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

BASIC Initial Intake Checklist

90 minutes $200

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

Please complete the following steps to prepare for your appointment:

- Please set aside 45-60 minutes to complete the intake forms and medication log.
- Download / print, complete and bring to your appointment the following forms. Please use pen, (not pencil) and print single-sided so that your completed sheets can be incorporated into our charting system:

  - ☐ BASIC Initial Intake Questionnaire
  - ☐ Consent & HIPAA forms
  - ☐ Medication and Supplement Log

- Please bring in the actual bottles of supplements, vitamins, herbs, and medications so that our practitioner can review the products with you.
- Please read our practice policies and FAQs
- Please bring COPIES of any medical records that may help us understand your health history and/or current health concerns. We CAN NOT make copies of your records at our office. Please FAX your medical records to our office: (866) 375-0949
- Please arrive at least 10 minutes prior to your scheduled appointment time so that we can be sure to have everything ready so we can begin on time.

In order to provide you with the highest level of care, our practitioner must have your completed intake forms. If you arrive at your appointment without completed forms, you will be required to schedule another consult appointment at an additional cost ☹

BASIC INITIAL INTAKE FORM

Traditional Health Clinic and Salt Spa

6210 Highland Place Way, Knoxville, TN 37919

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

GENERAL INFORMATION

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

Preferred Name:

Date of birth ___/____/_____ Age _____ ☐ single ☐ married ☐ separated ☐ divorced ☐ widow/er ☐ long term partnership

Gender ☐ male ☐ female

Genetic Background ☐ African ☐ European ☐ Native American ☐ Mediterranean ☐ Bi Racial ☐ Asian ☐ Hispanic ☐ Middle Eastern ☐ Other _____

Highest Education Level ☐ High School ☐ Under-Graduate ☐ Post-Graduate

Job Title:

Nature of Business / Occupation:

For how many years: Hours worked each day / week:

Previous job(s):

For how many years:

Primary Address Number, Street Apt. No..

City State Zip

Alternate Address Number, Street Apt. No..

City State Zip

Home phone 1 _____ Home phone 2 _____

Work Phone _____ Cell Phone _____

FAX _____ Email _____

Emergency Contact: Name: _____ Their phone _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Their relationship to you:

Who are your primary healthcare provider(s)? Name(s): _____

Office Location(s): _____

Date and reason(s) last seen: _____

Referred by: ☐ Website / Internet ☐ Media [TV/Radio/Paper] ☐ Friend of Family Member ☐ Healthcare Provider

☐ Other _____

Your height: Your weight:

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

Do you have pets? Type and number:

ALLERGIES / SENSITIVITIES

Medications / Supplements / Foods Reaction

_____ _____

_____ _____

_____ _____

_____ _____

COMPLAINTS / CONCERNS

What do you hope to accomplish in your visits with me?

1._____

2._____

What do you believe is the source of your problems?

_____

What kind of treatment are you looking for?

_____

What makes you feel worse? What makes you feel better?

_____

Please list current and ongoing problems in order of priority

Problem and date first noticed	mild/moderate/severe	effect on daily activities	prior treatment and success?
1)			
2)			
3)			
4)			

What are the major stressors in your life?

1) 3)

2) 4)

Unfortunately abuse of all kinds (verbal, emotional, physical and sexual) are leading contributors to chronic stress and immune system dysfunction. If you are experiencing abuse it is very important that you feel comfortable letting us know so that we can support you and optimize your treatment outcome.

Do you currently feel safe in your home? ☐ Yes ☐ No
Do you feel safe, respected and valued in your current relationship? ☐ Yes

PERSONAL MEDICAL HISTORY

☐ = *Past Condition (less than 6 months)* O = *Ongoing Condition (greater than 6 months)*

DISEASES / DIAGNOSIS / CONDITIONS **[**Check appropriate box and provide approximate dates]

GASTROINTESTINAL
- ☐ O Irritable Bowel Syndrome
- ☐ O Inflammatory Bowel Disease
- ☐ O Crohn's
- ☐ O Ulcerative Colitis
- ☐ O Gastritis or Peptic Ulcer Disease
- ☐ O GERD (reflux)
- ☐ O Celiac Disease
- ☐ O Constipation or Diarrhea
- ☐ O Diverticulosis / Diverticulitis
- ☐ O Other _____

CARDIOVASCULAR
- ☐ O Heart Attack
- ☐ O Other Heart Disease
- ☐ O Stroke
- ☐ O Elevated Cholesterol
- ☐ O Arrhythmia (irregular heart rate)
- ☐ O Hypertension (high blood pressure)
- ☐ O Rheumatic fever
- ☐ O Mitral Valve Prolapse
- ☐ O Other _____

