

ACUPUNCTURE HEALTH HISTORY

CLIENT INFORMATION

1. Name: _____
First Middle Last

2. Address: _____
Street Apt City State Zip

3. Home Phone: _____ 4. Cell Phone: _____ 5. Email address: _____

6. Date of Birth: _____ 7. Gender: _____ 8. Marital Status: _____ 9. Spouse's Name: _____

EMPLOYMENT INFORMATION

Full Time Part Time Retired Unemployed Student

10. Occupation: _____ 11. Employer: _____

12. Employer's Address: _____
Street Address City State Zip Phone

HEALTH CARE INFORMATION

13. Primary Care Physician: _____
Name Specialty Phone

14. Physician Address: _____
Street Apt City State Zip

15. Have you ever received acupuncture? YES NO

16. If yes, please list the names of any acupuncturist that you have sought treatment from previously.

Name Street Ste State Zip Phone

17. Who may we thank for referring you? _____

18. (MINORS ONLY) List guardian names, addresses and contact information.

Name Street State Zip Phone

Name Street State Zip Phone

19. In case of an emergency, please call: _____
Name Relationship

ALLERGIES

28. Please list all known allergies.

ALLERGEN	TYPICAL REACTION	ALLERGEN	TYPICAL REACTION
Animal hair/dander		Food	
Chemicals		Mold	
Drugs/medications		Pollens	
Dust		Other	

HEALTH SCREENING HISTORY

29. Please complete the following chart.

EXAM/TEST	DATE	RESULTS	EXAM/TEST	DATE	RESULTS
Blood Panel			Pap Smear		
Cholesterol			Prostate Exam		
Colonoscopy			PSA		
Complete Physical Exam			Sexually Transmitted Disease Screening		
Liver Panel			Thyroid Panel		
Mammogram			Urinalysis		
Other (please specify)			Other (please specify)		

PAST MEDICAL HISTORY

30. Please complete the following chart for yourself and each family member by placing an X in the appropriate box. Use the blank columns for additional family members.

Health History	SELF	MOTHER	FATHER	SISTER	BROTHER		
Age							
Allergies							
Asthma							
Cancer							
Chemical Dependency							
Chronic Fatigue Syndrome							
Diabetes							
Fibromyalgia							
Gastrointestinal Disorder							
Heart Disease							
High Blood Pressure							
Mental Illness							
Multiple Sclerosis							
Osteoporosis							
Seizures							
Stroke							
Thyroid Disorder							
Other (please specify)							

REVIEW OF SYSTEMS

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cough | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Colds & Flu | <input type="checkbox"/> Wheezing |

41. Have you experienced any other respiratory problems? (circle one) YES NO

DERMATOLOGY

- | | | |
|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Pimples | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Ulcerations |

42. Have you experienced any other skin problems? (Circle one) YES NO

CARDIOVASCULAR

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Palpitations |

43. Have you experienced any other heart or circulation problems? (Circle one) YES NO

GASTROINTESTINAL

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal Cramping | <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mucus in Stools |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Blood in the Stool | <input type="checkbox"/> Gas | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting |

44. Have you experienced any other digestive problems? (circle one) YES NO

GENITOURINARY

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Burning Urination | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Cloudy Urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Urination at Night |
| <input type="checkbox"/> Decreased urination | <input type="checkbox"/> Painful Urination | |

45. Have you experienced any other genitourinary problems? (circle one) YES NO

WOMEN'S HEALTH

- | | | |
|--|---|--|
| <input type="checkbox"/> Absence of a period | <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Decreased sex drive |
|--|---|--|

- | | | |
|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Suicidal Thoughts |

60. On a scale from 1-10, please rate your stress level: 1 2 3 4 5 6 7 8 9 10

61. What are major stress factors in your life? _____

62. Please rate your emotional health: (circle one) excellent good fair poor unstable crisis

63. Are you currently in psychotherapy, counseling or involved in a support group? YES NO

NUTRITION

64. Please describe your typical diet in the chart below. Include beverages such as water, soda, tea, coffee, or alcohol.

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK

65. Please indicate any of the following substances which apply to you now or in the past.

Alcohol	Yes	No	_____ amount per day/week	_____ age began	_____ age quit
Crack/cocaine	Yes	No	_____ use per day/week	_____ age began	_____ age quit
Heroin	Yes	No	_____ use per day/week	_____ age began	_____ age quit
Marijuana	Yes	No	_____ use per day/week	_____ age began	_____ age quit
Tobacco (cigarettes)	Yes	No	_____ cigarettes per day/week	_____ age began	_____ age quit
Other Recreational Drugs	Yes	No	_____ use per day/week	_____ age began	_____ age quit

66. Have you ever been treated for substance abuse? YES NO

EXERCISE

67. What type of exercise do you do? _____

68. How frequent and for how long? _____

69. Are you training for any specific event or have specific exercise goals? _____

SLEEP

70. How many hours per night do you sleep? _____

71. Do you feel rested when you wake up? YES NO

72. Do you have insomnia? YES NO

73. Do you have any other difficulties sleeping? _____

ENERGY

74. How would describe your energy: (circle one) excellent good average tired exhausted

75. Have you experienced any significant change in your energy level? YES NO

GOALS

76. What are your current health goals? _____

77. What potential obstacles do you have in the achieving these goals? _____

ADDITIONAL COMMENTS

Please address any additional concerns or conditions. Please include anything else about yourself that you would like me to know. You may also include any concerns or questions that you have specifically about acupuncture.

