BEAVERTON LUPIN ACUPUNCTURE

NATALIA PAPAZIAN, L.Ac, license 170022

Phone :(503) 803 5040

PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name _____ Date of Birth _____ Age _____

Address _____ City & State _____ Zip _____

Email _____ Phone (H) _____ (C) _____

Occupation & Employer _____

Relationship status: _____ Name of Partner _____

Emergency Contact Name & Phone _____

Primary Care Physician Name & Phone

_____

Are you currently under their care? [ ] Yes [ ] No

Are you seeing any other providers right now? (ND, DO, LAc, LMT, PT etc.)

Who & for what? _____

How did you hear of our office? _____

HEALTH HISTORY QUESTIONAIRE

What is your primary concern, condition, injury or illness?_____

_____

How long has it bothered you?_____

Describe what caused it/how it started:_____

_____

_____

How does this condition affect you? (Interference with work, sleep, appetite, etc.)_____

_____

Have you received treatment for this condition?_____ When?_____

From Whom?_____Diagnosis?_____

Results of Treatment?_____

Has the condition gotten: Better: _____ Worse:_____ Same:_____

Please put a check next to conditions that you have experienced within the last three months. Indicate the length of time you have had this condition:

GENERAL:

☐ Poor Appetite _____ ☐ Insomnia _____ ☐ Disturbed Sleep _____
☐ Localized Weakness _____ ☐ Cravings _____ ☐ Strong Thirst _____
☐ Weight Gain _____ ☐ Weight Loss _____ ☐ Changes in Appetite _____
☐ Sweating Easily _____ ☐ Tremors _____ ☐ Bleed or Bruise Easily _
☐ Night Sweats _____ ☐ Fever _____ ☐ Chills _____
☐ Sudden Energy Drop (time of day?) _____ ☐ Poor Balance _____
☐ Other unusual or abnormal conditions you have noticed in your general sense of health?_____

SKIN & HAIR:

☐ Rashes _____ ☐ Ulcerations _____ ☐ Hives _____
☐ Itching _____ ☐ Eczema _____ ☐ Pimples _____
☐ Dandruff _____ ☐ Hair Loss _____ ☐ Recent Moles _____
☐ Changes in hair or skin texture
Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT:

☐ Dizziness _____ ☐ Concussions _____ ☐ Migraines _____
☐ Glasses _____ ☐ Spots in Front of Eyes _____ ☐ Eye Pain _____
☐ Poor Vision _____ ☐ Night Blindness _____ ☐ Color Blindness _____
☐ Cataracts _____ ☐ Blurry Vision _____ ☐ Earaches _____
☐ Ringing in Ears _____ ☐ Poor Hearing _____ ☐ Eyestrain _____
☐ Sinus Problems _____ ☐ Recurrent Sore Throat _____ ☐ Nose Bleeds _____
☐ Grinding Teeth _____ ☐ Sores on Lips/Tongue _____ ☐ Facial Pain _____
☐ Teeth Problems _____ ☐ Headaches _____ ☐ Jaw Clicks _____
Any other head or neck problems? _____

CARDIOVASCULAR:

☐ Dizziness _____ ☐ Low Blood Pressure _____ ☐ Chest Pain _____
☐ Irregular Heartbeat _____ ☐ High Blood Pressure _____ ☐ Fainting _____
☐ Cold Hands/Feet _____ ☐ Swelling of Hands _____ ☐ Swelling of Feet _____
☐ Blood Clots _____ ☐ Difficulty Breathing _____ ☐ Phlebitis _____
Any other heart or blood vessel problems? _____

RESPIRATORY:

☐ Cough _____ ☐ Coughing up Blood _____ ☐ Asthma _____
☐ Bronchitis _____ ☐ Pain w/ Deep Inhalation _____ ☐ Pneumonia _____
☐ Difficulty Breathing when Lying Down _____
☐ Production of Phlegm (color?) _____
Any other lung problems? _____

GASTROINTESTINAL:

☐ Nausea _____ ☐ Vomiting _____ ☐ Diarrhea _____
☐ Constipation _____ ☐ Gas _____ ☐ Belching _____
☐ Black Stools _____ ☐ Blood in Stools _____ ☐ Indigestion _____
☐ Bad Breath _____ ☐ Rectal Pain _____ ☐ Hemorrhoids _____
☐ Abdominal Pain/Cramps _____ ☐ Chronic Laxative Use _____
Any other problems with stomach or intestines? _____

GENITO-URINARY:

☐ Pain on Urination _____ ☐ Frequent Urination _____ ☐ Blood in Urine _____
☐ Urgency to Urinate _____ ☐ Unable to Hold Urine _____ ☐ Kidney Stones _____
☐ Decrease in Flow _____ ☐ Impotence _____ ☐ Sores on genitals _____
Do you wake up at night to urinate? _____ If so, how often? ____
Any particular color to your urine? _____

