the undersigned, certify that I am financially responsible for all charges for services and medicinal products provided to me (or my dependent) by Invisible Grace Acupuncture Clinic.

- In addition, I acknowledge that payment is due at the time of each visit.
- In the event that my account becomes more than ninety days past due, I agree to pay interest at the rate of 1.5% per month, or a minimum of \$10.00 per month until such time my account is paid in full.
- I also agree to pay for any reasonable attorney fees and expenses incurred in collecting all sums not paid when due.

I acknowledge that the Invisible Grace Acupuncture Clinic will **NOT** bill my insurance company directly and that I am entitled to submit insurance claims independently. Should my insurance company need my health care information to process my claim, I hereby authorize the Invisible Grace Acupuncture Clinic to release any and all information necessary to secure the payment of benefits to me.

My signature is an acknowledgement that:

- 1) I have read the policies listed above and agree to abide by the same; and
- 2) that I voluntarily consent to receive treatment from the practitioners of the Invisible Grace Acupuncture Clinic.

Signature of Patient or Responsible Party Date

Relationship to Patient (if applicable) Date



I, _____, consent to the use or disclosure of my protected health information by Gwen LoVetere, L.Ac., M.Ac.O.M. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care operations of Gwen LoVetere, L.Ac., M.Ac.O.M. I understand that diagnosis or treatment of me by Gwen LoVetere, L.Ac., M.Ac.O.M may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the health care operations of the practice. Gwen LoVetere, L.Ac., M.Ac.O.M.is not required to agree to the restrictions that I may request, however, if Gwen LoVetere, L.Ac., M.Ac.O.M. agrees to a restriction that I request, that restriction is binding.

Protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Healing Path Holistic Medicine Clinics notice of Privacy Practices prior to signing this document and a copy of the Privacy Practices document has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Gwen LoVetere, L.Ac., M.Ac.O.M. with respect to my protected health information.

Gwen LoVetere, L.Ac., M.Ac.O.M. reserves the right to change the privacy practices that are described in the notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the HIPPA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Gwen LoVetere, L.Ac., M.Ac.O.M. reserves the right to leave a message on the patient’s home answering machine/recorder. As the patient, I consent to this right.

I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Description of Personal Representative Authority

Date



CURRENT HEALTH HISTORY

Main Purpose of this Appointment:

To what extent does this problem interfere you're your daily activities? [work, sleep, exercise, sex, etc.]

Major Current Health Concerns:

Other treatments you have received for theses conditions: *(please circle all that apply)*

