rev 2.6.17

Red Earth
Acupuncture and Oriental Medicine

Restoring your body's ability to heal...

Your Confidential Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone #: _____ (**Please circle**: home/mobile/work)

Secondary Phone #: _____ (**Please circle**: home/mobile/work)

E-Mail:_____

Preference for reminders: Email/Text /Phone Call **For text reminders, list your mobile provider:** _

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____

Who referred you or how did you hear about Red Earth Acupuncture and Oriental Medicine? _____

Who is your primary care physician? _____

Employer: _____ **Position:** _____

Employer Address: _____

Spouse/Parent Information:

First Name: _____ **Last Name:** _____ **DOB:** _____

Occupation: _____ **Employer:** _____

Home/Work # _____ **Mobile #**_____ **E-Mail:**_____

Patient Name: _____

How would you rate your current health? (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your level of energy? (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Concerns

List below how you want us to help you, in order of importance?
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Medical History

	Yes	No	If so, where?
Have you ever had Acupuncture?			

Please place a check (✓) in response to each question as it **currently** applies to you.

Energy Level

Yes	No		Yes	No	
		Do you fatigue easily?			Do you have cold feet?
		Do you need to take naps?			Do you have cold hands?
		Do you generally feel cold?			Do you wake up sweating at night?

Patient Name: _____

Please list all medication and herbal products that you are currently taking including both prescription and natural medicines (herbs, homeopathies, vitamins, nutritional supplements).

Medication	Dosage	Reason	Began

Any drug allergies? Yes _____ No _____ If yes, please identify:

Patient Name: _____

Sleep

How long does it take you to fall asleep?
What time do you typically fall asleep?
How many times do wake up at night?
What time do you typically wake up?
Do you feel rested in the morning? Yes _____ No _____

Please place a check (✓) in response to each question as it **currently** applies to you.

Appetite and Taste	Yes	No
Has your appetite altered recently?		
Do you have a poor appetite?		
Do you have poor digestion?		
Do you experience acid reflux?		
Do you have epigastric (stomach) distention?		
Do you have abdominal (large intestine) distention?		
Are you experiencing belching?		
Do you tend to binge eat and/or purge?		
Do you exhibit symptoms of anorexia nervosa?		
Do you have flatulence (gas)?		
What is your preferred taste? **Please Circle:** Salty Sour Bitter Sweet Spicy		
Do you have cravings? **Please list:**		
What is (are) your favorite food(s)? **Please list:**		

Patient Name: _____

Please estimate the percentage (%) of your daily diet. The total should equal 100%.

0 - 100%	Category
	Animal products (eggs, meat, poultry, fish, wild meat or birds, etc.)
	Dairy products (cheese, milk, cream, etc.)
	Vegetables
	Fruit
	Grains (Non processed grains and white or brown rice)
	Refined Carbohydrates (processed grains and flours)
	Legumes (beans, lentils, peas)
	Snacks (chips, pretzels, energy bars, etc)
	Processed foods (Fast food, prepackaged, etc.)
100%	**TOTAL**

List any food sensitivities or allergies.

Food	Reaction

Patient Name: _____

Please place a check (✓) in response to each question as it **currently** applies to you.

Yes	No	Thirst
		Do you have excessive thirst?
		Do you experience a lack of thirst?

Approximately how many glasses of water do you drink a day? _____

Are your stools:	**Yes**	**No**
Normal (daily with consistent shape and size)?		
Hard (small or large and/or pellet-like)?		
Loose (possibly with undigested food)?		
Erratic (sometimes hard and sometimes loose)?		
Do you have bowel movements fewer than five (5) times a week?		
Do you experience chronic constipation?		
Do you experience chronic diarrhea?		
Do you experience urgency before a bowel movement?		
Is there ever blood and puss (mucus) in your stool?		
Do you have hemorrhoids?		

Emotions

Do you experience **excessive**:		
Anger _____ Sadness _____ Worry _____ Fear _____ Anxiety _____	**Yes**	**No**
Do you experience mood swings?		

