Integrative Health Services
4465 N. Oakland Ave. Suite 200-S, Shorewood, WI 53211
(414) 906.0285 www.inhealthservices.com

Patient Information

NAME _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____ CELL ( ) _____

STREET _____

CITY _____ STATE _____ ZIP _____

PLACE OF BIRTH _____ MARITIAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER

IN CASE OF EMERGENCY NOTIFY _____ PHONE ( ) _____

EMAIL ADDRESS _____

BLOOD TYPE_____ REFERRED BY _____
(naturopathic consult only).

INSURANCE _____

I understand that I am here to learn about nutrition and better health practices and/or to received acupuncture treatments and that I will be offered information about food supplements and herbs as a guide to better health.

I fully understand that those who counsel me are not medical doctors and I am not here for medical-diagnostic purposes or medical treatment procedures. There services performed by Meredith Young or others are at all times restricted to consultation on the subject of natural health or Chinese medicine intended for the maintenance of the best possible state of wellness.

_____ _____

SIGNATURE DATE

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from licensed acupuncturists with Integrative Health Services. I understand that acupuncturists practicing in the state of Wisconsin are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin 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, infection, 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.

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. I have informed my practitioner of all substances to which I have had allergic reactions.

Chinese Massage, Acupressure, Guasha Therapy, Cupping Therapy, TDP Mineral Wave Lamp, Moxibustion, Magnet Therapy, Ear seeds: I understand that I may also be given the aforementioned therapies 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: local bruising, redness, minor bums, infection, 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

Chinese Nutrition Therapy: I understand that my practitioner is not a licensed dietitian and is providing dietary guidance based on Chinese medicine principles of nutrition. I understand that I need to immediately consult with my practitioner if I feel I am experiencing adverse effects from these dietary recommendations.

Should I experience any problems, which I associate with any of the treatments described above, I should call Integrative Health Services as soon as possible. In case of a medical emergency, I should seek immediate medical care at the hospital emergency room.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask the practitioner for a more detailed explanation.

PRINTED NAME _____ SIGNATURE _____ DATE _____

ADDRESS _____

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Payment Policy

- Payment is to be made at the time of service
- Returned checks for insufficient funds will be charged a $35 banking fee
- Credit card payments in the form of mastercard and visa are welcome
- Payment schedules can be arranged with the practitioner
- **Each new client referral is worth 10% off your next visit**

Cancellation Policy

We hope to encourage the consideration for others when cancelling an appointment. Only 24 hours is requested for all cancellations. Appointments not cancelled 24 hours prior will be charged at $25 per hour of missed appointment (Example: a two-hour appointment will incur a $50 charge). This charge will be due prior to your next scheduled appointment. We understand certain emergency circumstances prevail and will take those under consideration on a case-by-case basis. Thank you for your help and adherence to this policy.

By signing below, patient acknowledges receipt and understanding of the payment and cancellation policy of Integrative Health Services.

_____ _____

SIGNATURE DATE

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Notice of Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Information that we use or disclose based on the authorization you are giving us may be subject to redisclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

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.
- 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, Worker's Compensation insurance providers and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your requesting to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. This will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I have received a copy of the Notice of Privacy Practices. I understand this notice defines my rights under the federal regulations, and is intended to comply with federal patient privacy rights.

I have read the above policies and agree to their terms. I authorize you to use or disclose my health information in the manner described above.

PATIENT NAME (PRINTED)	PATIENT SIGNATURE	DATE

Health History

Today's Date _____

Integrative Health Services

Name _____ Date of Birth _____

Occupation _____ Age ___ Height ___ Sex ___ Number of children ___

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? ___ Are you pregnant? ___

Reason for office visit: _____ Date this began: _____

_____

_____

Date of last physical exam _____ Practitioner name & phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome: _____

What types of therapy have you tried for this/these problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic

☐ acupuncture ☐ conventional drugs ☐ other

Current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major hospitalizations, surgeries, injuries: Please list all procedures, complications (if any) and dates:

Year:	Surgery/Illness/Injury:	Outcome:
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress: (e.g., changes in job, work, residence, finances, legal problems):

_____

Do you consider yourself: ☐ underweight ☐ overweight ☐ reasonable weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months: _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? _____

Do you need: ☐ corrective lenses ☐ dentures ☐ hearing aid

☐ medical devices/ prosthetics/implants, describe: _____

Have you had recent changes in your ability to:

☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing our arms freely, turn your head, wiggle fingers...)

