

THREE RIVERS CLINIC, INC.

A Center for Healing

Patient Information

Date _____

First Name _____ M.I. _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell (_____) _____ E-mail _____

Birthdate _____ Life Status (S W M D G B L T) Partner's Name _____

of Children _____ Occupation _____ Employer _____

Please Circle: INSURANCE or CASH/CHECK **WE DO NOT ACCEPT CREDIT CARDS**

How did you hear about our clinic (if friend, please write name)? _____

HealthPartners Referring Clinic: _____

HealthPartners Referring Doctor: _____

Insurance Information (Please fill in one of the below areas)

1) Private Insurance: Please give your health insurance card to the front desk.

2) Auto Accident/Personal Injury: Company Name _____

Company Address _____

Claim Representative's Name _____ Phone (_____) _____

Date of Accident _____ Name of Insured _____

Relationship of Insured to Patient _____ Claim No _____

3) Worker's Compensation: Date of Injury _____ Claim No _____

Employer _____ Position _____

Contact at Workplace _____ Phone (_____) _____

4) Attorney: Name _____ Phone (_____) _____

HEALTH HISTORY QUESTIONNAIRE

1

Name _____	Date _____	
Age _____	Height _____	Weight _____
Relationship Status: Single _____	Married/Life Partner _____	Other _____
Family Physician _____		
Other Health Care Providers: _____		

MAIN PROBLEM YOU WOULD LIKE TO ADDRESS: _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? _____

Is so, what is it? _____

Do you have other current problems? Describe them. _____

What kinds of treatment have you tried? _____

What medications, vitamins, or other treatments are you now taking/doing? _____

PAST MEDICAL HISTORY (indicate how long you have had symptom on the line after the symptom):

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Venereal Disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Rheumatic Fever _____ | |
| <input type="checkbox"/> Other significant Illnesses (describe) _____ | | |

OTHER RELEVANT MEDICAL HISTORY (including illnesses, childhood and other, and accidents):

FAMILY MEDICAL HISTORY (indicate who had the symptom on the line after the symptom):

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Other _____ |

OCCUPATION: _____

Occupational stress factors (physical, psychological, chemical): _____

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, please describe: _____

Please describe your average daily diet: _____

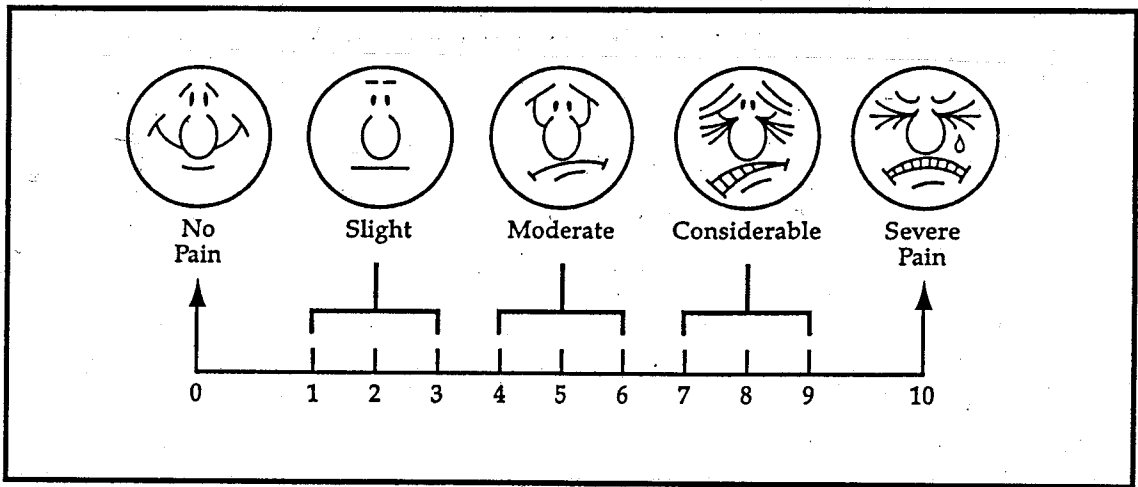
Please check any of the following habits that apply. Indicate how much and how often you consume them:

- Cigarette smoking _____
- Coffee, tea, or cola _____
- Alcoholic beverages _____
- Sugar _____
- Other _____