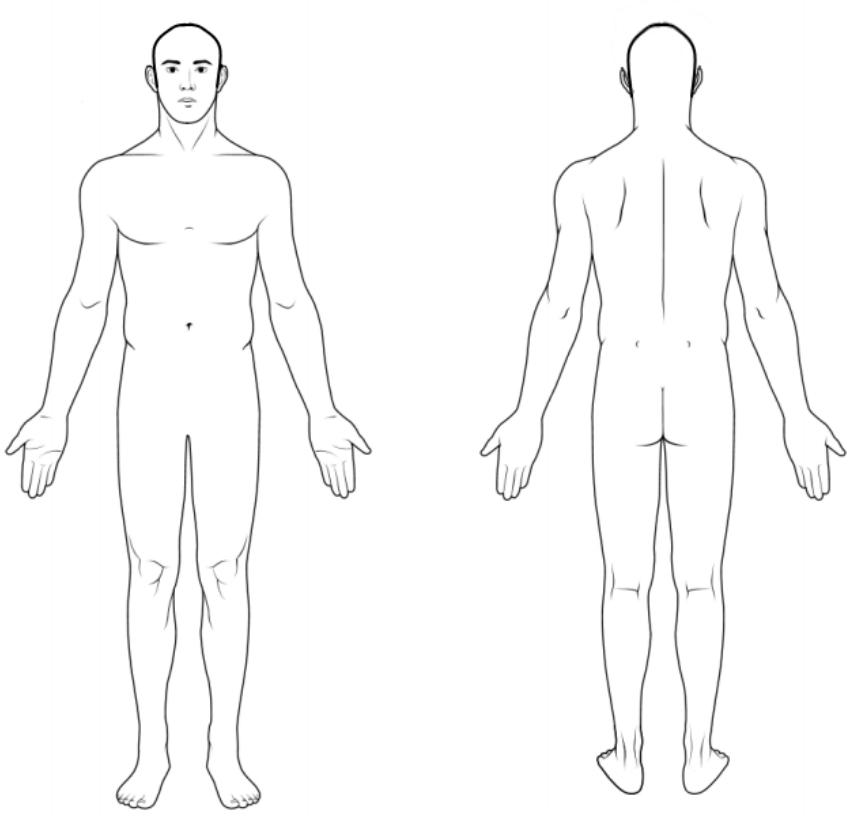
Exercise

In what type of exercise do you engage?	
How many days a week do you exercise?	
How do you feel after you exercise?	
Do you feel compelled to exercise? Yes _____ No _____	

Patient Name: _____

Pain

Please indicate where you are experiencing pain or discomfort:



Do you suffer from:			
Describe		**Describe**	
Back pain?		Muscle weakness?	
Neck aches?		Muscle Cramps?	
Joint pain?		Abdominal cramps?	
Muscle aches?		Tendon pain?	
Numbness?		Other?	

Patient Name: _____

Please indicate with a check (✓) if you now have or have had any of the following symptoms or issues.

Now	Past		Now	Past		Now	Past	
		Allergies			Frequent colds			Mental illness
		Anemia			Hay Fever			Mononucleosis
		Anxiety			Dizziness, vertigo			Venereal disease
		Arthritis			Edema			Ulcers
		Asthma			Head injury			Gallstones
		Bruising easily			Headache			Nose Bleeds
		Cancer			Heart murmur			Numbness
		Candida			Heart Palpitation			Prostate issues
		Cholesterol			Hepatitis Type: __			Sciatic pain
		Chronic fatigue			Herpes			TMJ
		Constipation			Hypertension			Vision issues
		Depression			Hypothyroidism			- near sighted
		Diabetes			Kidney Stones			- far sighted
		Diarrhea			Low sex drive			use glasses
		Digestive problems						

Patient Name: _____

Women Specific

Menstrual History

1. Onset of Menstruation? Age:		
2. Length of Cycle (number of days from beginning of each cycle)?		
3. **Please place a check (✓) in response to each question as it currently applies to you.**	**Yes**	**No**
Is your period regular?		
Is your ovulation painful?		
Is the length of your period greater than five (5) days?		
Is the length of your period less than five (5) days?		
Is your flow excessive?		
Is your flow scanty?		
Do you discharge clots?		
Do you get headaches during menstruation or ovulation?		
Do you experience pre-menstrual syndrome (PMS)?		
Please list any other menstrual issues you are experiencing:		

