Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919
Tel: (865) 588-1125 www.TraditionalHealthClinic.com

Advanced Initial Intake Checklist

Thank you for selecting our Advanced Initial Intake. We are looking forward to helping you get well and stay well.

We have included the checklist below to assist you in preparing for your initial consultation. Please note that your completed intake forms and medical records must be received at our office at least 7 days prior to your appointment. This will allow us to make the most of our scheduled time together and will enhance the quality of your care. If your packet is late or incomplete, you may be required to schedule another consult appointment to complete the intake phase of your care.

We realize that most people have never prepared for a medical consultation like this – it can be quite a project that may require considerable time and unusual efforts on your part. Our patients tell us that it's worth the investment and that they appreciate our efforts to gather and organize as many pieces of your health puzzle as possible. This is a key difference in our approach as compared to the conventional medical approach of "disease care."

Your intense self-reflection required in the process of compiling your complete health history marks the beginning of your health and wellness partnership with our practitioner. Take time and enjoy the process of getting your complete health story ready for someone who really wants to hear it.

Please complete the following steps:

Let us know if you are unable to download the documents. Please print out as single sided pages and complete using ink (not pencil).

- ☐ Complete the Advanced Initial Intake Questionnaire
- ☐ Complete the Personal and Medical History Timeline
- ☐ Complete the 3-Day Diet Diary
- ☐ Complete the Medication and Supplement Log
- ☐ Bring in all supplements, vitamins, herbs, and medications so that our practitioner can review the actual bottles
- ☐ Complete Consent & HIPPA Forms, and Agreement to Cancellations and Late Appointment Policies
- ☐ Mail or drop off all completed forms at least 7 days prior to your scheduled initial appointment
- ☐ Please arrive at least 10 minutes before your scheduled appointment time to be sure we have all your materials organized and we are both ready to get started on time
- ☐ Please read our practice policies and FAQs

Medical Records:

- ☐ Obtain medical records from all healthcare providers as far back as possible. Include labs (blood, saliva, urine, minerals, hair, stool, ultrasounds, radiology reports, etc.). These should be sent to you - not to our office (see next step)
- ☐ Make copies of medical records. We require a copy for our files and are not able to copy these for you. Please arrange in chronological order with most recent documents on top
- ☐ Mail or drop off **all forms** to Traditional Health Clinic at 6210 Highland Place Way, Knoxville, TN 37919. Records must be received at least 7 days prior to your appointment
- ☐ Please do not FAX records to us

NOTE: We require 48 hours notification if you cannot make your initial intake appointment.
A cancellation fee of $75 will be charged if you do not show up for your appointment and do not give notice at least 48 hours prior to your scheduled appointment time.

ADVANCED INITIAL INTAKE QUESTIONNAIRE

Will Foster, L.Ac.,
Traditional Health Clinic and Salt Spa
6210 Highland Place Way, Knoxville, TN 37919

Tel: (865) 588-1125 www.TraditionalHealthClinic.com Email: clinic@traditionalhealthclinic.com

Please take the time to carefully answer each part of each question by checking/circling/writing your answers. Please print clearly. Your information will be kept completely CONFIDENTIAL. Thank you!

Last name First name Middle Initial Today's date / / 20___

Street address: City State Zip

Home phone: Email address:

Date of birth / Time of birth / Place of birth Age Sex □ single □ separated □ married □ divorced

Work phone: Employer: Occupation: For how many years: Hours worked per week:

Your current height: Your present weight:

In case of emergency notify: Their phone: Their relationship to you: Their contact address:

Children: Number and their ages Number of children living at home:
Pets:

How did you hear about our clinic?

Who are your primary healthcare provider(s)? Office Location(s):

Date of most recent physical examination: Have you had acupuncture before?

Please list your **major health concerns** (and any accompanying symptoms) in order of importance to you.

	Health Concern	Date first noticed	Effect on daily activities
1)			
2)			
3)			
4)			

What are your objectives in seeing me as a practitioner?

1) _____

2) _____

What are the **major stressors** in your life?

1) 3)

2) 4)

How motivated are you to receive guidance and make changes for your health?

Family Health History

Please list your family members' current age and any medical conditions they have had.

Family Member | Age | Medical Condition(s)

Mother: _____

Father: _____

Siblings: _____

_____

Are there any conditions that run in your extended family?