Please describe any use of drugs for non-medical purposes: _____

Living Situation: Alone With Family or Partner Housemates

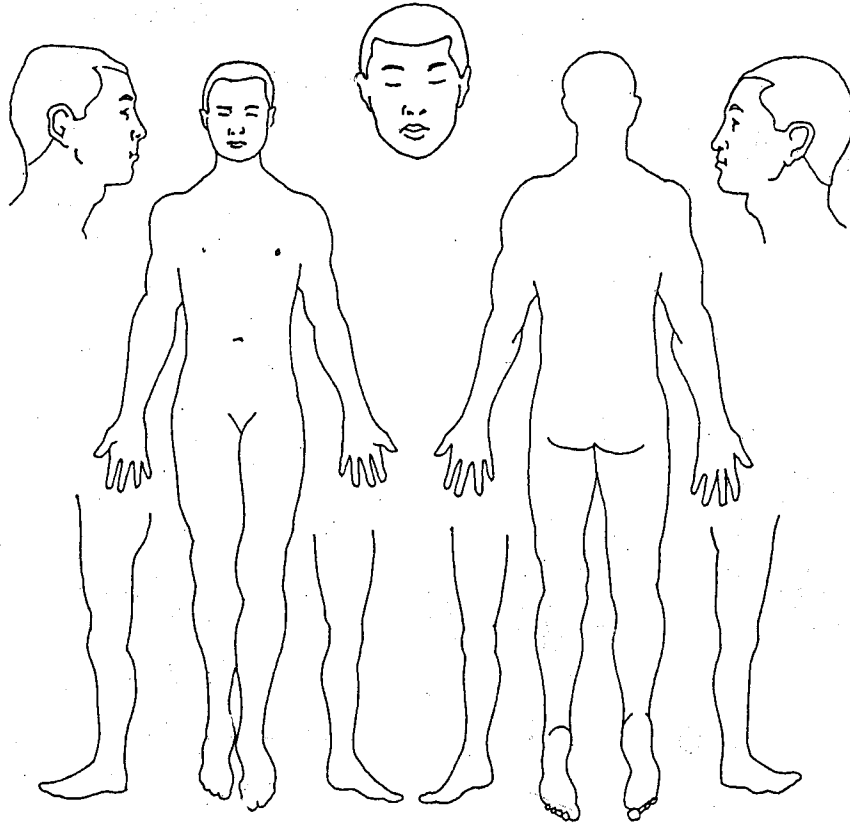
MUSCULOSKELETAL:



Below, please check off the areas of pain you experience and **rate the pain** according to the above pain scale (enter number from the scale after the symptom you experience). Then describe your pain (constant, intermittent, radiating, burning, shooting, stinging, tingling, throbbing, aching, stabbing, sharp, dull, fixed location, moves round, etc.) and also describe what makes the pain change (heat, cold, damp, dry, weather changes, rest or activity, foods or beverages, positions, etc.). Give as much information as possible:

- Neck pain _____
- Back pain/where? _____
- Areas numbness or tingling _____
- Stiffness/limitation movement _____
- Muscle pains/aches _____
- Muscle weakness _____
- Shoulder pains _____
- Muscle spasm _____
- Knee pain _____
- Foot/ankle pains _____
- Hip pain _____
- Hand/wrist pains _____

INDICATE PAINFUL OR DISTRESSED AREAS:



HEADACHE

Headaches? Yes _____ No _____ Migraines _____ Tension Headache _____ Other _____
 How long have you had these symptoms? _____
 On a scale of 1-10 (with 10 being the most severe pain) please note the range of severity _____
 How often do you have these headaches? _____
 Please describe the location and nature of the pain _____
 What makes the headache worse? _____ Better? _____
 Are there things that trigger your headache (foods, hormones, smells, etc.)? _____
 Do you use medication and if so, what? _____

QUALITY OF LIFE ASSESSMENT:

	<u>0=</u>	<u>Pre-treatment testing</u>					<u>5=</u>	
Stress	no stress	0	1	2	3	4	5	extreme stress
Sleeping	little or no sleep	0	1	2	3	4	5	restful sleep
Depression	no depression	0	1	2	3	4	5	severe depression
Overall energy	extreme fatigue	0	1	2	3	4	5	good balanced energy
Anxiety	no anxiety	0	1	2	3	4	5	extreme anxiety
Sense of well-being	discontent	0	1	2	3	4	5	extremely satisfied
Ability to conduct daily activities at home	poor	0	1	2	3	4	5	excellent
Ability to work outside of the home	poor	0	1	2	3	4	5	excellent
Overall emotional state	poor	0	1	2	3	4	5	excellent

Using the Point Scale below, rate each of the following symptoms (in the box) based upon your typical health profile. Also, please indicate the length of time you have had each condition on the line following the symptom.