Strong **like** for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong **dislike** for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you prefer: ☐ warmth (i.e., food, drinks, weather, etc.) ☐ cold (i.e., food, drinks, weather, etc.) ☐ no preference

Is your sleep disturbed at the same time each night? ___ If yes, what time? ___

Time of day you feel the most energy or least symptoms:

☐ 7 a.m. – 9 a.m.	☐ 9 a.m. – 11 a.m.	☐ 11 a.m. – 1 p.m.	☐ 1 p.m. – 3 p.m.
☐ 3 p.m. – 5 p.m.	☐ 5 p.m. – 7 p.m.	☐ 7 p.m. – 9 p.m.	☐ 9 p.m. – 11 p.m.
☐ 11 p.m. – 1 a.m.	☐ 1 a.m. – 3 a.m.	☐ 3 a.m. – 5 a.m.	☐ 5 a.m. – 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. – 9 a.m.	☐ 9 a.m. – 11 a.m.	☐ 11 a.m. – 1 p.m.	☐ 1 p.m. – 3 p.m.
☐ 3 p.m. – 5 p.m.	☐ 5 p.m. – 7 p.m.	☐ 7 p.m. – 9 p.m.	☐ 9 p.m. – 11 p.m.
☐ 11 p.m. – 1 a.m.	☐ 1 a.m. – 3 a.m.	☐ 3 a.m. – 5 a.m.	☐ 5 a.m. – 7 a.m.

Check the general symptoms that you experience **every day**.

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

MEDICAL HISTORY

☐ Arthritis
☐ Allergies/hay fever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure issues
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Infection, chronic
☐ Inflammatory bowel
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
☐ Other _____

MEDICAL (MEN)

☐ Benign prostatic hyperplasia (BPH)
☐ Prostate cancer
☐ Decreased sex drive
☐ Infertility
☐ Sexually transmitted disease
☐ Other _____

MEDICAL (WOMEN)

☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
☐ Other_____
☐ Age of first period_____
☐ Date of last gynecological exam _____ Results of last mammogram: + or -
☐ Pap: + or -
☐ Form of birth control ____
☐ # of children____
☐ # of pregnancies _____
☐ C-sections ____
☐ Surgical menopause
☐ Menopause
☐ Date of last menstrual cycle: _____
☐ Length of cycle ___(days)
☐ Interval of time between cycles _____(days)
☐ Any recent changes in normal menstrual flow? (e.g., heavier, large clots, scanty) _____

FAMILY HEALTH HISTORY

(parents & siblings)

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzhemier's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Strike
☐ Suicide
☐ Other_____

HEALTH HABITS

☐ Tobacco: cigarettes #/ day ___
cigars #/ day ___
☐ Alcohol:
wine: glasses/day or wk___
liquor: glasses/day or wk__
beer: glasses/day or wk __
☐ Caffeine:
coffee: #6 oz cup/day ___
tea: #6 oz cup /day ___
soda: # of cans/day ___
☐ Other sources: _____
☐ Water: # glasses /day___

EXERCISE

Circle average # days per wk:
5-7 3-4 1-2
Circle duration per workout:
>45min. 30-45 min. <30 min.
☐ Walk
☐ Run, jog, jump rope
☐ Weight lift
☐ Swim
☐ Box
☐ Yoga

NUTRITION & DIET

☐ Mixed food diet (animal & Vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carb restriction
☐ The Zone Diet
☐ Total calorie restriction
Circle specific food restrictions:
dairy wheat eggs soy
corn all gluten other _____

FOOD FREQUENCY

Servings per day:
- Fruits (citrus, melons, etc.) ____
- Dark green or deep yellow/ orange vegetables ____
- Grains (unprocessed) ____
- Beans, peas, legumes ____
- Dairy, eggs ____
- Meat, poultry, fish ____

EATING HABITS

☐ Skip breakfast
☐ Two meals per day
☐ One meal per day
☐ Graze (small freq. meals)
☐ Food rotation
☐ Eat constantly (whether hungry or not)
☐ Generally eat on the run
☐ Add salt to food

CURRENT SUPPLEMENTS

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening primrose /GLA
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., lutein, resveratrol, etc.)
☐ Herbs - tea
☐ Herbs - extracts
☐ Chinese herbs
☐ Ayurvedic herbs
☐ Homeopathy
☐ Bach flowers
☐ Protein shakes
☐ Superfoods (bee pollen, phytonutrient blends)
☐ Liquid meals
☐ Other _____

WOULD YOU LIKE TO:

☐ Have more energy
☐ Be stronger
☐ Have more endurance
☐ Increase your sex drive
☐ Be thinner
☐ Be more muscular
☐ Improve your complexion
☐ Have stronger nails
☐ Have healthier hair
☐ Be less moody
☐ Be less depressed
☐ Be less indecisive
☐ Feel more motivated
☐ Be more organized
☐ Think more clearly & be more focused
☐ Improve memory
☐ Do better on tests in school
☐ Not depend on over-the counter medications (aspirin, ibuprofen, anti-histamines)
☐ Stop using laxatives or stool softeners
☐ Be free of pain
☐ Sleep better
☐ Have agreeable breath
☐ Have agreeable body odor
☐ Have stronger teeth
☐ Get less colds and flus
☐ Get rid of your allergies
☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)