Jason Trombley, AP, LMT
Acupuncture/Massage Therapy Intake Form

Instructions:
This page is a general information and medical history
The next 2 pages are symptoms you have and/or are experiencing in the past 3 to 6 months
Please read & sign the last 2 pages

Name: _____Phone:(H)_____(C)_____(W)_____

Address:_____Age:_____Ht:_____Wt:_____

City:_____St:_____Zip:_____Birthdate:_____Sex:_____

E-mail:_____Occupation:_____

Physician:_____Referred By:_____

Emergency Contact: Name:_____Phone:_____

Main Problem:_____Onset:_____

Other Concurrent Therapies:_____

Past Medical History (include date):

Significant Illnesses: ___ Cancer ___ Diabetes ___ Blood Pressure ___ Heart Disease ___ Hepatitus
___ Rheumatic Fever ___ Thryoid Disease ___ Seizures ___ Other

Surgeries: _____

_____

Significant Trauma (auto accidents, fall, etc.): _____

_____

Birth History (prolonged labor, forcepts delivery, etc): _____

Allergies (drugs, chemicals, foods, etc.): _____

_____

Medicines Taken Within Last 2 Months (include vitamins, over-the-counter drugs, herbs, etc.): _____

_____

_____

Occupational Stresses (chemical, physical, psychological, etc.): _____

Exercise: _____

Comments: _____

Average Daily Diet:

Morning	Afternoon	Evening

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Family Medical History: ___ Diabetes ___ Cancer ___ High Blood Pressure ___ Heart Disease ___ Stroke ___ Seizure ___ Asthma ___ Allergies ___ Alcoholism ___ Other _____

General:

□ Poor Appetite	□ Heavy Appetite	□ Poor Sleep	□ Heavy Sleep	□ Insomnia
□ Fatigue	□ Tremors	□ Vertigo	□ Cold Hands	□ Cold Feet
□ Cold Back	□ Cold Abdomen	□ Fevers	□ Chills	□ Night Sweats
□ Sweats Easily	□ Cravings	□ Localized Weakness	□ Poor Coordination	□ Change in Appetite
□ Sudden Energy Drop at ___ ___ (time)		□ Pecular Taste/Smells _____		
□ Strong Thirst (cold/hot drinks		□ Bleed/Bruise Easily (where) _____		

_____

Skin and Hair:

□ Rashes	□ Ulcerations	□ Hives	□ Itching	□ Eczema
□ Pimples	□ Dandruff	□ Loss of Hair	□ Purpura	
□ Change in Hair/Skin Texture		□ Other Hair/Skin Problems _____		

Head, Eyes, Ears, Nose, & Throat:

□ Dizziness	□ Concussions	□ Migraines	□ Glasses	□ Eye Strain
□ Eye Pain	□ Poor Vision	□ Night Blindness	□ Color Blindness	□ Cataracts
□ Blurry Vision	□ Earaches	□ Ringing in Ears	□ Poor Hearing	□ Nose Bleeds
□ Sinus Problems	□ Mucus	□ Dry Throat	□ Dry Mouth	□ Copius Saliva
□ Teeth Problems	□ Jaw Clicks	□ Grinding Teeth	□ Facial Pain	□ Gum Problems
□ Spots in Eyes	□ Lips/Tongue Sores	□ Recurrent Sore Throats (___/month)		

□ Headaches (when/where) _____

□ Other Head or Neck Problems _____

Cardiovascular:

□ High Blood Pressure	□ Low Blood Pressure	□ Chest Pain	□ Irregular Heartbeat
□ Difficulty Breathing	□ Fainting	□ Cold Hands/Feet	□ Swelling Hands/Feet
□ Blood Clots	□ Difficulty Breathing	□ Phelbitis	

□ Other _____

Respiratory:

□ Cough □ Cough Blood □ Asthma □ Bronchitis
□ Pneumonia □ Difficulty Breathing When Lying Down □ Tight Chest
□ Production of Phlegm _____ what color? _____
□ Other Lung Problems _____

Gastrointestinal:

□ Nausea □ Vomiting □ Diarrhea □ Bowel Movement
□ Gas □ Belching □ Black Stools _____ Frequency
□ Bad Breath □ Rectal Pain □ Hemorrhoids _____ Color
□ Constipation □ Bloody Stools □ Sensitive Abdomen _____ Odor
□ Pain or Cramps □ Laxative Use: ___/week; type _____ _____ Texture/Form
□ Other Problems: _____

Genito-Urinary:

□ Pain on Urination □ Frequent Urination □ Blood in Urine □ Urgency to Urinate
□ Unable to Hold Urine □ Kidney Stones □ Veneral Disease □ Impotency
□ Wake up to Urinate How often _____/night; time _____ Other Problems: _____
_____

Pregnancy & Gynecology:

□ Number Pregnancies ___ □ Number Births ___ □ Premature Births □ Miscarriages □ Age First Menses
□ Period (days) _____ □ Duration _____ □ Irregular Periods □ Flow _____ □ Clots
□ Last PAP _____ □ Last Menses _____ □ Vaginal Discharge □ Vaginal Sores □ Breast Lumps
□ Menopause □ Birth Control (type/duration) _____
□ Changes in Body/Psyche Prior to Menstruation _____

Musculoskeletal:

□ Neck Pain □ Muscle Pains □ Back Pain (where?) _____ □ Joint Pains (where?) ____
□ Other Joint or Bone Problems _____

Neuropsychological:

□ Seizures □ Areas of Numbness □ Poor Memory □ Concussion □ Depression
□ Bad Temper □ Easily Stresses □ Treated for Emotional Problems □ Anxiety
□ Considered/ Attempted Suicide
□ Other Neurological or Psychological problems? _____

Notes: _____

_____

Jason Trombley, AP, LMT
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at WV Acupuncture.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the WV Acupuncture, Inc. as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*_____ *X*_____

Patient's Signature Date Explained by me and signed in my presence Date

Jason Trombley, AP, LMT
304-282-5553

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:
X_____ _____ _____
Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:
☐ Accepted _____ _____ _____
☐ Denied Signature Title Date

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information.:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 304-282-5553.

Yours truly,

Jason Trombley, A.P., LMT