Physical Health Information

Circumstances of your **birth** : □ premature □ prolonged labor □ forceps delivery □ drug induced delivery □ C-section

Did your mother smoke / drink / take drugs / experience trauma when pregnant with you? Please explain:

Did either of your parents smoke when you were growing up?

Immunizations / vaccinations:

Health problems / illnesses for which you have had medical treatment : Please provide approximate dates.

Please describe and give approximate dates for the following:
□ accidents □ hospitalizations □ surgeries □ blood transfusions □ significant blood loss

Any history of sexually transmitted disease(s)? Treatments Used:

Drug sensitivities or reactions?

Substance abuse of any kind?

Recreational drug use: Drug(s) of choice in the Past: Use: □ Casual □ Moderate □ Excess

Present: Use: □ Casual □ Moderate □ Excess

History of Exercise? What kind(s)? How often?

Please rate your overall **energy level** on a scale of one to ten (one is lowest) 1 2 3 4 5 6 7 8 9 10

Are there times of the day when you feel especially □ tired What time:
□ energetic What time:

Have you ever had **sleep problems**? □ past □ present Please describe:

Have you ever used any sleeping aides (drugs, supplements, self help techniques, etc.)? Which ones?

Has your job schedule or home environment ever interfered with normal sleep patterns? How so and for how long?

What time do you usually go to sleep at night? What time do you usually wake up in the morning?

Have you had any trouble falling asleep? What keeps you awake?

Have you often awoken during the night? What has woken you up? What time do you wake?

Have you had trouble falling back to sleep after you have awoken? What do you do to fall asleep?

Do you wake feeling rested? Do you have trouble waking / getting out of bed in the morning?

Have your dreams disturbed your sleep? What type of dreams bother you?

Do you snore? Do you have sleep apnea (stop breathing while sleeping)? Do you sleep-walk or sleep-talk?

Do you nap during the day? How frequently and for how long?

What is your overall feeling of your **body temperature**? Do you typically feel: □ hot □ cold □ fluctuates □ normal / stable
Do you feel you are **heat or cold sensitive**?

When do parts of your body feel: □ colder □ warmer

Do you feel better or worse in certain conditions / times of the year? (heat, cold, humidity, dryness, wind; winter, spring summer, fall)

Do you **perspire:**
□ normally □ little or not at all □ only under exertion □ spontaneously □ more than average □ excessively
□ at night □ cold sweats □ unusual odor □ Other:

Do you use antiperspirants / deodorants? Do they contain aluminum?

Do you have any **acute or chronic pain** problems? Please describe location(s):

Please **describe sensations of pain** as best as you can: □ intense □ sharp □ burning □ boring □ tearing □ piercing
□ stabbing □ dull □ aching □ heavy □ cramping □ fixed □ moving □ comes and goes □ constant □ throbbing
□ spontaneous □ painful with pressure □ accompanied by swelling □ radiates to:
□ Other (please describe):

Have you experienced any **numbness or tingling** anywhere in your body? □ past □ present If so: where and when?
□ Neuropathy?

Skin: □ dryness □ itching □ rashes □ acne □ hives □ moles □ warts □ ulcerations
□ sensitivity □ birthmarks □ varicose veins □ dandruff □ itchy scalp □ psoriasis □ eczema □ dermatitis
□ color changes □ bruise easily □ Other:

Do you use lotion? What kind? (brand): How often: Where on your body:
Do you use sun screen? What kind? (brand and SPF): How often?
Do you use artificial tanning products or tanning beds?

Body Modification (Tattoo / Piercing) / Cosmetic Surgery:

Scars: Cause and Location: Do any of your scars bother you?

Hair: Is your hair naturally: □ straight □ curly □ kinky □ dry □ brittle □ oily
□ growth rate (fast / slow / normal) □ hair loss □ early graying / whiting □ use of chemicals for hair

Nails: □ dry / brittle □ soft / hard □ growth rate (fast / slow/ normal) □ ridges □ white specks □ discoloration
□ fungal problems (where?) □ misshapen □ use of nail polish / remover □ Other:

Any **eye / vision** complaints? Do you wear glasses or contact lenses?
□ redness □ itchiness □ watery □ blurry □ heat in the eyes □ light sensitivity
□ dryness □ poor night vision □ glaucoma □ cataracts □ macular degeneration □ color blindness
□ floaters (objects floating across field of vision) □ grit in the eyes □ near or farsightedness □ Other:

