

**HEALTH HISTORY**

**Date:**

Name: \_\_\_\_\_ sex: \_\_\_\_\_ age: \_\_\_\_\_

Address: \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate phone # \_\_\_\_\_ email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Emergency contact: \_\_\_\_\_

Relationship Status: single married living w/ partner separated divorced widowed

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about our clinic/ Referred by: \_\_\_\_\_

Physician: \_\_\_\_\_ Physician phone#: \_\_\_\_\_

Have you been treated with Acupuncture or Chinese Herbal Medicine before? \_\_\_\_\_

**MAIN COMPLAINTS**

**Please write in your top 1 to 3 health complaints/concerns in order of importance to you.**

**1** \_\_\_\_\_

When did this start? \_\_\_\_\_

Heat: (circle one)	makes better	makes worse	no change
Cold:	makes better	makes worse	no change
Damp weather:	makes better	makes worse	no change
Exercise/Activity	makes better	makes worse	no change

Level of discomfort/pain 1-----5-----10

**2** \_\_\_\_\_

When did this start? \_\_\_\_\_

Heat: (circle one)	makes better	makes worse	no change
Cold:	makes better	makes worse	no change
Damp weather:	makes better	makes worse	no change
Exercise/Activity	makes better	makes worse	no change

Level of discomfort/pain 1-----5-----10

### 3

---

When did this start? \_\_\_\_\_

Heat: (circle one)	makes better	makes worse	no change
Cold:	makes better	makes worse	no change
Damp weather:	makes better	makes worse	no change
Exercise/Activity	makes better	makes worse	no change

Level of discomfort/pain 1-----5-----10

## HEALTH HISTORY

Please circle and fill in all that apply

Cancer:	you	family	Year_____	Type(s)_____
Diabetes	you	family	Year_____	
Hepatitis	you	family	Year_____	
High Blood Pressure	you	family	Year_____	
Heart Disease	you	family	Year_____	
Stroke	you	family	Year_____	
Seizure Disorder	you	family	Year_____	
Thyroid Disease	you	family	Year_____	
Asthma	you	family	Year_____	
Pacemaker	you	family	Year_____	
Osteoporosis	you	family	Year_____	
Herpes	you	family	Year_____	
AIDS/HIV	you	family	Year_____	
Other STD	you	family	Year_____	Type(s) _____
Rheumatic Fever	you	family	Year_____	
Alcoholism	you	family	Year_____	
Allergies	you	family	Year_____	Type(s) _____
Mental Illness	you	family	Year_____	
Kidney Disease	you	family	Year_____	
Anemia	you	family	Year_____	

## HABITS

Substance	Amount per week	If Quit, Year?
Coffee/Tea	-----	
Soda	-----	
Tobacco	-----	
Alcohol	-----	
Drugs	-----	

## EXERCISE

Do you exercise regularly? Yes No  
If so, what and how often? \_\_\_\_\_

## MEDICATIONS & SUPPLEMENTS

Please note any medications, herbs or supplements that you take regularly

---

---

---

---

**MEDICATIONS & SUPPLEMENTS**

Circle any of the following that you are taking or have taken in the past

Phenytoin (Dilantin)	taking now	took in the past
Warfarin (Coumadin)	taking now	took in the past
Digoxin/Digitoxin (Lanoxin)	taking now	took in the past
Lithium (Lithobid)	taking now	took in the past
Antidepressants (including Elavil)	taking now	took in the past
Statin Drugs	taking now	took in the past
Oral Contraceptive Pills	taking now	took in the past
Corticosteroids	taking now	took in the past
Beta blockers	taking now	took in the past

**INJURIES & SURGERIES**

Please note what happened to what body area and when it occurred (including dental)

---



---



---



---



---

**DIET & NUTRITION**

Please describe what you typically eat throughout each day

**Breakfast** \_\_\_\_\_

**Lunch** \_\_\_\_\_

**Dinner** \_\_\_\_\_

**Snacks** \_\_\_\_\_

**Do you crave certain foods? Yes No**  
**If yes, which foods/food types do you crave?**

---



---

# HEALTH HISTORY FOR MEN



## TEMPERATURE

Please circle all that apply

Relative to other people, I seem to feel:

### COLD

### NEUTRAL

### HOT

Cold hands/feet	Thirst for cold / hot drinks	Night sweats	Hot hands/feet/chest
Chills	Thirst, no desire to drink	Unusual sweats	Hot flashes
Cold in the bones	Absence of thirst		Hot in afternoon
Areas of numbness	Excessive thirst		Hot in at night

## MOISTURE

Please circle all that apply

Dry skin	Dry mouth	Edema/swelling	Oily skin
Dry hair	Dry lips	Rashes	Oily hair
Dry eyes	Dry throat	Itching	Pimples
Dry brittle nails	Dry nose/bleeding	Dandruff	Weight gain/loss

## DIGESTION

Please circle all that apply

BM: How often? ___x/every ___days	Gas	Nausea/Vomiting	Bloating
Stools keep shape? Y N	Dry Stools	Bad breath	Difficult to pass
Alternating diarrhea/constipation (IBS)	Belching	Heartburn	Tired after BM
Indigestion	Poor appetite	Excessive hunger	Foul smelling stools

## ENERGY

Please circle all that apply

Sudden energy drop	Dependence on caffeine/stimulants	Short of breath	Poor memory
<i>Time of day:</i> ___am/pm	Wired/ungrounded	Heart Palpitations	Dizzy/lightheaded
Energy drop after eating	Hard to concentrate	Blood pressure high/low	Body/limbs heavy
Fatigue	Body/limbs weakness	Bleed/Bruise easily	Headaches

## SLEEP

# hours per night ___	Difficulty falling asleep	Wake ___x/night @ ___am/pm
Wake to urinate	Disturbing dreams	Restless sleep
Not rested upon waking		

## EMOTIONS

What emotions dominate your experience?

Anger	Grief	Irritability
Depression	Worry	Fear
Obsessive Thinking		Timid/Shy
Sadness	Indecision	

## EARS, NOSE, THROAT

Please circle all that apply

Poor vision	Poor hearing	Night blindness	ringing in ears
Red eyes	Excess earwax	Itchy eyes	Sore throat
Spots in front of eyes	Dental problems	Sinus congestion	Mouth sores
Phlegm	Cough		

## URINARY

Please circle all that apply

Fluid in = fluid out? Yes No

Urgency to urinate	Decrease in flow	Frequent urination	Dribbling
--------------------	------------------	--------------------	-----------

Pain on urination	Difficulty starting/stopping	Burning sensation
-------------------	------------------------------	-------------------

Incontinence	Cloudy urine	Kidney stones	Blood in urine
--------------	--------------	---------------	----------------

## REPRODUCTIVE

Please circle and fill in all that apply

Are you sexually active? Y N

Prostate disease	Erectile dysfunction	Genital Pain	Jock Itch
------------------	----------------------	--------------	-----------

Premature ejaculation	Vasectomy	Sores on genitals	Hernia
-----------------------	-----------	-------------------	--------

Discharge	Hemorrhoids	Change of sexual drive: increase	decrease
-----------	-------------	----------------------------------	----------

## Informed Consent

I hereby request and consent to the performance of the following on myself or whom I am legally responsible by the licensed acupuncturists on staff at the Center for Integrative Medicine (CIM) who now or in the future treat me while employed by, are working or associated with, or serving as back up for CIM: acupuncture, moxibustion, cupping and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas on my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat or cold therapy, electrical and/or magnetic stimulation and aromatherapy; the prescription of herbal medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my practitioner the nature and purpose of acupuncture and Oriental Medicine Procedures. Although I am aware that acupuncture and the other procedures in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks associated with acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risks of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if these symptoms occur, or if I become pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise such judgment during the course of my treatment as the practitioner feels at the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read or have had read to me, this informed consent form. I have also had an 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 conditions(s) for which I seek treatment at the CIM clinic.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(or Patient representative)

## **COMMON QUESTIONS ABOUT ACUPUNCTURE**

### ***Is Chinese medicine safe?***

Traditional Chinese medicine has been practiced for thousands of years on millions of people with an amazing record of safety and efficacy. Side effects and risks associated with acupuncture and herbs are significantly lower than those associated with Western medicine and all needles used are sterile, single use and disposable.

