Yu Jin Lee, LAc.
GroundSpring Healing Center
8283 SW Barbur Blvd.
Portland, OR 97219

Initial Intake Form

Chinese medicine and holistic medical model utilizes the patient's whole picture of health in order to treat the root cause of the symptoms that you are experiencing. Please fill out this form as thoroughly as possible. More information I have, better the service I can provide you. That having said, you are welcomed to provide only the information with which you are comfortable.

Patient Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Occupation: _____

Address: _____
Street City, State Zip

Phone: _____ Can I contact you through text?_____ voicemail?_____

Email: _____ Can I contact you through email? _____

Marital Status: ☐ Single ☐ Married ☐ Partnership
☐ Divorced ☐ Separated ☐ Other _____

With Whom Do you live? ☐ Alone ☐ Spouse ☐ Friends
☐ Parents ☐ Children ☐ Other _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

What are your most important health concerns and goals? _____

_____

_____

_____

Please list any medications and/or supplements that you currently take. _____

_____

_____

_____

Do you have any allergies to food, drugs, or other environmental allergens? _____

_____

_____

What hospitalizations or surgeries have you had and when? _____

_____

_____

_____

Have you experienced any major traumas? Please explain. _____

_____

_____

Height: _____ Weight: _____ Past maximum weight and when: _____

Blood pressure: _____ (most recent if known)

Childhood illnesses

☐ Scarlet fever ☐ Diptheria ☐ Rheumatic fever ☐ Mumps ☐ Measles

☐ German Measles ☐ Chicken pox ☐ Other _____

Immunizations

☐ Diptheria ☐ Rheumatic fever ☐ Measles/Mumps/Rubella ☐ Polio

☐ Pertussis ☐ Tetanus ☐ Hep A&B ☐ Others _____

Life Style

What are your main interests/hobbies? _____

Do you feel you have a healthy diet and eat regularly? Do you have food cravings (ie sugar/salt)?

_____

_____

Do you exercise? If so, what type and how frequently? _____

_____

Do you sleep well and awake rested? How many hours? _____

_____

Do you have a spiritual practice? _____

Do you use recreational drugs? _____ How much and how often ? _____

Do you use tobacco? _____ How much and how often? _____

Do you use alcohol? _____ How much and how often? _____

Have ever been treated for alcohol/drug dependence? _____ When? _____

Self and Family History

	Father	Mother	Self	Siblings	Children	Grandparents
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disorder	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Asthma/Hayfever/Hives	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Gall Bladder Disease	☐	☐	☐	☐	☐	☐
Ulcer	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Goiter	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐	☐	☐
Eye Disease	☐	☐	☐	☐	☐	☐
Alcoholism/Drug abuse	☐	☐	☐	☐	☐	☐

Father:

Health ☐ Good ☐ Poor

Age (current or at death) _____

If deceased, cause of death

_____

Mother:

Health ☐ Good ☐ Poor

Age (current or at death) _____

If deceased, cause of death

_____

Review of Systems

Please circle that applies.

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

SKIN
Rashes Y P
Eczema/Psoriasis Y P
Acne/Boils Y P
Itching Y P
Color Change Y P
Lumps Y P
Night Sweats Y P

HEAD
Headache Y P
Head injury Y P

EYES
Impaired vision Y P
Glasses/Contacts Y P
Eye Pain Y P
Tearing/Dryness Y P
Glaucoma Y P
Cataracts Y P

EARS
Impaired hearing Y P
Ringing Y P
Earache Y P
Dizziness Y P

NOSE and SINUSES
Frequent colds Y P
Frequent nose bleeds Y P
Stuffiness Y P
Hay fever Y P
Sinus problems Y P

MOUTH and THROAT
Sore throat Y P
Gum problems Y P
Hoarseness Y P
Dental cavities Y P

NECK
Swollen glands Y P
Goiter Y P
Pain/Stiffness Y P

RESPIRATORY
Cough Y P
Wheezing Y P
Asthma Y P
Bronchitis Y P
Pneumonia Y P
Pleurisy Y P
Emphysema Y P
Shortness of breath
at night Y P
lying down Y P
Tuberculosis Y P

CARDIOVASCULAR
Heart disorder Y P
Angina Y P
High blood pressure Y P
Murmurs Y P
Rheumatic fever Y P
Chest Pain Y P
Swelling of ankles Y P
Palpitations/Fluttering Y P