Any **ear / hearing** problems? □ ringing in the ears □ hearing difficulties □ excessive wax □ sensitivity to sounds
□ discharge □ recurring / chronic earaches or infections □ ear tubes / implants □ Other:

Teeth: □ history of extensive dental work (born with extra teeth, extractions, braces, etc.) □ mercury amalgam replacement
number of fillings: ____mercury (silver)amalgam ____composite ____gold □ root canals □ bridges
□ crowns □ sensitivity to temperature (hot or cold / sugar) □ looseness of teeth □ discoloration of teeth

Gums: □ bleeding □ receding □ gingivitis □ sores / ulcers □ periodontal disease □ Other:

Mouth / Tongue: □ sores / ulcers □ bad breath □ thick coating on the tongue (please describe color, etc.):
□ tongue sensitivity □ Other:

Lips: □ unusual coloration □ moisture problems □ lipstick / lip balm / etc. use □ Other:

Throat / Glands: □ swelling □ soreness □ dryness □ itchiness □ feeling of something stuck in throat
□ difficulty swallowing □ Other:

Voice: □ speech pathologies / difficulties □ sighing □ weak / strong voice □ stuttering / stammering
□ Do you sing? □ hoarseness of voice □ Other:

Muscular Tension: places where you hold tension: □ neck □ shoulders □ upper / middle / lower back □ abdomen
□ pelvis □ hips □ thighs □ calves □ ankles / feet □ Other:

Does your body usually feel: □ flexible or □ tight/stiff

Muscular Weakness: □ Atrophy □ Shaking upon exertion □ Twitching □ Cramping □ Other:
Which muscles? When / How often?

Bones / Joints: □ joint pain □ joint swelling / redness □ sensation of heat / coldness □ fluid in joints
□ dry / abrasive / noisy joints □ ostepenia / osteoporosis □ bone fracture or injury □ tendonitis / bursitis

Memory / Concentration / Will Power: □ poor short term memory □ poor long term memory □ easily distracted
□ poor retention □ irresolute □ Other:

How is your **sense of smell**? How is your **sense of taste**?

Have you had any type of paralysis? Seizures? Have you had any head injuries? Concussions?

Have you ever felt **dizzy** or had a spinning sensation?
When did this occur? □ upon standing □ under stress □ bending over □ tipping head backwards □ Other:
How long did it last? How long has this been happening?

Have you experienced **headaches?** □ never □ rarely □ occasionally □ frequently (how frequent?) □ constantly
Do you have any history of **migraine headaches**? Do you experience any type of migraine aura?

Please describe your **headache symptoms**:
Location: □ forehead □ temples □ back of head □ top of head □ behind eyes
□ sinuses □ one sided □ entire head □ shifting / moving □ fixed position
□ Other:
Sensations: □ dull / heavy / achy pain □ sharp / intense pain □"band around head"
□ nausea / vomiting □ throbbing / pulsating □ visual disturbances
□ poor mental functions □ Other:

Please describe the level of pain during headaches: (slight pain) 1 2 3 4 5 6 7 8 9 10 (severe / debilitating pain)

What makes headaches better? □ rest / sleep □ quietness □ stillness □ movement □ bright light □ darkness
□ lying down □ remaining upright □ food □ caffeine □ drugs (which ones?)
□ heat □ cold □ pressure □ humidity □ Other:

Do your headaches occur at certain times of day / night? When?

Do you feel there is an emotional component to your headaches?

Do you have any **history of respiratory illness**?
□ hayfever or airborne allergies □ allergy to animals □ asthma □ pneumonia □ bronchitis
□ emphysema □ pleurisy □ sleep apnea □ COPD □ other:

Do you have any **respiratory or breathing difficulties**?
□ shortness of breath □ labored / difficult breathing □ wheezing □ cough □ chest congestion
□ painful breathing □ shallow breathing □ holding breath □ irregular breathing □ positional breathing difficulties

□ sinus congestion □ recurring sinus infections □ runny nose □ sneezing □ post nasal drip □ nose bleeds
□ sore throat □ dry throat □ swollen glands □ Other:

Is one of your nostrils usually clearer than the other? Which one?

Have you ever been a **smoker / tobacco chewer**? How many / how much per day & for how long?

Have you had any significant exposure to **second hand smoke**?

How often do you contract a common cold / flu? How recently have you been exposed to or have had a cold / flu?

Do you have sensitivities or reactions to any chemicals?

