

ALEXA HULSEY, L.AC.
 ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE
 THE SPA OF COOL SPRINGS
 539 COOL SPRINGS BLVD, SUITE 140 • FRANKLIN, TN 37067 • 615-771-0003

NEW PATIENT INTAKE FORM

DATE: _____

Last Name	First Name	Middle Initial	Sex	Date of Birth	Marital Status	Are you pregnant?
Street Address			City		State	Zip
Home Phone		Cell Phone		Work Phone		
Which phone # should we use for primary contact?		Email address			Would you like to be added to our email newsletter list?	
Occupation		Employer			Have you ever had acupuncture?	
Primary Physician		Last date MD consulted		Referred by:		
Emergency contact name:			Emergency contact phone number			

What is your present complaint/concern?

Significant Past Illnesses:

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Meniere's | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Have a pacemaker | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mumps | <input type="checkbox"/> Polio |

Other Illnesses _____

Surgeries (include procedure and dates): _____

Significant Trauma (auto accidents, falls, broken bones, etc.): _____

Average Daily Food Intake

Morning _____

Midday _____

Evening _____

Family Medical History: please indicate Mother, Father, Sister, or Brother

- | | | | | | |
|--|---------|---|---------|---------------------------------------|---------|
| <input type="checkbox"/> Cancer | M F S B | <input type="checkbox"/> Alcoholism | M F S B | <input type="checkbox"/> Seizures | M F S B |
| <input type="checkbox"/> Asthma | M F S B | <input type="checkbox"/> Mental Illness | M F S B | <input type="checkbox"/> Emphysema | M F S B |
| <input type="checkbox"/> Arthritis | M F S B | <input type="checkbox"/> Stroke | M F S B | <input type="checkbox"/> Hypertension | M F S B |
| <input type="checkbox"/> Allergies | M F S B | <input type="checkbox"/> Obesity | M F S B | <input type="checkbox"/> Diabetes | M F S B |
| <input type="checkbox"/> Heart Disease | M F S B | <input type="checkbox"/> Thyroid Problems | M F S B | | |

Height _____ **Weight** _____

Habits

- | | | | |
|-------------------------------------|-------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Tea | <input type="checkbox"/> Drugs | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Soda | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Salt |

Physical Symptoms

Please check all symptoms you have experienced in the past 6 months. Circle those that have been most troublesome.

General

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Fevers | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Awaken fatigued | <input type="checkbox"/> Chills | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Cold back | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Waken easily | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Cold abdomen | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Unable to fall asleep | <input type="checkbox"/> Gnawing hunger | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cravings | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Excessive sleep | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Unable to stay asleep | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Frequent naps |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Obesity | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Recent weight loss/gain |

Head

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Nasal congestion |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sneezing spells | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Grind teeth |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Loss of teeth | <input type="checkbox"/> Sore tongue |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Frequent head colds | <input type="checkbox"/> Pain in teeth | <input type="checkbox"/> Facial pain/tics |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sore gums/bleeding | <input type="checkbox"/> Facial paralysis |
| <input type="checkbox"/> Eye pain/itching | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lips or tongue sores | <input type="checkbox"/> Excess saliva |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Mucus | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Stuffy or runny nose |
| <input type="checkbox"/> Floaters/spots in eyes | <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Eyes watering | <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Bad breath | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> _____ |

Respiratory

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing/gasping | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Short of breath | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chronic chest colds | <input type="checkbox"/> Tightness in chest |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seasonal Allergy | <input type="checkbox"/> Excessive phlegm | |

Skin and Hair

- | | | | |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fingernail problems | <input type="checkbox"/> Hives | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in hair/skin | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Boils | <input type="checkbox"/> Itching | <input type="checkbox"/> Painful scars |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Purpura | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Lumps or bumps |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Warts and growths | <input type="checkbox"/> Pasty/pale complexion | <input type="checkbox"/> _____ |
-
-

Gastrointestinal

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> IBS | <input type="checkbox"/> Colitis | <input type="checkbox"/> Bowel frequency |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Stomachache | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pain/cramps | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Rectal pain/itch | <input type="checkbox"/> Fecal incontinence |
| <input type="checkbox"/> Food sits in stomach | <input type="checkbox"/> Diarrhea/loose stool | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Sweet taste in mouth | <input type="checkbox"/> Black stools | <input type="checkbox"/> Intestinal gurgling |
| <input type="checkbox"/> Ulcer | | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Bad breath |
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-

Cardiovascular

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Skipped beats | <input type="checkbox"/> Vascular spiders |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Raynaud's disease | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Mitral valve prolapse |
-
-

Genitourinary

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Burning or pain with urination | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Feeling of incomplete urination |
| <input type="checkbox"/> Urinary incontinency | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Flank pain |
| <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Dribble urine with sneeze | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Painful sex |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Difficulty or slow starting stream | <input type="checkbox"/> STD | <input type="checkbox"/> Change in sexual energy |
| <input type="checkbox"/> Weakened urine stream | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infertility |
| | | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> _____ |
| | | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
-
-

Musculoskeletal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Bone problems |
| <input type="checkbox"/> Muscle cramps/spasms | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pain down legs | <input type="checkbox"/> Disc problems |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Whiplash | <input type="checkbox"/> Numbness/tingling |
| | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Trembling/tremors | <input type="checkbox"/> Joints cracking |

