

**Confidential Patient Intake Form** - Please use back of page for more space.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Number Street City State Zip

Telephone Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ May we add you to our Email Update list? Yes or No

How do you prefer to communicate messages? \_\_\_Email \_\_\_Text \_\_\_Phone call/Voicemail

Gender: \_\_\_\_\_ Lives with: \_\_\_\_\_ Children? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone Relationship

Primary Care Physician: \_\_\_\_\_  
Name Institution

Who can we thank for referring you? \_\_\_\_\_  
Name

Have you had acupuncture before? Y N When? \_\_\_\_\_ Where? \_\_\_\_\_

What are you here to work on? \_\_\_\_\_

Have you seen an MD for this? \_\_\_\_\_ When? \_\_\_\_\_ Diagnosis? \_\_\_\_\_

Please describe any major illnesses or surgeries and when they happened: \_\_\_\_\_

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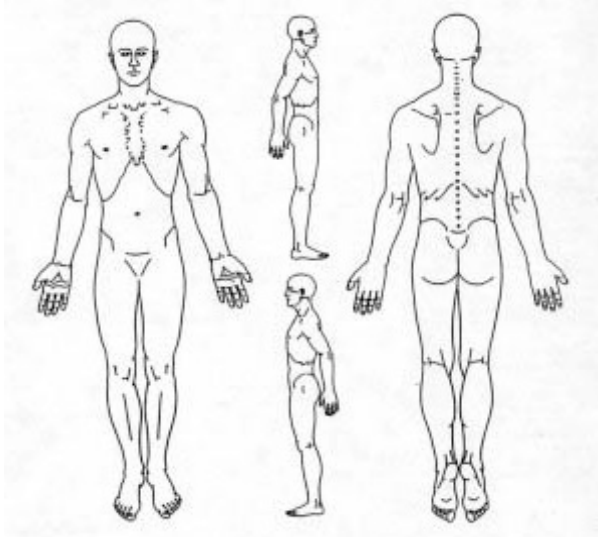
Please list all known Allergies (use the back if you need more space): \_\_\_\_\_

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**Please list all medications and supplements are you taking, use the back if you need more space:**

Medication/Supplement Name	Reason Taking / Dx.	How Long	Dose & Freq.	Last Dose

Please mark on the diagram where you have pain:



Describe the pain: \_\_\_\_\_

Does it travel? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Do you have any particular food cravings? \_\_\_\_\_

Do you use: Tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Caffeine? \_\_\_\_\_ Recreational drugs? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_ What activities? \_\_\_\_\_

Sleep: Do you sleep well? \_\_\_\_\_ If you wake up, why? \_\_\_\_\_

Do you go back to sleep easily? \_\_\_\_\_ Do you feel rested when you get up? \_\_\_\_\_

How is your energy level (1 to 10 range)? \_\_\_\_\_ Work/Occupation: \_\_\_\_\_

**Women:** Are you pregnant? \_\_\_\_\_ When was your most recent period? \_\_\_\_\_ Regular periods? \_\_\_\_\_

How many days between periods? \_\_\_\_\_ How old when first period? \_\_\_\_\_ Final Period? \_\_\_\_\_

Do you have PMS? \_\_\_\_\_ Moodiness/Emotional? \_\_\_\_\_ Bloating? \_\_\_\_\_ Breast Swelling? \_\_\_\_\_

During your period: Cramps? \_\_\_\_\_ Clots? \_\_\_\_\_ Heavy flow? \_\_\_\_\_ Scanty flow? \_\_\_\_\_ # of days: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ What form of birth control do you use? \_\_\_\_\_

Have you ever been pregnant? \_\_\_\_\_ Number of: Live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

How old are your children? \_\_\_\_\_ Last Birth/Miscarriage/Abortion: \_\_\_\_\_

Are you trying to get pregnant? \_\_\_\_\_ For how Long? \_\_\_\_\_ Interventions: \_\_\_\_\_

Date of last gynecological exam: \_\_\_\_\_ Breast Imaging: \_\_\_\_\_ Type: \_\_\_\_\_

**Men:** Last Prostate exam: \_\_\_\_\_ Enlarged Prostate? \_\_\_\_\_ Prostate cancer? \_\_\_\_\_

Urinary problems: Dribbling urine? \_\_\_\_\_ Slow start of stream? \_\_\_\_\_ Burning? \_\_\_\_\_

Erectile difficulty? \_\_\_\_\_ Testicular pain/swelling? \_\_\_\_\_ Night time frequency? \_\_\_\_\_

**MEDICAL HISTORY:** ✓ for any problem you have **now**    X for any problem you've had **in the past**.

Please write on back of the page anything else not listed, and additional details.