How many times during the day do you **urinate**? How many times at night?

Color / quality of your urine:
□ 'normal' □ clear □ dark yellow □ reddish (blood) □ cloudy □ foamy □ odorous □ burning / painful
□ difficult □ hesitant □ dribbling □ retention □ urgent □ frequent □ weak stream □ bed wetting
□ incontinence (lack of control with jumping / laughing / coughing / sneezing, etc.) □ Other:

Any history of kidney and/or urinary tract infections? Frequency:
Date of last one:

Any history of kidney stones? Frequency: When did you last have kidney stones?

Do you have regular **bowel movements**? How many each day? Week?

What time(s) of day do you normally have a bowel movement?

Do you experience **constipation** or **diarrhea**? □ past □ present
When and for how long?

What is the consistency of your stools: □ well formed □ hard / pellets □ loose / unformed □ alternating consistency

Color of stool: □ brown □ yellow/tan □ black □ red (blood) □ white/grey □ green □ alternates

Any mucous regularly in the stool? Color of mucous: □ clear □ white □ yellow □ green / brown

Any difficulty passing stools? Any pain associated with passing stool? □ before □ during □ after

Do you have a feeling of incomplete evacuation after passing stools?

Have you ever used laxatives? □ past □ present □ intermittent □ long term Which types / brands?

Have you used a stool softener or fiber product? □ past □ present What brand and how often?

Have you used enemas or colonics? □ past □ present How frequently?

Have you suffered from **hemorrhoids** or **fissures**? □ past □ present
□ protruding □ bleeding

Have you ever experienced: □ palpitations □ fast/slow heart rate □ arrhythmia □ fibrillations □ heart disease
□ blood clots □ phlebitis □ rheumatic fever □ fainting □ ankle swelling □ heart murmur
□ angina/chest pain □ heart related surgery □ bleeding/clotting disorders □ Other:

How frequently (daily, weekly, monthly)? Do they occur in relation to any particular activity?

How long do they last when they do occur (seconds, minutes, hours)?

Have you ever had: □ low blood pressure □ high blood pressure

Have you ever had elevated cholesterol?

Do you ever have any unusual swelling in your arms or legs?

WOMEN ONLY IMPORTANT: REGARDLESS OF AGE AND STAGE OF LIFE

PLEASE RESPOND TO THE FOLLOWING QUESTIONS ABOUT YOUR HEALTH – PAST AND/OR PRESENT

Age of first menses (menarche): Dates of last period: Are you currently trying to get pregnant?

Date of last gynecological exam: Date of last PAP smear:

Number of pregnancies: Number of abortions (dates): Number of miscarriages (dates):

Have you had any difficulties with conception? If yes, please describe:

Have you had any Laparoscopies? When? Why?

Do you want to have (more) children?

Any birthing difficulties? □ C-section □ premature □ prolonged □ hemorrhaging □ ectopic pregnancy
□ severe pain □ induced labor □ Other (please describe):

Have you had postpartum depression? Postpartum weakness? Other postpartum complications?

Have you ever used birth control drugs or practiced birth control methods? Type(s)? When and for how long?

Have you had a hysterectomy? □ Partial □ Complete Date: Reason for hysterectomy:

Have you had menopausal symptoms? Since when? Please describe:

Have you ever used hormone replacement therapy? For what and for how long?

Have you ever missed periods (other than when pregnant / lactating)? If so, please describe:

Has your cycle always been regular? If not, please explain:

How many days between the start of each cycle? How many days do/did you typically flow?

Please describe the quantity and quality of the flow:
□ light □ normal □ heavy □ clotting □ Other:
□ pale □ bright red □ dark red □ brown

Have you ever had unusual bleeding / spotting or vaginal discharge between periods or otherwise?

Have you experienced pain / cramps associated with your period? For how many years?
□ before period □ during period □ after period □ mild □ strong □ intense / debilitating

The pain was / is reduced with: □ warmth / heat □ rest / inactivity □ activity / movement □ start of period
□ drugs (name): □ Other:

Have you experienced any of the following before or during your period?
□ water retention □ breast tenderness / swelling □ fatigue □ emotional ups / downs
□ depression □ irritability □ headaches □ nausea/vomiting
□ low back pain □ change in bowel habits □ food cravings
□ Other:

Any vaginal dryness or itching? Bleeding and / or pain during or after intercourse? Libido issues?