Any other problems with your genital/urinary functions? _____

REPRODUCTIVE & GYNECOLOGIC:

☐ Menstrual Clots _____ ☐ Painful Menses _____ ☐ Unusual Menses _____
☐ Changes in body/psyche prior to menstruation _____ Duration _____
☐ Irregular Menses _____ ☐ Menopause (Age) _____ ☐ Other Problems _____
Age at 1st Menses _____ Time between Menses _____ Duration _____
First day of last Menses _____ # of Pregnancies _____ # of Births _____
Miscarriages _____ Abortions _____ Premature Births _____
Birth Control? _____ If so, type? _____ How Long? _____

MUSCULOSKELETAL:

☐ Neck Pain _____ ☐ Muscle Spasms _____ ☐ Knee Pain _____
☐ Back Pain _____ ☐ Muscle Weakness _____ ☐ Foot/Ankle Pain _____
☐ Hand/Wrist Pain _____ ☐ Shoulder Pain _____ ☐ Hip Pain _____
Any other joint/bone problems? _____

NEUROPSYCHOLOGICAL:

☐ Seizures _____ ☐ Dizziness _____ ☐ Loss of Balance _____
☐ Area of Numbness _____ ☐ Poor Memory _____ ☐ Lack of Coordination _____
☐ Concussion _____ ☐ Depression _____ ☐ Anxiety _____
☐ Bad Temper _____ ☐ Easily Susceptible to Stress ___
Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological/psychological problems? _____

LIFESTYLE:

Do you follow a regular exercise program? _____

Please describe your average daily diet: _____

_____

_____

☐ Cigarette Smoking _____ ☐ Coffee, Tea & Cola _____☐ Alcoholic Beverages ____
_____

Medications taken within the last two months (vitamins, drugs, herbs, etc.): _____
_____

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

_____

NATALIA PAPAZIAN, L.Ac, license 170022

Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient for whom I am legally responsible) by the acupuncturist Natalia Papazian. I understand that methods of treatment used in this practice may include, but are not limited to acupuncture, cupping, electrical stimulation, laser acupuncture, massage, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, include bruising, slight bleeding at the needling sight upon removal of the needle, 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 acupuncturist used I sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

As part of treatment, the acupuncturist may recommend nutritional therapy. The nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I do not expect the acupuncturist to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand that the acupuncturist may review my patient records and lab reports, but all my records will be kept confidential and will not be release 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, have been told about the risk 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 conditions(s) for which I seek treatment.

_____

Patient Signature Date

Or signature of Patient Representative and relationship to patient

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HIPPA PRIVACY ACT ensures that all of your personal and health information remains confidential at all times between this office, and you only.

Acupuncturists, like all providers of professional medical services, are now required by law to inform their clients of their policies regarding privacy of patient information. My office has been and continues to be bound by very high professional standards of confidentiality. We have always protected your personal health information and will continue to do so.

Types of Personal Information We Collect

Personal and health information about you that is provided by you when you fill out the initial visit information form

Parties to Whom We Disclose Information

For current and former patients, I do not disclose any personal or health information obtained in the course of my practice except as required or permitted by law for billing your insurance company for payment of services. Permitted disclosures include providing information to your insurance company who needs to know that information to assist in providing reimbursement for services that you have received.

Protecting the Confidentiality and Security of Current and Former Patient's Information

Records are maintained relating to professional services, as required by professional law, and to be able to assist with professional needs and services. In order to guard your nonpublic personal and health information, physical, electronic, and procedural safeguards that comply with professional privacy standards are in place.

Employee Authorization and Accountability

Any person employed within this facility shall sign a contract waiver of accountability regarding exposure to all private information. No employee shall change, alter or deform any information without prior approval from a supervisor or within the contract guidelines of their operating position. Any employee found to have violated the privacy policy shall be deemed on probation pending investigation and possible termination upon immediate notice.

Should you have any questions at any time please do not hesitate to bring something to my attention.

Sincerely,
Natalia Papazian

I acknowledge that I have read and understand the privacy policy as stated above:

Print Name: _____ Signature: _____ Date: _____

CANCELLATION POLICY

24 hour advance notice is required when cancelling an appointment so someone else can schedule an appointment. If you are unable to give me 24 hour an advance notice you will be charged the full amount of your appointment.

No-shows or missed appointment you will be charged the full amount of your appointment.

I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will immediately due and payable.

Your signature indicates that you have read, understand and agree with the above information.

Signature of patient (or parent or minor) _____

Printed Name of patient_____

Date_____