

# MONTANA ACUPUNCTURE ASSOCIATES, LLC

## Patient Information

Date: \_\_\_\_\_ Phone # for follow-up: \_\_\_\_\_

Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Home) (Work) (Cell)

E-mail \_\_\_\_\_

Sex  Male Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Female Age \_\_\_\_\_

Emergency Contact \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Name) (Phone) (Relationship)

Employer \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Phone \_\_\_\_\_  
Named Insured \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you?

- Phone Book \_\_\_\_\_
- Newspaper \_\_\_\_\_
- Radio \_\_\_\_\_
- Referred by \_\_\_\_\_
- Sign \_\_\_\_\_
- Internet \_\_\_\_\_
- Other \_\_\_\_\_

**Please check (✓) symptoms you currently have or have had in the past year.**

General

- Chills
- Dizziness
- Fatigue
- Fevers
- Forgetfulness
- Headache
- Insomnia
- Nervousness
- Numbness
- Sweats
- Weight Gain
- Weight Loss

Gastrointestinal

- Abdominal Pain
- Black Stools
- Bloating
- Blood in Stools
- Constipation
- Diarrhea
- Difficulty Swallow
- Gas
- Heartburn/Reflux
- Hemorrhoids
- Indigestion
- Nausea
- Poor Appetite
- Stomach Pain
- Vomiting
- Vomiting Blood

Eye, Ear, Nose, Mouth, Throat

- Blurred Vision
- Bleeding Gums
- Cataract
- Double Vision
- Earache
- Eye Pain/Strain
- Glasses
- Hay Fever
- Hearing Loss
- Hoarseness
- Nosebleeds
- Olfactory problems
- Recurrent Sore Throat
- Red/Inflamed Eye
- Ringing in Ears
- Sinus Problems
- Sores on Lips/Tongue
- Taste Changes
- Teeth Problems
- Vision of Halos

Musculoskeletal

(Pain, Weakness, Numbness)

- Arms
- Back
- Feet
- Hands
- Hips
- Joints
- Legs
- Muscle
- Neck
- Shoulders

Skin

- Blood not Clotting
- Bruise easily
- Discoloration
- Lumps in Groins
- Lumps Underarm
- Skin Problem

Cardio-Respiratory

- Asthma
- Chest Pain
- Coughing Blood
- High Blood Pressure
- Irregular Heart Beat
- Low Blood Pressure
- Night Sweats
- Persistent Cough
- Phlegm Production
- Poor Circulation
- Recurrent Bronchitis
- Shortness of Breath
- Swelling of Ankles
- Varicose Veins

Genito-Urinary

- Abnormal Urine Color
- Blood or Pus in Urine
- Burning Urination
- Frequent Urination
- Kidney Stone
- Poor Bladder Control
- Urgency to Urinate

Men Only

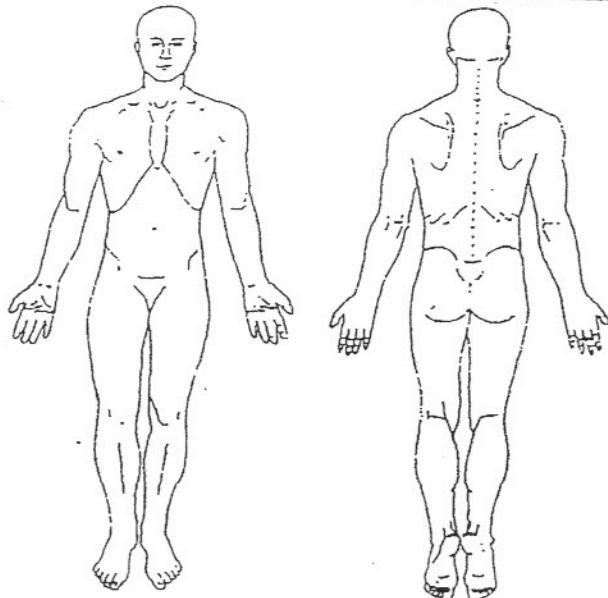
- Breast Lump
- Genital Pain
- Impotence
- Lump in Testicles
- Penile Discharge

Women Only

- Abnormal PAP Smear
- Bleeding b/w Periods
- Breast Lump
- Contraceptives (BCP)
- Irregular Periods
- Menopause Status
- Painful Periods
- Vaginal Discharge
- Sores on Genitalia

**PAIN EVALUATION**

|              |             |                  |              |
|--------------|-------------|------------------|--------------|
| ///-stabbing | xxx-burning | 000-pins&needles | ***-numbness |
|--------------|-------------|------------------|--------------|



**PAIN SCALE**

SEVERE PAIN: 10/10  
NO PAIN: 0/10

1. Please refer to the graphic for pain areas
2. Mark areas according to type of pain given in graphics
3. For each pain area use a "fraction scale" for intensity-  
Slight Pain=2-3/10 Moderate Pain=5-7/10