I have read the above information and certify it to be true and hereby authorize Jessica L. Molleur, Lic.Ac., DNBAO to do whatever is necessary for the care and management of this complaint.

Signature of client or legal guardian: _____ Date: _____

Client Agreement and Policies

Welcome to OMBE and the office of Jessica L. Molleur, Lic.Ac., DNBAO. To familiarize you with the financial and billing policies of our office, I would like to explain how your medical bills will be handled.

Declaration: You are the primary person responsible for your bill. Charges for the treatment are due at the time of service, unless other payment arrangements are made.

Payment Methods: OMBE accepts cash, checks, MasterCard and Visa as methods of payment for services. A credit card is required to reserve your appointment. A receipt will be furnished for you upon request. If you wish to submit claims to your insurance company, a detailed description of your visit will be made available to you upon written request.

Returned Checks: If your check is returned by the bank due to insufficient funds, there will be an additional \$25.00 charge added to your account which you are responsible to pay.

Cancellation Policy: Thank you in advance for observing OMBE's 24-hour cancellation policy. If you need to reschedule or cancel your appointment, please call OMBE (617.447.2222) 24-HRS in advance of your scheduled session. If you are unable to provide 24-HRS notice for the scheduled appointment, you will be responsible for the full charge of the session.

I have had the opportunity to read and discuss all of the above information, and I fully understand all of its meaning and its terms. I am aware of and accept these polices noted above.

Client Signature: _____ Date: _____

Office Signature: _____ Date: _____

OMBE Privacy Policies Notice

This notice describes how your medical information may be used and disclosed, how you can access this information, and how your privacy is being protected at OMBE. OMBE, all health care providers at OMBE, and all associates providing service at OMBE are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. The privacy of your medical records is important to us and we are committed to protecting your medical records. We create a record of the services you receive at OMBE in a paper chart and on a computer. We need this record to provide you with quality care and to comply with certain legal requirements. In order to maintain the service level that you expect from a health care office, we may need to share limited personal medical and financial information. Your medical records are the property of this health care office, but the information in the medical record belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.

How OMBE May Use or Disclose Your Health Information

Treatment: We use medical information about you to provide your health care. We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or health care operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with OMBE. We may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may share this information with a physician who will need to treat you, or a laboratory that performs a test.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. For example, we may disclose your health information to your insurance provider or a third party for the purpose of payment, to receive prior approval, or to determine whether your plan will cover the treatment.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Health Care Operations: We may use and disclose medical information about you to operate this health care practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence, and qualifications of our staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud detection and compliance programs. We may also share your medical information with our "business associates", such as our appointment scheduling and billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. Additionally, the health care practice has an open waiting room where patients may be seen by other patients. The secure area around the front desk also has a computer and fax machine that may be visible to the public. This area is limited to OMBE staff and health care providers only and the computer has an automatic screen saver that is activated after two minutes without activity.

Appointment Reminders: We may contact you for appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine, or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Notification and Communication with Family: We may disclose your health information to notify a family member or another person responsible for your care about your location and general condition in the event you are sick or injured. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. We may disclose this information in an emergency situation.

Marketing: We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

Required by Law: When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may, and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Health & Safety: We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; and reporting domestic violence. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Special Government Functions: If you are a member of the armed forces, we may release protected health information about you if it relates to military and veteran activities. We may also release your protected health information for national security purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Deceased Persons: We may disclose your health information to coroners, medical examiners, funeral directors, or organizations involved in procuring, banking, or transplanting tissues.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit in our use or disclosure. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable communication requests submitted in writing.

Right to Inspect and Copy: You have the right to inspect and copy your health information. To access your health information, submit a written request detailing the information you want access, inspect, or copy. We will charge a reasonable fee, as allowed by federal law. We may deny your request under limited circumstances. You have the right to appeal our decision if we deny access your child's records in the case that access could cause harm to your child.

Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about OMBE's denial and how you can disagree with the denial within thirty (30) days of receipt of your written request. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this office, except that this office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the Treatment, Payment, Health Care Operations, Notification and Communication with Family paragraphs. Additionally, this office does not have to account for disclosures otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this office has received notice from that agency or official that providing this accounting would be likely to impede their activities.

More About OMBE's Privacy Policy

We reserve the right to amend this Privacy Policies Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain. You have the right to request a current copy of this Notice which is maintained on our website and at the front desk. If you would like a more detailed explanation of these rights, to exercise one or more of these rights, or submit any complaints in regards to this Notice, please contact our Privacy Officer, Jessica Molleur. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

OMBE Privacy Policies Acknowledgement

OMBE Integrative Health Center 551 Boylston Street, 4th Floor Boston, MA 02116 617.447.2222 www.ombecenter.com

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I have received, read, and understood OMBE's Privacy Policies Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

Signature of Patient or Authorizes Representative

Date