ORIENTAL MEDICINE INTAKE FORM

Name:____ **Date:**________________________

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. ___________________________________ Approx. Date of Onset:_________________________
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other____________________

2. ___________________________________ Approx. Date of Onset:_________________________
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other____________________

3. ___________________________________ Approx. Date of Onset:_________________________
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other____________________

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1.___________________________________ 4.___________________________________
2.___________________________________ 5.___________________________________
3.___________________________________ 6.___________________________________

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1.___________________________________ 4.___________________________________
2.___________________________________ 5.___________________________________
3.___________________________________ 6.___________________________________

Please list **allergies** that you have to any of the following:

Drugs:______________________________ Foods:____

Other (i.e. pollen, paint, etc.):____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

____
____
____

Personal Habits:

☐Tobacco packs/day__________
☐Alcohol drinks/wk___________
☐Coffee/tea/cola cups/day___________
☐Recreational drugs times/wk___________

☐High Stress Level Reason________________

Do you follow any diet regimens/restrictions?
☐Yes ☐No
If Yes, describe:____________________________

Work Activity:

☐Sitting % of time_____________
☐Standing % of time_____________
☐Light labor % of time_____________
☐Heavy labor % of time_____________

Exercise:
Do you exercise regularly? ☐Yes ☐No
If Yes, describe & tell how often:_________________________________
____
____

FAMILY INFORMATION

Do you have children? ☐Yes ☐No If Yes, how many?__________Ages______________________

Are you, or could you be currently pregnant? ☐Yes ☐No Due date______________________

Please check if you have had (in the **last three months**)

GENERAL

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Changes in appetite
- ❑ Weight loss/gain
- ❑ Cravings
- ❑ Peculiar tastes
- ❑ Strong thirst
- ❑ Fevers/Chills
- ❑ Sweat easily
- ❑ Localized weakness
- ❑ Bleed / bruise easily
- ❑ Sudden energy drop (time?)
- ❑ Fatigue
- ❑ Tremors
- ❑ Poor sleeping
- ❑ Heavy sleeping
- ❑ Dream disturbed sleep
- ❑ Night sweats
- ❑ Dizziness

SKIN AND HAIR

- ❑ Rashes/Hives
- ❑ Itching
- ❑ Dry skin
- ❑ Dandruff
- ❑ Ulcerations
- ❑ Eczema/Psoriasis
- ❑ Loss of hair
- ❑ Pimples/Acne
- ❑ Fungal infections
- ❑ Recent moles
- ❑ Change in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Concussions
- ❑ Glasses/Contacts
- ❑ Eye strain/pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Excessive tearing
- ❑ Poor/blurry vision
- ❑ Night blindness
- ❑ Cataracts/Glaucoma
- ❑ Spots in front of eyes
- ❑ Earaches/Infections
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Excessive phlegm – color_____________
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Swollen glands
- ❑ Sores on lips/tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Teeth problems
- ❑ Gum problems
- ❑ TMJ disorder
- ❑ Grinding teeth
- ❑ **Headaches** (location, triggers, severity)?

Other head & neck concerns:

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Fainting
- ❑ Cold hands/feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Phlebitis

Other heart or blood vessel concerns:

RESPIRATORY

- ❑ Cough
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Pain with deep breath
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Production of phlegm - color?_________ Is it ☐thick or ☐thin

Other lung related concerns:

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Hiccups
- ❑ Belching
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Mucus in stools
- ❑ Acid Regurgitation
- ❑ Abdominal pain
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Bedwetting
- ❑ Kidney stones
- ❑ Impotency
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Premature ejaculation
- ❑ Nocturnal emissions
- ❑ Sores on genitals
- ❑ Frequent urinary tract infections
- ❑ Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Hand/wrist pains
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Cramps/spasms
- ❑ General joint pain/stiffness
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Joint with limited range of motion____________

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Loss of balance
- ❑ Areas of numbness
- ❑ Tics
- ❑ Lack of coordination
- ❑ Memory loss
- ❑ Concussion
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily susceptible to stress
- ❑ History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses______ If no longer menstruating, approximate date ceased____________