POINT SCALE

- 0—*Almost never* have the symptom
 1—*Occasionally* have it, effect is *not severe*
 2—*Occasionally* have it, effect is *severe*
 3—*Frequently* have it, effect is *not severe*
 4—*Frequently* have it, effect is *severe*

GENERAL:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fatigue _____ | <input type="checkbox"/> Hyperactivity _____ | <input type="checkbox"/> Restlessness/hyperactive _____ |
| <input type="checkbox"/> Poor appetite _____ | <input type="checkbox"/> Insomnia _____ | <input type="checkbox"/> Strong thirst _____ |
| <input type="checkbox"/> Weight gain _____ | <input type="checkbox"/> Tremors _____ | <input type="checkbox"/> Bleeding or bruising easily _____ |
| <input type="checkbox"/> Night sweats _____ | <input type="checkbox"/> Fever _____ | <input type="checkbox"/> Chills _____ |
| <input type="checkbox"/> Sudden energy drop (time of day?) _____ | <input type="checkbox"/> Poor balance _____ | |
| <input type="checkbox"/> Do you wake feeling rested? _____ | | |

Other unusual or abnormal conditions you have noticed in your general sense of health? _____

SKIN AND HAIR:

- | | | |
|--|--|--|
| <input type="checkbox"/> Rashes _____ | <input type="checkbox"/> Ulcerations _____ | <input type="checkbox"/> Hives _____ |
| <input type="checkbox"/> Itching _____ | <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Pimples _____ |
| <input type="checkbox"/> Dandruff _____ | <input type="checkbox"/> Dryness _____ | <input type="checkbox"/> Psoriasis _____ |
| <input type="checkbox"/> Hair Loss _____ | <input type="checkbox"/> Changes in hair or skin texture _____ | |

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT:

- | | | |
|---|--|---|
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Concussions _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Poor Vision _____ | <input type="checkbox"/> Spots in front of eyes _____ | <input type="checkbox"/> Eye pain _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Night blindness _____ | <input type="checkbox"/> Watery or itchy eyes _____ |
| <input type="checkbox"/> Blurry vision _____ | <input type="checkbox"/> Eyestrain _____ | <input type="checkbox"/> Dark circles/bags under eyes _____ |
| <input type="checkbox"/> Ringing in ears _____ | <input type="checkbox"/> Poor hearing _____ | <input type="checkbox"/> Earaches/ear infections _____ |
| <input type="checkbox"/> Itchy ears _____ | <input type="checkbox"/> Recurrent sore throats _____ | <input type="checkbox"/> Swollen/tender glands _____ |
| <input type="checkbox"/> Stuffy nose _____ | <input type="checkbox"/> Sneezing attacks _____ | <input type="checkbox"/> Excessive mucous _____ |
| <input type="checkbox"/> Hay fever _____ | <input type="checkbox"/> Post nasal drainage _____ | <input type="checkbox"/> Sinus problems _____ |
| <input type="checkbox"/> Grinding teeth _____ | <input type="checkbox"/> Sores on lips or tongue _____ | <input type="checkbox"/> Facial pain _____ |
| <input type="checkbox"/> Teeth problems _____ | <input type="checkbox"/> Jaw clicks _____ | |
| <input type="checkbox"/> Difficulty swallowing or gagging _____ | | |

Any other head or neck problems? _____

POINT SCALE

- 0—*Almost never* have the symptom
 1—*Occasionally* have it, effect is *not severe*
 2—*Occasionally* have it, effect is *severe*
 3—*Frequently* have it, effect is *not severe*
 4—*Frequently* have it, effect is *severe*

CARDIOVASCULAR:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness_____ | <input type="checkbox"/> Low blood pressure_____ | <input type="checkbox"/> Chest pain_____ |
| <input type="checkbox"/> Irregular heartbeat_____ | <input type="checkbox"/> High blood pressure_____ | <input type="checkbox"/> Fainting_____ |
| <input type="checkbox"/> Cold hands/feet_____ | <input type="checkbox"/> Swelling of hands_____ | <input type="checkbox"/> Swelling of feet_____ |
| <input type="checkbox"/> Blood clots_____ | <input type="checkbox"/> Shortness of breath_____ | <input type="checkbox"/> Phlebitis_____ |
| <input type="checkbox"/> Rapid or pounding heart beat_____ | | |

Any other heart or blood vessel problems? _____

RESPIRATORY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cough_____ | <input type="checkbox"/> Coughing up blood_____ | <input type="checkbox"/> Asthma_____ |
| <input type="checkbox"/> Bronchitis_____ | <input type="checkbox"/> Pain w/deep inhalation_____ | <input type="checkbox"/> Pneumonia_____ |
| <input type="checkbox"/> Frequent colds_____ | <input type="checkbox"/> Respiratory allergies_____ | <input type="checkbox"/> Difficulty breathing_____ |
| <input type="checkbox"/> Production of phlegm (color?)_____ | | |

Any other lung problems? _____

GASTROINTESTINAL:

- | | | |
|--|---|---|
| <input type="checkbox"/> Nausea_____ | <input type="checkbox"/> Vomiting_____ | <input type="checkbox"/> Diarrhea_____ |
| <input type="checkbox"/> Constipation_____ | <input type="checkbox"/> Gas_____ | <input type="checkbox"/> Belching_____ |
| <input type="checkbox"/> Black stools_____ | <input type="checkbox"/> Blood in stools_____ | <input type="checkbox"/> Indigestion_____ |
| <input type="checkbox"/> Bad breath_____ | <input type="checkbox"/> Rectal pain_____ | <input type="checkbox"/> Hemorrhoids_____ |
| <input type="checkbox"/> Food allergies_____ | <input type="checkbox"/> Chronic laxative use_____ | <input type="checkbox"/> Bloating_____ |
| <input type="checkbox"/> Binge eating/drinking_____ | <input type="checkbox"/> Craving certain foods_____ | <input type="checkbox"/> Compulsive eating_____ |
| <input type="checkbox"/> Eating restriction_____ | <input type="checkbox"/> Water retention_____ | |
| <input type="checkbox"/> Abdominal pain or cramps_____ | | |

Any other problems with stomach or intestines? _____

GENITO-URINARY:

- | | | |
|---|--|---|
| <input type="checkbox"/> Pain/burning urination_____ | <input type="checkbox"/> Frequent urination_____ | <input type="checkbox"/> Blood in urine_____ |
| <input type="checkbox"/> Urgency to urinate_____ | <input type="checkbox"/> Unable to hold urine_____ | <input type="checkbox"/> Kidney stones_____ |
| <input type="checkbox"/> Decrease in flow_____ | <input type="checkbox"/> Sexual difficulties_____ | <input type="checkbox"/> Sores on genitals_____ |
| <input type="checkbox"/> Vaginal pain or burning_____ | <input type="checkbox"/> Prostate trouble_____ | |
| <input type="checkbox"/> Discharge from penis/vagina_____ | | |

Do you wake at night to urinate? _____ If so, how often? _____

Any particular color to your urine? _____

Any other problems with your genital or urinary functions? _____

CONSENT FOR TREATMENT

I understand that the scope of practice of acupuncturists according to Minnesota State Law includes, but is not limited to, the following forms of therapy which all have benefits for specific types of problems:

USING ORIENTAL MEDICAL THEORY TO ASSESS AND DIAGNOSE A PATIENT; AND USING ORIENTAL MEDICAL THEORY TO DEVELOP A PLAN TO TREAT A PATIENT.

TREATMENT TECHNIQUES MAY INCLUDE:

- ❖ insertion of sterile acupuncture needles through the skin
- ❖ acupuncture stimulation including, but not limited to, electrical stimulation or the use of moxibustion
- ❖ cupping
- ❖ dermal friction
- ❖ acupressure
- ❖ herbal therapies
- ❖ dietary counseling based on Traditional Oriental Medical principles
- ❖ breathing techniques
- ❖ exercise according to Oriental Medical principles

RISKS OF THE ABOVE FORMS OF THERAPY INCLUDE:

- ❖ acupuncture needles inserted into the skin can cause pain or discomfort, bruising, infection, risks of feeling weak, fainting or nausea, and of broken needles.
- ❖ electro-acupuncture can cause some conditions to worsen. It should be used with caution in cases where the patient has a heart condition. It should not be used across the midline of the body.
- ❖ moxibustion can cause burns when used in areas with compromised sensation and/or circulation or when improperly used.
- ❖ acupressure, cupping and massage may cause bruising and/or soreness.
- ❖ herbs have different properties and may have adverse reactions/side effects if improperly used.

CONSENT FOR TREATMENT continued

I hereby acknowledge that I have been advised of the benefits and risks of acupuncture and associated methods used in this practice. I understand these risks and benefits and consent to accept treatment using these methods. I agree to release below named acupuncturist from all legal responsibility for practices done here except in the case of negligence or unsafe practice on the part of said acupuncturist. I am aware that other modalities of healing which may be used during my treatment may include hypnotherapy, visualization, guided imagery, and Healing Touch.

I understand that Vicky Radel and Karen Nielsen have completed formal programs of study, are NCCAOM certified (National Commission for the Certification of Acupuncturists and Oriental Medicine), and are licensed in the State of Minnesota as acupuncturists. Vicky Radel is also MN Licensed R.N.

I do / do not have a pacemaker or bleeding disorder.

I have been / have not been examined by a physician or other licensed health care provider. (You are advised to see your physician about the problem for which you have come here to be treated.)

Client Signature

Date

Vicky Radel, R.N., L.Ac.

Date

Karen Nielsen, L.Ac.

Victoria Huitt, L.Ac.

Shannon Moy, L. Ac.

Carrie Beckman, L. Ac.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your right concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient understands and agrees to allow this office to contact them by telephone, mail, or e-mail with appointment reminders, information about our clinic facilities, treatment alternatives, and other health-related information that may be of interest to them.
3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the clinic will not be able to submit claims to insurance carriers or other third party payers and the health care provider has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Printed Name

Signature

Date