Patient Name: _____

Gynecological History

Are you presently pregnant?	Please indicate with a check (✓) whether you experience the following issues.		
Yes ____ No ____ Due date: _____	Do you have a history of:	**Yes**	**No**
Previous pregnancies?	Amenorrhea (no period)		
Number of live birth: _____	Chronic yeast infections		
Full term: _____	Ectopic pregnancy		
Preterm: _____	Endometriosis		
Number of miscarriages: _____	Irregular periods		
Do you have difficulty getting pregnant?	Partner's Male sub-fertility		
Yes ____ No ____	Menstrual cramps		
Did you have difficulty after childbirth?	Miscarriage		
Yes ____ No ____	Ovarian cyst		
Have you experiences postpartum depression?	Pelvic Inflammatory Disease		
	Polycystic Ovarian Syndrome		
Yes ____ No ____	Endometrial thickness (lining)		
If yes, please indicate the date(s): _____	Uterine fibriods		
_____ _____ _____	Excessive vaginal discharge		
Have you completed menopause?	Painful intercourse		
If yes, please indicate # of years post: _____	Urinary tract infections (UTI)		
Have you had a hysterectomy?			
If yes, please indicate date: _____			

Patient Name: _____

Men Specific

Please place a check (✓) in response to each question as it currently applies to you.	Yes	No
Do you regularly have a morning erection?		
Do you experience the following?		
Prostate issues		
Difficulty urinating		
Dribbling after urination		
Diminished libido		
Excess libido		
Difficulty achieving an erection		
Difficulty maintaining an erection		
Premature ejaculation		
Nocturnal emission		
Spermatorrhea (involuntary discharge)		
Pain on the inside of the legs or heels		
Feeling of incomplete bowel evacuation		
Lack of energy		
Migrating aches and pains		
Avoid activity		
Leg nervousness at night		
Please list any other urinary and or genital issues you are experiencing:		

Patient Name: _____

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Hill Country Health, LLC dba Red Earth Acupuncture and Oriental Medicine Clinic** (hereafter Red Earth Acupuncture) may use and disclose health information [treatment, payment or healthcare operations (TPO)] about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Red Earth Acupuncture** Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Red Earth Acupuncture** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Red Earth Acupuncture** at **1836 Hwy 54 W, Fayetteville, GA 30214**.

With my consent, **Red Earth 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 T PO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Red Earth Acupuncture** may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, **Red Earth Acupuncture** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Red Earth Acupuncture** restricts how it uses or discloses my Protected Health Information (PHI) to carry out TPO.

By signing this form, I am consenting to **Red Earth 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, **Red Earth Acupuncture** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

Patient Name: _____

Office Policies

Fees
Acupuncture and Moxibustion Therapies with David Toone L.A.c.
Initial Visit, consultation, diagnosis and treatment: $165
Follow-up Visits: Adults: $97; Children (ages 10 and under): $50

Acupuncture and Moxibustion Therapies with Rawls Whittlesey L.Ac.
Initial Visit, consultation, diagnosis and treatment: $135
Follow-up Visits: Adults: $85; Children (ages 10 and under): $45

Herbal Therapies
Herbal Consult with David Toone: $45
Herbal Consult with David Toone, while being treated by Rawls Whittlesey: $25
Adult: Tier 1 herbs $10/day, Tier 2 herbs $15/day
Children: Tier 1 herbs $5/day, Tier 2 herbs $7.50/day

Making Appointments: For healing to be most effective, a series of visits is usually necessary. We advise that you schedule in advance to ensure continuity of appointments.

Cancellation Policy: Missed appointments without prior notification are subject to a late cancellation fee, equaling 50% of the visit charge. If possible, please provide a 24-hour advance cancellation notice so that we may staff the office properly and that other patients can be helped in that time slot.

Payment Policy: We charge for services provided. Payment is due at the time of service. We accept cash, checks, Visa, Master Card, American Express, Discover and HSA cards. Returned checks are charged a $10 fee.

Insurance: We provide a Superbill, which contains the information you need to submit a claim for reimbursement to your insurance carrier. Please check with your insurance carrier to determine if acupuncture is covered under your plan. Payment is due at the time of services. Please note we do not know of any herbal therapies that are covered under insurance at this time.

Childcare Policy: We do not offer childcare in the clinic. However, we are a child-friendly practice. Please do not leave children unattended if they are very young or may become disruptive.

Change of Address: Please notify us when your address or phone number changes as soon as possible.

Mobile Phones: Please turn off your cell phones before entering treatment rooms.

_____ _____
Patient Name (Please Print) Relationship to Patient

_____ _____
Patient Signature (or Guardian if Patient is a minor) Date