No pain Mildly annoying Nagging, uncomfortable Distressing, miserable Intense, horrible Worst possible, unbearable

Current level of pain 0 1 2 3 4 5 6 7 8 9 10

Do you exercise regularly? yes / no Type of exercise: _____ Duration: _____ Frequency: _____

Women

- Vaginal burning/itching
- Vaginal discharge
- Yeast infection
- Vaginal sores
- Spotting between period
- Endometriosis
- Change in flow
- Ovarian cysts
- Vaginal infections
- Abnormal pap
- HPV
- STD's
- Hysterectomy
- Fibroids
- Water retention
- Irregular menses
- Clots
- Painful menses
- Breast lumps
- Breast tenderness/pain
- Breast discharge
- PMS
- Hot flashes
- Increase in sex drive
- Decrease in sex drive
- Vaginal itching
- Sexually active
- HRT
- Menopausal
- Changes in body/psych prior to menstruation
- Last period _____
- Age of first period _____
- Duration of period _____
- Number of pregnancies _____
- Number of births _____
- Number of miscarriages _____
- Date of last pap _____
- Date of last mammogram _____
- Birth control used _____
- Age of menopause _____

Men

- Testicular pain
- Genital itching
- Prostate enlargement
- Nocturnal emissions
- Loss of semen during day
- Premature ejaculation
- Erectile dysfunction
- Prostatitis
- Increase in sex drive
- Decrease in sex drive
- Hernia

Neuro/Psychological

- Seizures
- Areas of numbness
- Concussion
- Excessive worrying
- Work/family problems
- Feel overwhelmed
- Forgetful
- Paralysis
- Optimistic
- Pessimistic
- Depression
- Anxiety/nervousness
- Poor memory
- Poor concentration
- Unusual fears
- Agitation
- Treated for emotional problems
- Stroke
- Dull thinking
- Decisions difficult
- Lose temper easily
- Easily stressed
- Feel unhappy
- Fatigue
- Drug addiction
- Hold a grudge
- Fearful
- Perfectionist
- Repeated thoughts
- Disorientation
- Mood swings
- Considered/attempted suicide
- Hyperactivity
- Motivation low
- Motivation normal
- Motivation high

What is your dominant emotion? _____ Describe your major life stresses: _____

How do you deal with emotions? Stuff them? Explode? Express them as they occur? _____

Stress level: very high high medium low very low

What do you do for fun? _____

Do you have pets? yes / no Do you participate regularly in a faith-based group? yes / no

Describe your marriage/relationship: _____

Describe your current living situation: _____

Please feel free to elaborate on any physical or emotional symptoms:

Informed Consent for Treatment

By signing below, I do hereby voluntarily consent to be treated with Traditional Chinese Medicine, including modalities of acupuncture, herbology, tuina, cupping, moxibustion, nutrition, acupressure, warming, electro-acupuncture, and other types of hands-on healing, by licensed acupuncturist Alexa Hulsey, L.Ac.

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.

Cupping: I understand that I may receive cupping as a part of my treatment, which involves the application of glass suction jars to the skin.

Chinese Herbs: I understand that herbal and nutritional supplements may be recommended to me. 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 these substances, I should suspend taking them and call my acupuncturist as soon as possible.*

Acupressure/Tuina Massage: I understand that I may be given acupressure/tuina massage as part of my treatment.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture.

I understand that the potential risks of any of the above treatment modalities include, but are not limited to, local bruising, minor bleeding, fainting, pain and discomfort, and the possible aggravation of symptoms existing prior to the treatment. I understand that I may refuse any treatment and that I am free to discontinue my treatment at any time.

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

I understand that my medical records will be kept confidential and only disclosed with my permission or summarized anonymously. I hereby authorize Licensed Acupuncturist Alexa Hulsey to verify my medical history or condition with my physician, if required, and to release my medical records to my insurance company if they so require in order to honor my insurance claim.

I voluntarily consent to the above procedures. I understand these techniques are not a substitute for conventional medical care. I realize that no guarantees have been given to me regarding cure or improvement of my condition and that no treatment program is effective for everyone.

Payment is due at the time services are rendered. Any arrangements otherwise must be made in advance.

We require at least a 24 hour notice be given to change or cancel your appointment. You will be charged a \$25 cancellation fee for any appointments missed or cancelled within 24 hours.

Signature: _____ Date: _____

Printed Name: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing your health insurance for a medical service.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help you with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our offices to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, of health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive it electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Policy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA: The US Department of Health, Office of Civil Rights, toll free 877-696-6775

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Notice of Privacy Practices Acknowledgement

A record of the health care services that we provide to you is used and disclosed by this office when providing you with treatment, collecting payments for treatment provided to you and in other health care operations.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, our obligations in protecting your health information and your rights regarding the information contained in your medical record.

We will not use or disclose the information contained in your record in any way that is inconsistent with the policies detailed in our current Notice of Privacy Practices.

If you have questions or would like additional information about this notice, please notify our office.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual

Date

Printed name if signed on behalf of patient

Relationship to patient (parent, legal guardian, etc.)

This form will be retained in your medical record.