GASTROINTESTINAL
Heartburn Y P
Change in appetite Y P
Nausea/Vomiting Y P
Vomiting blood Y P
Excessive gas Y P
Blood in stool Y P
Hemorrhoid Y P
Jaundice (yellow skin) Y P
Liver disease Y P
Bowel movement
How often? _____
Is this a change? _____

URINARY
Pain on urination Y P
Frequent Y P
Frequent at night Y P
Inability to hold Y P
Frequent infection Y P
Kidney stones Y P
Blood in urine Y P
Impaired urination Y P

MUSCULOSKELETAL
Joint pain/stiffness Y P
Arthritis Y P
Broken bones Y P
Sprains Y P
Muscle spasms/cramps Y P
Weakness Y P

PERIPHERAL VASCULAR
Deep leg pain Y P
Cold hand/feet Y P
Varicose veins Y P

NEUROLOGIC
Fainting Y P
Seizures Y P
Paralysis Y P
Muscle weakness Y P
Numbness/Tingling Y P
Loss of memory Y P

EMOTIONAL

Depression	Y	P
Mood swings	Y	P
Anxiety/Nervousness	Y	P
Tension	Y	P

ENDOCRINE

Hypothyroid	Y	P
Hyperthyroid	Y	P
Diabetes	Y	P
Heat/Cold intolerance	Y	P
Excessive thirst	Y	P
Excessive hunger	Y	P
Fatigue	Y	P

BLOOD

Anemia	Y	P
Easy bleeding/bruising	Y	P

MALE REPRODUCTIVE

Hernias	Y	P
Testicular masses	Y	P
Testicular pain	Y	P
Prostate disease	Y	P
Venereal disease	Y	P
Discharge/sores	Y	P

Are you sexually active? _____

Erectile difficulties Y P

Sexual orientation

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Homosexual
- ☐ Other:

_____

FEMALE REPRODUCTIVE

Age menses began? _____

Average days of bleeding?

_____

Length of cycle? _____

Irregular cycles	Y	P
Bleeding between periods	Y	P
PMS	Y	P
Painful menses	Y	P
Excessive flow	Y	P
PCOS	Y	P
Endometriosis	Y	P
Breast tenderness/pain	Y	P
Nipple discharge	Y	P

Have you reached menopause? If so when? _____

Menopausal symptoms	Y	P

Are you sexually active? _____

Sexual difficulties	Y	P
Vaginal pain/infection	Y	P
Venereal Disease	Y	P

Sexual orientation

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Homosexual
- ☐ Other:

_____

Birth control of choice:

now: _____

past: _____

_____

# of pregnancies _____

# of live births _____

# of miscarriages _____

# of abortions _____

Difficulty conceiving? _____

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Informed Consent to Treat - Procedures/Risks/Alternatives

Acupuncture

- Acupuncture is the insertion of needles through the skin to adjust the body's energy. The goal is to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being.

Side effects from acupuncture can include, but are not limited to: slight bruising, minor bleeding, fainting and possible aggravation of symptoms. More serious complications, such as pneumothorax, are possible but extremely rare.

Moxibustion

- *Direct Moxibustion* is the application of a protective salve (usually Spring Wind Burn Cream) and an herb (dried Chinese mugwort) onto the skin. The herb is burned until you feel the heat, then the herb is removed from the skin. Moxibustion is done to adjust the body's energy to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being.
- *Indirect Moxibustion* is the use of an herbal stick that is burned and held a few inches away from the skin. This herbal stick warms the area to adjust the body's energy to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being.

Side effects from *direct* and *indirect moxibustion* can include: reddening of the skin, risk of burn, risk of scarring, respiratory aggravation, and possible aggravation of symptoms.

Herbal and Dietary Supplement Treatment

- Chinese Herbal and Dietary Supplement is the use of prepared herbs and dietary supplements to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being.

Side effects from herbal and dietary supplement treatment can include, but are not limited to: digestive complaints, headaches, and possible aggravation of symptoms. If any side effects are felt, you should discontinue the use of the herb/supplement and call me to consult on the issue.

TDP Lamp

- The TDP lamp is designed to provide heat to an area of the body to alleviate pain, provide relief from a variety of symptoms related to an illness, and support overall health and well-being.

Side effects that may be experienced from the lamp include, but are not limited to: reddening of the skin, risk of burn, risk of scarring and possible aggravation of symptoms existing prior to treatment.

If any side effects are felt after the treatment, it is important to contact me directly at (503) 961-4688 or yujinlee.LAc@gmail.com. As a reminder, there are many other alternative treatment options which can be discussed with a Primary Care Provider or any other healthcare provider of choice.