- ( ) Pregnancies
- ( ) Miscarriages
- ( ) Children born
- ( ) Abortions
- Last Menses \_\_\_/\_\_\_/\_\_\_
- Last PAP \_\_\_/\_\_\_/\_\_\_
- Mammogram \_\_\_/\_\_\_/\_\_\_
- Are You Pregnant? \_\_\_\_\_

# PATIENT HISTORY

1. What is your major complaint? \_\_\_\_\_
2. How did this condition develop? \_\_\_\_\_
3. How long has this condition persisted? \_\_\_\_\_
4. Have you ever received any treatment for this condition?  Yes  No  
If yes, where? \_\_\_\_\_  
When? \_\_\_\_\_  
By whom? \_\_\_\_\_  
What was the diagnosis? \_\_\_\_\_  
What kind(s) of treatment? \_\_\_\_\_  
What were the results of treatment? \_\_\_\_\_

5. List the substances that you are allergic to: \_\_\_\_\_

6. (Female Only) Are you pregnant or do you suspect that you may be pregnant?  Yes  No

7. List medications you are currently taking.

| <u>Medications</u> | <u>Dosage</u> | <u>Purpose</u> | <u>For How Long?</u> |
|--------------------|---------------|----------------|----------------------|
| _____              | _____         | _____          | _____                |
| _____              | _____         | _____          | _____                |
| _____              | _____         | _____          | _____                |
| _____              | _____         | _____          | _____                |

8. Have you tried acupuncture or Chinese medicine before?  Yes  No

9. List any major surgeries you have had.

| <u>Date</u> | <u>Problem</u> |
|-------------|----------------|
| _____       | _____          |
| _____       | _____          |
| _____       | _____          |
| _____       | _____          |

10. Significant illness (please check all that apply):
- Rheumatic Fever     Heart Disease     Diabetes     Thyroid Disease     Cancer  
 High Blood Pressure     Venereal Disease     Hepatitis     Seizures     AIDS  
Other \_\_\_\_\_

11. Significant Trauma (auto accident, falls, etc.) \_\_\_\_\_

# **MONTANA ACUPUNCTURE ASSOCIATES, LLC**

## **Our Clinic Protects Your Health Information and Privacy**

Dear Valued Patient,

This notice describes our 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. In order to maintain the level of service that you expect from our office, we 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.

### ***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 (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, worker's compensation and your employer, and other third party administrators (e.g., requests for medical records, claim payment information)

In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you - e.g., your name, address, Social Security number, etc.)

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (406) 541-2399.

**Douglas K. Womack, D.O.M., L.Ac., M.M.Q.**  
***Montana License #211***

# MONTANA ACUPUNCTURE ASSOCIATES, LLC

## CONSENT TO TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica and/or Nutritional Substances by a licensed acupuncturist at Montana Acupuncture Associates, LLC. I understand that acupuncturists practicing in the state of Montana 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/Moxibustion.** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction, 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, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that only sterile disposable needles are used by this Clinic. I understand that no guarantees concerning its use and effects are given to me and that I'm free to stop acupuncture treatment at any time.

**Chinese Herbs and Nutritional Supplements.** I understand that substances from the Oriental Materia Medica and Nutritional Supplements may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that some Herbs and Nutritional Supplements are contra-indicated during pregnancy and I agree to notify the Acupuncturist if I am or become pregnant. 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 effects 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. *Should I experience any problems, which I associate with the substances, I should suspend taking them and call the Montana Acupuncture Associates, LLC, Clinic as soon as possible.*

**Acupressure/Tui-Na Massage.** I understand that I may also be given acupressure/tui-na massage 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 bruising, 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 administered electro-acupuncture with 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 I may refuse this treatment. I agree to notify the practitioner if I have a pace maker or other bio-electrical device on or in my body prior to being administered Electro-Acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed explanations. I hereby give my permission and consent to treatment.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

# HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I hereby authorize **Montana Acupuncture Associates, LLC** to use and/or disclose the protected health information described below to my insurance carrier and/or my other healthcare practitioners.
2. Authorization for Release of Information. Covering the period of health care from  
 \_\_\_\_\_ to \_\_\_\_\_ **OR**  all past, present and future periods:
  - a.  I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
  - OR**
  - b.  I hereby authorize the release of my complete health record with the exception of the following information:
    - Mental health records
    - Communicable diseases (including HIV and AIDS)
    - Alcohol/drug abuse treatment
    - Other (please specify): \_\_\_\_\_
3. This medical information may be used by the person/institution I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until  
 (date or event) \_\_\_\_\_ **OR**  revoked by me in writing
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Personal Representative

\_\_\_\_\_  
Relationship to Patient