METABOLIC / ENDOCRINE
- ☐ O Type 1 Diabetes
- ☐ O Type 2 Diabetes
- ☐ O Hypoglycemia
- ☐ O Metabolic Syndrome (Insulin Resistance)
- ☐ O Hypothyroidism (low thyroid function)
- ☐ O Hyperthyroidism (overactive thyroid function)
- ☐ O Endocrine Problems
- ☐ O Adrenal Problems
- ☐ O Polycystic Ovary Syndrome (PCOS)
- ☐ O Infertility
- ☐ O Hormone Replacement Therapy (HRT)
- ☐ O Weight Gain
- ☐ O Weight Loss
- ☐ O Frequent Weight Fluctuations
- ☐ O Bulimia
- ☐ O Anorexia
- ☐ O Binge Eating Disorder
- ☐ O Eating Disorder (pls describe_____)
- ☐ O Other _____

CANCER
- ☐ O Lung Cancer
- ☐ O Breast Cancer
- ☐ O Colon Cancer
- ☐ O Ovarian Cancer
- ☐ O Prostate
- ☐ O Skin Cancer
- ☐ O Other _____
- ☐ O Cancer Treatment(s) _____
  _____

REPRODUCTIVE AND URINARY SYSTEMS
- ☐ O Kidney Stones
- ☐ O Gout
- ☐ O Interstitial Cystitis
- ☐ O Urinary Tract Infections
- ☐ O Yeast Infections
- ☐ O Erectile Dysfunction
- ☐ O Sexual Dysfunction
- ☐ O Other _____

MUSCULOSKELETAL / PAIN
- ☐ O Osteoarthritis
- ☐ O Fibromyalgia
- ☐ O Chronic Pain
- ☐ O Other _____

INFLAMMATORY / AUTOIMMUNE
- ☐ O Chronic Fatigue Syndrome
- ☐ O Autoimmune Disease
- ☐ O Rheumatoid Arthritis
- ☐ O Lupus SLE
- ☐ O Immune Deficiency Disease
- ☐ O Herpes – Genital
- ☐ O Severe Infectious Disease
- ☐ O Poor Immune Function (frequent infections)
- ☐ O Food Allergies
- ☐ O Environmental Allergies
- ☐ O Multiple Chemical Sensitivities
- ☐ O Latex Allergy
- ☐ O Raynaud's Disease
- ☐ O Other _____

RESPIRATORY DISEASES

- O Asthma
- O Chronic Sinusitis
- O Bronchitis
- O Emphysema
- O Pneumonia
- O Tuberculosis
- O Sleep Apnea
- O Other _____

SKIN DISEASES

- O Eczema
- O Psoriasis
- O Acne
- O Melanoma
- O Ulcerations
- O Other _____

NEUROLOGICAL / MOOD

- O Depression
- O Anxiety
- O Bipolar Disorder
- O Schizophrenia
- O Headaches
- O Migraines
- O ADD / ADHD
- O Autism
- O Mild Cognitive Impairment
- O Memory Problems
- O Parkinson's Disease
- O Multiple Sclerosis
- O ALS
- O Seizures
- O Areas of Numbness
- O Lack of Coordination
- O Loss of Balance
- O Disorientation
- O Irritability / Easily Angered
- O Other _____

INJURIES

Check box if yes

- Back Injury
- Head Injury
- Neck Injury
- Broken Bones
- Burns
- Other _____

HOSPITALIZATIONS

- None

Date	Location	Reason(s)

DIAGNOSTIC TESTS AND DATES

Check box if yes and provide date

- Full Physical Exam
- Bone Density
- Barium Enema
- Colonoscopy
- Cardiac Stress Test
- CT Scan
- EBT Heart Scan
- EKG
- Hemoccult Test – test for blood in stool
- Liver scan
- NMR/MRI
- Upper Endoscopy
- Upper GI Series
- Sigmoidoscopy
- Ultrasound
- X-ray
- Other _____

SURGERIES

Check box if yes and provide date of surgery

- Appendectomy
- Hysterectomy +/- Ovaries
- Gall Bladder
- Back / Spine Surgery
- Hernia
- Prolapse Repair
- Tonsillectomy
- Adnoidectomy
- Dental Surgery
- Joint Replacement – Knee / Hip
- Heart Surgery – Bypass Valve
- Implants (Dental, Breast, Other)
- Angioplasty
- Pacemaker
- Other _____
- None

BLOOD TYPE:

A B AB O

Rh+ unknown

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:

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

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

Is there anything else you would like us know that you think or feel may be relevant to your case? If so, Please describe:

Patient Signature _____

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 HIPAA 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 <u>NOT willing</u> to be contacted as part of our efforts to learn about your experience.

____ I <u>do not</u> 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 & 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:_____

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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: _____ DATE: _____

PATIENT'S SIGNATURE: _____

If patient is dependent: PATIENT REPRESENTATIVE / GUARDIAN:

Name: _____ Signature: _____

Relationship to patient: _____

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

PRACTITIONER'S SIGNATURE: _____

DATE: _____

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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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Patient Name: **Date:**

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

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