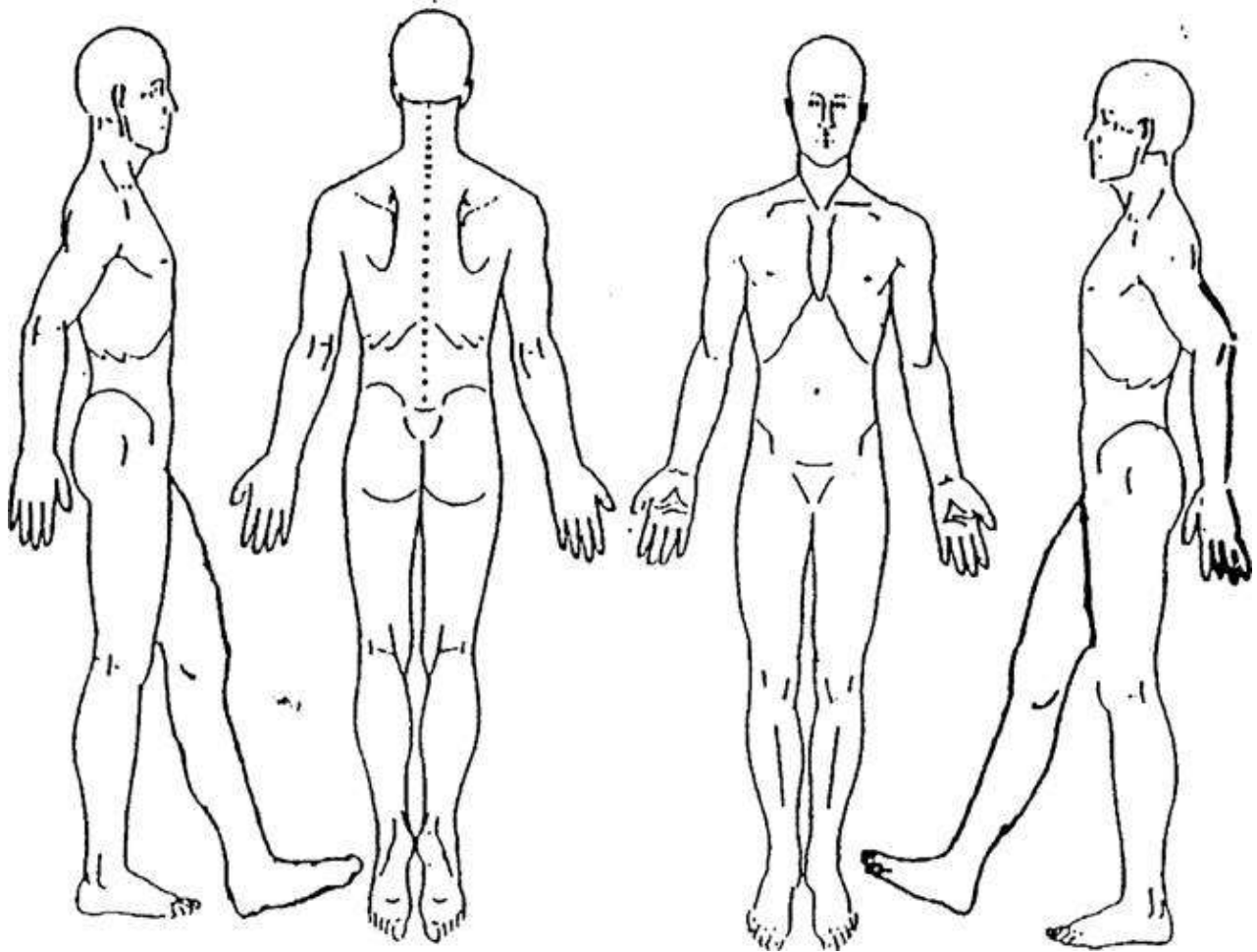
- Acupuncture Chiropractic Homeopathic MD Massage Naturopathic Osteopathy Shiatsu

Are there others in the family with the same condition? __Yes __No

If Yes, please explain: _____

Please list all medications, herbs, supplements, home remedies, etc. that you are taking *(please include amount, frequency and duration)*:

PLEASE INDICATE YOUR AREAS OF DISCOMFORT OR PAIN



Please briefly describe your pain (type, frequency, severity, duration):



HEALTH HISTORY

Have you been treated for any health conditions during the last 12 months? No Yes

If Yes, please explain:

PLEASE SPECIFY

History of Major Illnesses/Injuries/Trauma (include dates): None

Allergies (drugs, chemicals, foods, etc.): None

Family history of cancer - who/type: None

Currently:

Do you smoke or chew any tobacco products? No
 Yes, (what, how much per day?) _____

If you are a former tobacco user,
what was your former usage & when did you quit? _____

Are you routinely exposed to second-hand smoke? No
 Yes, (what, how much per day?) _____

Do you drink alcohol? No Yes, (what, how much per day?) _____

Do you drink caffeinated beverages? No
 Yes, (what, how much per day?) _____

Do you use any 'recreational' drugs? No Yes, (what, how much per day?) _____



MALES ONLY

Prostate concerns (PSA level, if applicable): _____ No Yes

Painful/excessive/decreasing urination: No Yes

Discolored urine: No Yes

Impotence: No Yes

Any other male, or other concerns, not addressed: No Yes

If Yes, please explain:



FEMALES ONLY

(Check all the conditions that apply to you)

- Menstrual irregularity Menstrual cramping Discharge between cycles
- PMS Breast lumps/pain Vaginal dryness
- Vaginal pain/infections Genital herpes Sexual dysfunction

Date of last Pap: _____

Date of last mammogram: _____

Age Menstruation started: ____

Days between cycles: ____ Usual days of flow: ____

Typical Flow: __Light __Medium __Heavy

Date of last menstruation: _____

Menopause completed? __Yes __No

Have you ever used birth control pills? __Yes __No

Please list all contraception methods ever used:

Current method(s): _____

Please list:

- number of pregnancies: ____
- number of live births: ____
- number of abortions: ____
- number of D&C's: ____
- number of Cesareans: ____

Hysterectomy, date of surgery: _____

Any other female, or other concerns, not addressed? __Yes __No

If Yes, please explain:



PRENATAL, INFANCY & CHILDHOOD HISTORY

Please provide as much information as you have available. Talk to family members to fill in gaps. Much of this information is frequently available as family stories.