Any history of: □ Yeast infections □ Pelvic inflammatory disease □ Endometriosis

How frequently do you have breast exams / mammograms? Have you ever had lactation difficulties?

Have you had any breast lumps / cysts / fibroids? Any bleeding or discharge from nipples?

MEN ONLY

Have you ever had any prostate problems? If so, please describe:

Ever had a vasectomy? When? Reversal of vasectomy?

Any physical problems with the penis / scrotum / testicles (masses / cysts / tumors)?

Any sensations of □ coldness □ numbness □ pain? Any swelling?
Any defect / deficiencies in sperm function or production?

Any experience of impotency (inability to have and / or maintain an erection)? Libido issues?

Have you ever experienced:
□ premature ejaculation □ wet dreams □ pain during / after sex / ejaculation
□ loss of sperm with urination and / or bowel movement □ tiredness / exhaustion after orgasm

SOCIAL/EMOTIONAL HEALTH AND LIFESTYLE INFORMATION for men and women

Are you an adopted child? At what age? If so, have you had or do you now have contact with parent(s)?

Are your parents separated or divorced? If so, what age were you at the time of the separation or divorce?

Number of brothers and sisters: Your place in sequence (first born, second born, etc.)

Significant childhood / adolescent / adult trauma.

Excessive use of technology: □ watch TV □ use computer □ use microwave □ use hair dryer □ use electric blankets
□ drive a lot □ use cell phone □ use headset
Excessive exposure to: □ electromagnetic fields □ radiation □ fumes □ excessive noise □ fluorescent lights
□ chemicals: □ Other:

Do you enjoy your life? Is your job satisfying to you?

What do you do for **recreation**? Any hobbies?

Are you satisfied with your significant relationships?

Do your home and work environments provide support for your health and well being?

How would you describe your personality?

What are your predominate emotions?

What are your greatest fears? What are your greatest desires?

What do you consider to be your greatest strength(s)? Weakness(es)?

What emotions come up when you feel stressed?

Do you have any **nervous habits**? Is there anything that you feel is a habit or addiction in your life?

Have you ever considered or attempted suicide?

Do you travel a lot? □ past □ present □ business □ pleasure

Recent **foreign travel** (within last 2 years): Any sickness during and/or after travel?

Foreign countries in which you have lived: Dates of residence:

Have you ever practiced **relaxation / meditation / prayer**?

DAILY ROUTINE

Please describe your daily routine from the time you wake in the morning until going to bed at night:
Please describe how you routine differs on your days off / weekends:

DIET AND NUTRITION

Were you breastfed? If so, for how long?

Please describe your **diet** in your youth:

Please describe your present diet: □ vegetarian □ vegan □ carnivore □ omnivore □ low salt □ low fat □ low sugar
□ low carbohydrate □ low protein □ high protein □ Other:

Have you followed any diets? Please describe the diet, diet objectives, length of time you adhered to it and the result:

Any experience with cleanses/detoxification programs or fasting?

Do you eat regular meals? Do you skip meals? If so, which one(s), how often and why?

Do you snack between meals? Typical snack foods:

Do you eat near bedtime or at night?

How often do you eat out? □ past □ present Where / what type of food when dining out:

What percentage of your food intake is raw?

Do you like to cook? Do you actually cook much? Do you enjoy eating?

Do you cook with: □ Aluminum pots □ Stainless Steel pots □ Non-stick pots □ Cast Iron pots
□ Clay pots □ Stoneware □ Glass / Pyrex □ Other:

Are you relaxed when you eat? Do you usually eat in a relaxed environment?

Do you often eat while: □ reading □ watching TV □ driving □ standing up □ talking □ Other:

Any history of eating disorders, emotional or binge eating? Please describe:

Do you crave any of the following foods? □ sweets □ breads □ fatty foods □ meats □ fish □ milk □ Other:

What do you usually drink with food / meals? □ cold fluids □ warm fluids □ hot fluids Please List:

Which tastes do you prefer: □ sweet □ salty □ sour □ pungent / spicy-hot □ bitter □ astringent

Do you strongly dislike any particular tastes or foods?

Have you used any artificial sweeteners? Which ones, how much and for how long?

How would you describe your **appetite**: □ normal □ weak □ strong □ variable □ constant

What factors cause appetite to vary and how so?
□ exercise □ caffeine □ medication □ stress □ time of day / month (when ?) □ weather /season □ Other:

How do you generally feel after eating? Does your energy level go: □ up □ down □ stay the same?