I understand that I may refuse any of these treatments, and discontinue treatment at any time. The treatment above has been explained to me, and I have had the opportunity to ask any questions I have regarding their application.

X_____

Patient Signature (Or Patient Representative) **Date**
(Please indicate relationship if signing for patient)

Printed Name:_____

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Financial and Office Policies

If your insurance plan covers acupuncture, I will submit your claim for you. You are responsible for your deductible, your co-pay and your co-insurance amounts. In the case of insurance billing, you are authorizing the release of any medical or other information necessary to process the insurance claim. You are also authorizing payment of medical benefits to me. If your insurance denies payment of a claim, you are responsible for the billed charges.

I accept cash or personal checks as well as credit cards namely Visa, Master Card, and American Express.

Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24-hours notice, you will be charged a $35 fee. Your insurance will not pay for a missed appointment.

Service	Fee
New patient, acupuncture (99201+97810)	**$140**
New patient, acupuncture with bodywork &/ cupping (99201+97810+97140)	**$180**
Return patient, acupuncture (97810)	**$85**
Return patient, acupuncture with bodywork &/ cupping (97810+97140)	**$125**
Bodywork; Tuina/Massage 30 min (97140x2)	**$80**
Bodywork; Cupping 15 min (97140)	**$40**
Moxibustion 15 min (97139)	$40
Chinese herbs (99070)	$20~$150
New Patient, evaluation (99203)	$165
Return patient, re-evaluation (99213)	$145
Acupuncture re-insertion (97811)	$60

Please indicate your understanding and acceptance of these policies by signing below.

_____

Patient Signature Printed Name Date
(Parent/Guardian Signature)

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NOTICE OF PRIVACY PRACTICES

Dear Valued Patient,

This notice describes my 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. Please review it carefully. The privacy of your health information is important to me.

MY LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this notice about our privacy practices, your rights concerning your health information, and our legal duties. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 2009, and will remain in effect until I replace it.

I reserve the right to make the changes in my privacy practices and the new terms of my notice effective for all health information that I maintain. Before I make significant changes in my privacy practices, I will revise this notice and make the new notice available for your review.

You may request a copy of my notice at any time. For more information about my privacy practices, or for additional copies of this notice, please contact me.

USES AND DISCLOSURES OF HEALTH INFORMATION

I use and disclose health information about you for **treatment, payment, and healthcare operations**. In order to maintain the level of service that you expect from my office, I 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. I may use or disclose your healthcare information to provide you with appointment reminders such as voicemail messages or emails. I may share your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that I may do so as described by the "Patient Rights" section of this notice. I may be required to disclose your health information when I am requires to do so by law. This may include disclosure to appropriate authorities if I have a reason to believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. Lastly, I will not use your health information for marketing communications without your written authorization.

Safeguards in place at my 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 I gather and use:

In administering your health care, I 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).

PATIENT RIGHTS

Access: You have the right to get copies of your health information. You must make a request in writing to obtain access to your health information. If you request a copy of the information, I may charge a fee for the costs of copying, mailing, or other associated supplies.

Your Authorization: In addition to my use of your health information in connection to my healthcare operations, you may give us a written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this notice.

Right to Amend: If you believe health information I have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as this office keeps the information. I may deny your request for an amendment if it is not in writing or does not include the reason to support the request.

Restriction: You have the right to request that we place additional restrictions on my use of your health information. I am not required to agree to these restrictions, but I will do my best to respect your wishes within reason and legal boundaries.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the U.S. Department of Health and Human Services. To file a complaint, please contact me at the number or address listed at the top first pate of this notice.

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Consent/Written Acknowledgement of Notice of Privacy Practices

I hereby consent to the use and disclosure of my protected health information Yu Jin Lee, LAc. for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Yu Jin Lee, LAc. prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Yu Jin Lee, LAc. may honor these requests, she is not required by law to do so. I also understand that revocations will be honored as of the date they are received by Yu Jin Lee, LAc. at the following address:

8283 SW Barbur Boulevard
Portland, OR 97219

- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Yu Jin Lee, LAc. by phone at: **503-244-1330**.
- I am aware that Yu Jin Lee, LAc. reserves the right to change the terms of her Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that she maintains. In the event of amendments, Yu Jin Lee, LAc. will make available a revised Notice of Privacy Practice for my review.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

THIS SECTION IS TO BE COMPLETED BY YU JIN LEE, LAC. IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement

[ ] Other (specify):

_____

Name and title of employee Date