For each question, check Yes, No, or Unsure, and add as much detail as you can.

A. PRIOR TO YOUR BIRTH:

Did your father drink excessive amounts of alcohol during the three month period prior to or during your conception? Yes No Unsure

If Yes, please describe

Did your mother drink excessive amounts of alcohol during the three month period prior to or during your conception? Yes No Unsure

If Yes, please describe

Parents' age at your conception: Mother Father

Did your mother have a prior history of miscarriages? Yes No Unsure

If Yes, please describe.

Was your mother exposed to toxins (e.g., chemicals at work or at home, etc.) around the time of your conception? Yes No Unsure

If Yes, please describe.



B. DURING YOUR MOTHER'S PREGNANCY:

Did your mother have any illnesses? Yes No Unsure

If Yes, please describe.

Did she have adequate nutrition? Yes No Unsure

If Yes, please describe

Did she experience any emotional shocks or stresses (e.g., death of someone close, loss of job, break-up of marriage)? Yes No Unsure

If Yes, please describe

Was she on any medications other than vitamins and mineral supplements? Yes No Unsure

If Yes, list those known.

During the pregnancy did she use: alcohol nicotine other drugs (specify) _____

Did she spend significant time in the presence of a smoker? Yes No Unsure

Describe any other conditions or habits that might have affected the pregnancy.

C. DELIVERY:

Was your birth: Early On Time Late Unsure

How early/late? _____

Nature of birth: Vaginal Cesarean

Was labor: Natural onset Induced Unsure

If induced, by what method? _____

Was the birth traumatic to you and/or your mother (e.g., high forceps)? Yes No Unsure

If Yes, please describe.

Was your mother medicated during delivery? Yes No Unsure

If Yes, please describe.

Describe any unusual circumstances surrounding your birth (e.g., breech, cord around neck, placenta previa).

At birth: Weight _____ lb., oz. Length _____ in.

Were you or your mother kept in the hospital beyond the usual post-delivery period? Yes No

If Yes, describe reason.

Were you placed in an incubator after birth? Yes No

If Yes, for what reason and how long?

D. YOUR INFANCY: (from birth to age one)

What was your general state of health at birth and during the first few months of your life?

Good Fair Poor Describe problems: _____

Were you: breastfed bottle fed combination

If breastfed exclusively, for how long? _____

Describe any special information about your nutrition as an infant. _____

Were there any emotional traumas in your infancy, either to you or to other members of your close family?

Yes No Unsure If Yes, describe them. _____



What were your early sleep patterns? _____

Did you have colic? _____

Other illnesses, hospitalizations, surgery, or traumas, during your infancy? (Please describe)

E. CHILDHOOD [ages one through 12]

Did you have any of the following recurring health problems in childhood?

- Earaches Yes No Unsure
- Colds and sore throats Yes No Unsure
- Digestive problems Yes No Unsure
- Musculoskeletal problems Yes No Unsure
- Developmental problems Yes No Unsure
- Others: Yes No Unsure

If Yes, please describe.

Any major illnesses other than the usual childhood illnesses? Yes No Unsure

If Yes, please describe. _____

In childhood, did you experience any trauma or abuse (please check all that apply):
 physical emotional sexual

If so, please describe briefly, including your age at that time.

Were you able to engage in normal physical activities commensurate with your age?
 Yes No Unsure

If No, please describe. _____

Did you have any learning disabilities during childhood?
 Yes No Unsure

If Yes, please describe disability. _____

Describe your general relationships with other children. _____



F. FAMILY HISTORY

Total number of siblings _____ [___brothers ___sisters]

What was your position (birth order) among them? _____

List the number of years between the oldest and youngest sibling. _____

Please list the major illnesses among your brothers and sisters, include age at death, if appropriate..

G. GENERAL COMMENTS

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