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Anxiety/ Nervousness	<input type="checkbox"/> Dribbling Urination	<input type="checkbox"/> Gall Stones
<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Hepatitis A/B/C
<input type="checkbox"/> Dementia	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Breast Pain or Discharge
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Menopause Symptoms
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> PTSD	<input type="checkbox"/> Anemia	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Aneurism	<input type="checkbox"/> Fibroids
<input type="checkbox"/> Tooth Grinding/TMJ	<input type="checkbox"/> Palpitations	<input type="checkbox"/> PMS
<input type="checkbox"/> Earaches	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> PCOS
<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Painful Intercourse
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Vaginal Dryness
<input type="checkbox"/> Migraine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Neuritis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Impotence
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Testicular Pain/Swelling
<input type="checkbox"/> Stroke	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Vasectomy/Tubal Ligation
<input type="checkbox"/> Dry Eyes/Excess Tearing	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Constipation
<input type="checkbox"/> Eye/Visual Problems	<input type="checkbox"/> Back Pain upper/mid/lower	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Bursitis – shoulder or knee	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Eczema	<input type="checkbox"/> Disc Problems	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Hives	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Rashes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Excess Appetite
<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Muscle Spasms or Cramps	<input type="checkbox"/> Frequent Hunger
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Gas/Belching
<input type="checkbox"/> Cough	<input type="checkbox"/> Osteoporosis/Bone Loss	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Get Sick Easily	<input type="checkbox"/> Pinched Nerves	<input type="checkbox"/> Hernia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Pleurisy		<input type="checkbox"/> Candida
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/> Diabetes Type 1 or 2
<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Edema
		<input type="checkbox"/> Fatigue
		<input type="checkbox"/> HIV/AIDS
		<input type="checkbox"/> Hypoglycemia
		<input type="checkbox"/> Hyper/Hypo Thyroid
		<input type="checkbox"/> Lupus
		<input type="checkbox"/> Obesity
		<input type="checkbox"/> Poor/Slow Wound Healing
		<input type="checkbox"/> Unexplained Weight Loss
		<input type="checkbox"/> Weight Gain

## Lafayette Acupuncture & Functional Medicine - Benjamin Dierauf, LAc

2920 Camino Diablo #210-C, Walnut Creek CA 94597 (925) 297-4785 bdierauf@gmail.com

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<b>Fee Schedule:</b>	<u>Same day discount</u>	<u>Regular Fee</u>
Patient visit (1-sided acupuncture)	\$115	\$145
Patient visit (2-sided acupuncture)	\$160	\$220
Initial visit evaluation + acupuncture	\$175	\$285
Massage	\$50	\$80
Electro-stimulation	\$80	\$155
Suction Cups / Guasha-Scraping	\$65	\$90

### **Cancellation Policy:**

Less than 24 hours cancellation notice and/or missed appointments will be billed at \$115. If an emergency prevents you from keeping your appointment, arrangements can be made. PLEASE BE ON TIME. If you know you will be late, please call. Every effort will be made to reschedule you for a later time. Fees for missed appointments are NOT covered by insurance.

I have read this cancellation policy and agree to its terms.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Benefit Assignment and Release of Information:**

I \_\_\_\_\_, hereby assign all medical benefits to which I am entitled, as covered by private insurance or any other qualifying health plan, to Benjamin Dierauf, LAc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Benjamin E. Dierauf, LAc, to release all information necessary, including medical records, to secure payment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Financial Policy Statement:**

As a courtesy to you, it is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill for services rendered. Arrangements for payment of your estimated share must be made at the date of service. If your insurance carrier does not remit within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to us.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Patient Privacy Effective Date: March 3, 2013**

**Health Insurance Portability and Accountability Act (HIPAA)**

Benjamin Dierauf, LAc, is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that I communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Benjamin Dierauf, LAc. You may also send a written complaint to the US Department of Health and Human Services.

I have read, understand and agree to the above conditions:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Informed Consent for Acupuncture Treatment and Care**

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Benjamin Dierauf, LAc, a licensed acupuncturist, or other members of his office.

I understand the methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Suction Cupping, Electrical Stimulation, Spooning (Guasha), Acupressure, Tui-Na (Chinese massage), Manual Therapy, Chinese or Western Herbal Medicine, and Nutritional & Lifestyle Counseling.

I have had the opportunity to discuss with the above named Benjamin Dierauf and/or with other office personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping and spooning.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. I will notify my acupuncturist should I become pregnant or if I am trying to become pregnant (for which Oriental medicine can be very helpful). If I experience any gastro-intestinal upset or allergic reactions to the herbs I will stop taking the herbs and immediately inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name \_\_\_\_\_

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_