Laura LaDue, LAc

NEW PATIENT INTAKE

Name ____ **Date** _____________

Address ____

City ____________________ **State** ____________ **Zip** ________

Phone (H) _______________ **Phone (C)** _________________ **Phone (W)** _________________

Email ____

Date of Birth ___________________ **Age** _______ **Gender** ☐ Female ☐ Male

Weight ________ **Height** ________ **Are You Pregnant?** ☐ No ☐ Yes, # of weeks? ____________

Emergency Contact Name ____

Emergency Contact Phone ____

How were you referred? ____

Marital Status ☐ Single ☐ Married ☐ Partnered

Partner/ Spouse Name ____

Number and ages of Children ____

Who is your Primary Care Doctor? _________________________ **Phone** _________________

Date of last visit? _______________ **Reason for visit?** ________________________________

MEDICAL QUESTIONNAIRE

HEALTH CONCERNS YOU WOULD LIKE ADDRESSED WITH ACUPUNCTURE AND CHINESE HERBS

(In order of importance)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

CURRENT PRESCRIPTION MEDICATION *(Attach additional sheet if necessary.)*

Name	Dose	How Often	Reason
1.			
2.			
3.			
4.			

CURRENT SUPPLEMENTS – *Nutritional, Vitamins, Herbs, OTC. (Attach additional sheet if necessary.)*

Name	Dose	How Often	Reason
1.			
2.			
3.			
4.			

ALLERGIES

Medication/ Food/ Environment	What effect?
1.	
2.	
3.	
4.	

PAST MEDICAL HISTORY

Major Illnesses (Including childhood illnesses)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Major Injuries

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Hospitalizations and Surgeries (Please give month/year if possible)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Contagious Diseases

1. ______________________________
2. ______________________________
3. ______________________________

Emotional Trauma

1. ______________________________
2. ______________________________
3. ______________________________

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good P=Poor)						
Age (at death)						
Cause of Death						

Check and note all that apply to each family member

Cancer (type)						
Diabetes (type)						
Stroke						
Mental Illness						
Kidney Disease						
Obesity						
Heart Disease						
High Blood Pressure						

OCCUPATIONAL HISTORY

	Position Held	Type of Work	# of Years
Present			

Do you enjoy your work? ☐ Yes ☐ No

Previous ______________________________

HEALTHCARE MAINTENANCE

Test	Date	Result	Test	Date	Result
Physical Exam			Breast Exam (Doctor)		
Mammogram			Pap Smear/ Pelvic		
Colonoscopy			Prostate/ Testicle		
Eye exam/ Vision			MRI		
Hearing Test			X-Ray		
Dental Exam			Other		

HEALTH SYSTEMS

Y = a condition you have now **P =** a condition in the past

GENERAL

Fatigue Y P
Insomnia Y P

SKIN

Dry Skin Y P
Rash Y P
Hives Y P
Acne Y P

HEAD

Headache Y P
Head Injury Y P

EYES

Impaired Vision Y P
Eye Pain Y P
Dryness Y P
Double Vision Y P
Glaucoma Y P
Cataracts Y P

NOSE & SINUS

Frequent Colds Y P
Nose Bleeds Y P
Stuffiness Y P
Hay Fever Y P
Sinus Problems Y P

MOUTH & THROAT

Freq Sore Throats Y P
Sore Tongue Y P
Gum Problems Y P
Hoarseness Y P
Dental Cavities Y P

NECK

Lumps Y P
Swollen Glands Y P
Goiter Y P
Pain or Stiffness Y P

RESPIRATORY

Cough Y P
Sputum Y P
Spitting up blood Y P
Wheezing Y P
Asthma Y P
Bronchitis Y P
Pneumonia Y P
Pleurisy Y P
Emphysema Y P
Pain on breathing Y P
Tuberculosis Y P
Shortness of breath Y P

BLOOD

Anemia Y P
Bleed/Bruise Easily Y P

EARS

Impaired Hearing Y P
Ringing Y P
Earache Y P
Dizziness Y P
Vertigo Y P

GASTROINTESTINAL

Appetite Change Y P
Heartburn/Acid Reflux Y P
Thirst Change Y P
Nausea Y P
Vomiting Y P
Loose stool Y P
Diarrhea Y P
Blood in Stool Y P
Gas/Bloating Y P
Constipation Y P

MUSCULOSKELETAL

Joint Pain Y P
Joint Stiffness Y P
Arthritis Y P
Broken Bones Y P
Muscle Spasms Y P
Weakness Y P

PERIPHERAL VASCULAR

Deep Leg Pain Y P
Cold Hands/Feet Y P
Varicose Veins Y P

EMOTIONAL

Depression Y P
Mood Swings Y P
Anxiety Y P
Suicidal Y P

NEUROLOGIC

Fainting Y P
Seizures Y P
Paralysis Y P
Muscle Weakness Y P
Numbness/ Tingling Y P
Concentration Prob Y P
Loss of Memory Y P

URINARY

Pain on urination Y P
Increased frequency Y P
Frequency at night Y P
Inability to hold urine Y P
Frequent infections Y P