Does it depend on the type and / or amount of food eaten? Which foods cause which reaction?

What are your favorite foods? What foods do you eat regularly?

Please describe your **typical daily meals / snacks** and the **times** you eat them. *Please indicate your largest meal of the day.

Time	Meal	Foods / beverages
___:___ am	**Breakfast:**	
	Snacks (after breakfast):	
___:___ am / pm	**Lunch:**	
	Snacks (after lunch):	
___:___ pm	**Supper/Dinner:**	
	Snacks (after dinner):	
___:___ pm	After Supper/before sleep:	

Please indicate (circle and / or check) **liquid intake** amounts (ounces):

____Ounces per day / week / month □ Water (□ tap □ bottled □ filtered/purified)
____Ounces per day / week / month □ Coffee (□ caffeinated □ decaffeinated)
____Ounces per day / week / month □ Teas (□ caffeinated □ decaffeinated □ herbal) Which types of herbal teas:
____Ounces per day / week / month □ Soft drinks (type):
____Ounces per day / week / month □ Alcohol (type of alcohol: □ beer □ wine □ hard liquor)
____Ounces per day / week / month □ Juice (please give types):
____Ounces per day / week / month □ Other [energy drinks, etc.]:

Which **fats / oils** do you use?

□ margarine □ butter / ghee □ olive □ safflower □ sunflower □ corn □ Crisco □ canola □ grape seed
□ coconut □ peanut □ soybean □ sesame □ mayonnaise □ flax □ lard □ fish/cod liver □ Other:

Do you have any **digestive complaints**?

□ bad breath □ intestinal gas □ foul gas □ belching □ hiccups □ bloating □ nausea/vomiting
□ abdominal cramping □ pain (where?) □ pain relieved by passing gas? □ noisy stomach / intestines (gurgling, etc.)
□ heart burn □ acid reflux / regurgitation (GERD) □ hiatal hernia □ burning pain after eating
□ jaundice □ gall bladder disease □ liver disease (fatty liver, cirrhosis, hepatitis) □ IBS □ ulcers □ Other:

Do you have any **food sensitivities or allergies**?

Have you had any problems with **blood sugar fluctuations** (hypoglycemia, insulin resistance, diabetes, etc.)?

Do you chew **gum**? If so, what kind, how often, and since when?

Do you **chew your food** well or "inhale" it?

Would you like to **decrease / increase** your **body weight**? If so, by how much?

When did you last have a significant (more than 10 pounds) **change in weight**?

Please list any other health concerns you wish to address that have not been covered in this questionnaire:

Thank you for taking the time and effort to fill out this form. We look forward to working with you.

Your Signature _____ Date _____

Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919

Patient Name: _____ **Date:_____**

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: ***Last 10 years***

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

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6210 Highland Place Way, Knoxville, TN 37919

Patient Name: **Date:**

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement Name and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Cancellation and Late Appointment Policy

Late Appointments

We are committed to prompt service, and will work very hard, barring emergencies, to stay on time. We may ask you to reschedule if you arrive more than 10 minutes after your scheduled appointment time. Please arrive 10 minutes early for an appointment to complete any paperwork associated with your visit.

If the practitioner is more than 15 minutes late for your scheduled appointment, you will receive a 5% discount for your service fees for that appointment.

Cancellations

Patients are required to contact our office within 24 hours if they cannot make their appointment.

Patients will be charged the full price for a missed appointment that is not cancelled 24 hours in advance.

Agreed and signed,

Name_____

Date _____

Traditional Health Clinic HIPPA Contact Consent Information

Patient's Name _____ Date of Birth _____/_____/_____

May we contact you by home phone?	Yes	No	N/A
May we leave a detailed message?		Yes	No
May we leave a message with a call back number?	Yes	No	
May we contact you by cell phone?	Yes	No	N/A
May we leave a detailed message?	Yes	No	
May we leave a message with a call back number?	Yes	No	
May we contact you at work?	Yes	No	N/A
May we leave a detailed message?	Yes	No	
May we leave a message with a call back number?	Yes	No	
May we speak with someone else regarding your medical care?	Yes	No	

Name of Person_____ Relationship_____

Name of Person_____ Relationship_____

Name of Person_____ Relationship_____

From time to time we like to check in with our patients to learn how we can best meet their needs and provide the highest level of care possible.