First day of last menses_______ Length between menses:_______days Duration of period:______days

- ❑ Unusual flow (☐heavy or ☐light)
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Clots in flow
- ❑ Vaginal discharge – color___________
- ❑ Vaginal odor
- ❑ Vaginal dryness
- ❑ Vaginal sores
- ❑ Hot flashes
- ❑ Breast lumps/soreness

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP:________________ Results were: normal abnormal unsure

If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies______ Births_____ Miscarriages______ Abortions____

Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

Family History: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	**Who**	**Comments**
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Signature: ____ Date: __________________

NEW YORK CHIROPRACTIC COLLEGE
Notice of Patient Privacy Practices
Your Information. Your Rights. Our Responsibilities.

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.

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We may not be required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure that person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Offices for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

Effective: October 2, 2017

In the case of fundraising:

- **We may contact you for fundraising efforts, but you can tell us not to contact you again.**

Our Uses and Disclosures

We typically use or share your health information to:
Treat you. We can use your health information and share it with other professionals who are treating you. ***Example: A doctor treating you for an injury asks another doctor about your overall health condition.***
Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. ***Example: We use health information about you to manage your treatment and services.***
Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. ***Example: We give information about you to your health insurance plan so it will pay for your services.***

How else can we use or share your health information? **We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**
Help with public health and safety issues:

- **We can share health information about you for certain situations such as:**
  - **Preventing disease.**
  - **Helping with product recalls.**
  - **Reporting adverse reactions to medications.**
  - **Reporting suspected abuse, neglect, or domestic violence.**
  - **Preventing or reducing a serious threat to anyone's health or safety.**

Do research:

- **We can use or share your information for health research.**

Comply with the law:

- **We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.**

Respond to organ and tissue donation requests:

- **We can share health information about you with organ procurement organizations.**

Work with a medical examiner or funeral director:

- **We can share health information with a coroner, medical examiner, or funeral director when an individual dies.**

Address worker's compensation, law enforcement, and other government requests:

- **We can use or share health information about you:**
  - **For worker's compensation claims.**
  - **For law enforcement purposes or with a law enforcement official.**
  - **With health oversight agencies for activities authorized by law.**
  - **For special government functions such as military, national security, and presidential protective services.**

Respond to lawsuits and legal actions:

- **We can share health information about you in response to a court or administrative order, or in response to a subpoena.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice. **We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**

This Notice of Privacy Practice applies to the following New York Chiropractic College's Health Centers:
Depew Health Center 4974 Transit Rd. Depew, NY 14043,
http://www.depewhealthcenter.com/
Levittown Health Center 70 Division Ave. Levittown, NY 11756,
http://www.levittownhealthcenter.com/
Rochester Health Center 1200 Jefferson Rd. Rochester, NY 14623,
http://www.rochesterhealthcenter.com/
Seneca Falls Health Center 2360 State Route 89 Seneca Falls, NY 13148,
http://www.senecafallshealthcenter.com/
Campus Health Center
2360 State Route 89, Seneca Falls, NY 13148

Privacy Officer:
Wendy Maneri, Associate Dean of Chiropractic Clinical Education and Health Centers
wmaneri@nycc.edu
Phone: 315-568- 3262

NEW YORK CHIROPRACTIC COLLEGE HEALTH CENTERS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF NYCC’S PRIVACY PRACTICES

By signing below, I acknowledge receiving a copy of NYCC’s Notice of Privacy Practices.

_________________________________ _________________

Patient Name Patient’s DOB

____ _________________

Signature of Patient or Personal Representative* Date

*If signed by a Personal Representative, the following information must also be included:

____

Name of Personal Representative

____

Relationship of Personal Representative to Patient

For Administrative Use Only

I have made a good faith effort to obtain patient written acknowledgment but patient was unable/unwilling because:

Signature____

Date___________________________________

Effective: October 2, 2017