ENDOCRINE

Hypothyroid Y P
Heat/Cold Intolerance Y P
Excessive Thirst Y P
Excessive Hunger Y P
Hypoglycemia Y P
Low Blood Pressure Y P
Sugar Cravings Y P
Weight Gain
_____ lbs over _____ yrs/mos
Weight Loss
_____ lbs over _____ yrs/mos

CARDIOVASCULAR

Heart Disease	Y	P
Angina	Y	P
High Blood Pressure	Y	P
Heart Murmur	Y	P
Rheumatic Fever	Y	P
Chest Pain	Y	P
Swelling in ankles	Y	P
Palpitations	Y	P

MALE REPRODUCTIVE

Hernias	Y	P
Testicular mass	Y	P
Prostate disease	Y	P
STDs	Y	P
Diminished sex drive	Y	P
Erectile dysfunction	Y	P

FEMALE REPRODUCTIVE

Age Menses Began	________	
Average # of days	________	
Length of cycle	________	
Spotting	Y	P
Painful Intercourse	Y	P
Painful Menses	Y	P
Excessive Flow	Y	P
Birth Control	Y	P
What type?	________	
# of Pregnancies	________	
# of Live Births	________	
# of Miscarriages	________	
# of Abortions	________	
Difficulty Conceiving	Y	P
Sexually Active	Y	P
Diminished Sex drive	Y	P
Sexual Difficulties	Y	P

STDs	Y	P
PMS	Y	P
Irregular Periods	Y	P
Menopausal	Y	P
When did menses stop? ____________________		
Decreased Vaginal Lubrication	Y	P
Day/Night Sweats	Y	P
Hot Flashes	Y	P
Nipple Discharge	__ One breast __ Two breasts	

Have you ever had a

Hysterectomy	Y
When? ____________________	
Ovaries removed	Y
When? ____________________	
Tubal Ligation	Y
When? ____________________	

TYPICAL DIET

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Dietary Restrictions ____

I certify the information I have supplied is correct and accurate to the best of my knowledge.

____ ____________________

Signature of Patient or Patient Representative Date

HIPPA PRIVACY POLICY:
ACKNOWLEDGMENT OF RECEIPT

The LaDue Acupuncture, LLC, Notice of Privacy Practices provides a thorough explanation of how Laura LaDue, LAc may use and disclose your personal health information and your rights as a patient.

I, ____, acknowledge that I have received or been offered a copy of the LaDue Acupuncture, LLC, Notice of Privacy Practices.

____

Signature of Patient or Patient Representative Date

HIPAA PRIVACY PRACTICES PATIENT CONSENT FORM

By signing this form, you grant consent to LaDue Acupuncture, LLC, to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. The Notice of Privacy Practices provides more detailed information about how this information may be used or disclosed. You have a legal right to review the Notice of Privacy Practices in full.

The Notice of Privacy Practices is subject to change. You may obtain a copy of the revised notice by contacting Laura LaDue, LAc at 503-689-1048.

You have a right to request that I restrict how I use and disclose your protected health information for the purposes of treatment, payment, or health care operations. I will accommodate your reasonable written requests once you specify the alternatives. I am not required by law to grant your request. However, if I do decide to grant your request, I am bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that I have already used or disclosed your protected health information based on your previous consent

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Signature of Patient or Patient Representative Date

FINANCIAL POLICY

Participating Insurance Patients
LaDue Acupuncture, LLC, will bill your insurance company if you have coverage for acupuncture services. To properly bill your insurance, please provide accurate insurance information and notify us if your insurance information changes. All co-pays are due ***at the time of service.*** Please call your insurance company before an office visit to verify what portion of the visit you are responsible to pay. Be aware that your insurance company may not cover all of the services provided at LaDue Acupuncture, LLC, and you will be responsible for any fees associated with non-covered services.

Self-Pay Patients
Patients without insurance coverage for acupuncture services are required to pay in full ***at the time of service.*** You may receive a 25% discount when services are paid in full at the time of service, as administrative costs are saved when we do not have to bill an insurance company.

Methods of Payment
LaDue Acupuncture, LLC accepts cash, checks and most major credit cards.

Fees
Unpaid balances 30 days past due are charged $20 monthly. Accounts 90 days past due will be subject to discussion directly with Laura LaDue. If a satisfactory resolution cannot be reached, you may be released from LaDue Acupuncture, LLC. In the event that this occurs, you will receive a letter giving you a 30 day written notice, after which Laura LaDue, LAc will no longer be responsible for your care. A fee of $30 will be charged on any check that is returned for non-sufficient funds.

Cancellations and no shows
No shows and cancelations less than 24 hours' notice will accrue a $50 charge.

Acknowledgement, authorization to pay benefits to physician/clinic
I, the undersigned, assign all medical insurance benefits directly to LaDue Acupuncture, LLC. I hereby authorize LaDue Acupuncture, LLC, to release any information collected in the course of my examination or treatment to my insurance company to facilitate payment of benefits. I authorize the use of this signature on all my insurance submissions. I have read and understand the Financial Policy above and agree to all of the provisions herein.

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Signature of Patient or Patient Representative Date