Please initial below if you are NOT willing to be contacted as part of our efforts to learn about your experience.

____ I do not want to be contacted

Traditional Health Clinic – Notice of HIPAA Privacy Practice

The attached Notice describes how health information about you may be used, and your rights, regarding that information. Please review this summary and the full Notice carefully.

Traditional Health Clinic Pledge: Staff and employees of Traditional Health Clinic (THC) understand that information about you and your health is personal. We are committed to protecting your health information.

Who will follow rules in this notice: All THC staff and volunteers must follow these rules.

You have the right to:
-Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
-Ask to correct information that you believe is wrong in your health record.
-Ask that your health information not be shared with certain individuals.
-Ask that your health information not be used for certain purposes: for example, research.
-Ask that THC to send copies of your health record to whomever you wish (charges may apply).
-Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
-Specify where and how THC employees may contact you.
-Receive a paper copy of the full Notice of Privacy Practices.

Who is authorized to see confidential Patient Health Information (PHI) at THC?
The Acupuncturist may access the entire medical record, based on his "need to know". All other members of our workforce have access only to the information to do their jobs. The "Notice of Privacy Practices" describes the ways in which we may use PHI without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.
1. Treatment of the patient, including appointment reminders.
2. Payment of health care bills.
3. Health care operations and business operations, teaching and medical staff quality activities, research (when approved and with a written patient permission); health care communications between a patient and their health care practitioner.

Minimum Necessary Standard
THC will apply the "minimum necessary" standard regarding PHI. For example, although clinical Administration, Acupuncturists and other health care providers may need to view the entire record, a billing clerk or data entry staff member might only need to see a specific report to determine the billing codes. An admissions staff member may not need to see the medical record at all, only an order form with the admitting diagnosis and identification of the admitting physician.

Written Authorizations
To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules
Under HIPAA, there are certain exceptions to these rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with the THC privacy coordinator, or call 865-588-1125. If you believe your rights have not been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filling a complaint.

Printed Name:_____ Today's Date:____/_____/_____

Signature:_____ Date of Birth:___/____/_____

Relation (if other than patient):_____ Patient declined to sign receipt:_____

Patient unable to sign (witness signature):_____

Reason Unable:_____ Interpreter:_____

Traditional Health Clinic & Salt Spa
6210 Highland Place Way, Knoxville, TN 37919
Tel: (865) 588-1125

INFORMED CONSENT TO HEALTHCARE BY A LICENSED ACUPUNCTURIST

I hereby request and consent to the performance of the following on me (or the patient named below for whom I am legally responsible) by Will Foster, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Will Foster, including those working at his office or any other associated office whether signatories to this form or not:

Acupuncture and other oriental medical procedures including, but are not limited to:

- diagnostic techniques such as questioning, pulse evaluation, manual palpation on a variety of areas on my body, observation, range of motion evaluation, muscle, orthopedic and neurologic testing
- modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation
- the application of herbal oils, ointments, salves and/or liniments to the body
- the prescription of herbal and dietary supplements
- dietary recommendations
- advice regarding exercise regimens and lifestyle counseling

I have had an opportunity to discuss with the practitioner (Will Foster) the nature and purpose of Oriental medicine, Ayurveda and other oriental medical procedures. I understand that results are not guaranteed.

I understand that in the initial undertaking of treatment, the most effective results are obtained by receiving regular treatments each week at a frequency recommended by the practitioner for my specific condition. I realize that if treatments are less frequent or erratic, improvement in my condition will be less likely and slower. I also understand that if I am unable or unwilling to follow the doctor's recommendations regarding taking of herbs, supplements, exercise, or lifestyle change that the effectiveness of the acupuncture will be reduced and my progress impeded.

I understand and am informed that there are some risks to treatment, including but not limited to bleeding, bruising, inflammation, infections, burns, general aches, sprains, strains, dislocations, fractures, disc injuries, strokes, puncture of organs, pain or other strong sensations at the location where a needle is inserted or radiating from that location, nerve pain, aggravation of current symptoms and appearance of new symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the doctor's judgment based on the facts known at the time.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT'S PRINTED NAME: _____

PATIENT'S SIGNATURE: _____

If patient is dependent: PATIENT REPRESENTATIVE / GUARDIAN:

Name: _____ Signature: _____

Relationship to patient: _____

DATE: _____

I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

PRACTITIONER'S SIGNATURE: _____

DATE: _____