### ***Is Chinese medicine mind over matter?***

There are some people that argue Chinese medicine is only effective because of the *placebo* (or mind-over-matter) effect. Studies have consistently shown acupuncture to be between 65 - 85% effective, while the placebo effect is commonly shown to be about 30 - 35% effective (in studies of Eastern medicine and Western medicine alike). When you compare these two sets of statistics, it is clear that there is much more to Chinese medicine than mind over matter. In fact, you don't even need to "believe" in it for it to work. Chinese medicine does however embrace the power of mind over matter, and all kinds of holistic healing!

### ***How does acupuncture work?***

From a Chinese medical perspective acupuncture is effective through its ability to stimulate the body (including specific organs) and elicit a response that helps recreate balance and health from within. While there are many theories about the mechanisms of acupuncture from a western perspective (including theories that focus on its effects on neurotransmitters, the nervous system, and electrical conductivity) they remain theories.

### ***What should I know before my first visit?***

Initial treatments last 1-1/2 to 2 hours with the majority of that time spent discussing your health concerns and collecting a detailed health history. There is also ample time for questions and answers. Expect your acupuncturist to look at your tongue (please don't brush your tongue or chew gum if you can remember!), take your pulse, and possibly palpate acupuncture points on your body (especially your abdomen). You should wear loose clothes that are comfortable to lie down in for 30 minutes and be sure to eat within 4 hours of your appointment (no empty stomachs please).

### ***Can Chinese medicine be used with Western medicine?***

Absolutely! The Center for Integrative Medicine wishes to be supportive and useful in whatever capacity works for you. Whether you choose Chinese medicine alone or Chinese medicine with Western medicine (or anything else for that matter), we will strive to be a partner in your healthcare needs.

### ***Is acupuncture affordable?***

Although the thought of paying out-of-pocket for healthcare can be daunting, it is actually quite affordable and worthwhile when you consider the results and benefits. Treatments may be slightly more costly up front, but can save you tremendously in the long run because they focus on treating illness from its root, which can prevent relapses, future illness, reduce the need for long-term care including medications, and also benefit your quality of life. In other words, Chinese medicine is an investment with long-term benefits.

### ***How many treatments will I need?***

The number of treatments required will depend on your individual health concerns and will be specifically addressed during your report of findings (at your second visit). A general rule of thumb is to plan on one month of treatment for every one year you have had your health concerns. One month of treatment may include anywhere from 1 to 6 acupuncture appointments depending on whether you also take herbs and other factors.

**CENTER FOR INTEGRATIVE MEDICINE**  
**PATIENT DEMOGRAPHIC FORM**  
**(PLEASE PRINT)**

Primary Provider seen in our office: \_\_\_\_\_

**PATIENT INFORMATION**

Legal First Name: \_\_\_\_\_ Legal Last Name: \_\_\_\_\_

Middle Name \_\_\_\_\_ Name you prefer to go by \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: (please circle) Male Female

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone (\_\_\_\_\_) \_\_\_\_\_ (please circle) home cell work

Secondary Phone (\_\_\_\_\_) \_\_\_\_\_ (please circle) home cell work

SS# \_\_\_\_\_ Email Address \_\_\_\_\_

**Would you like to receive a copy of our monthly newsletter via email? YES NO**

Marital Status: S M D W Spouses Full Legal Name \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact (someone not living in your household)

Contact Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Primary phone \_\_\_\_\_ Secondary phone \_\_\_\_\_

Person responsible for bill if patient is a minor: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different): \_\_\_\_\_

**INSURANCE INFORMATION: (Please complete this section in full. Info needed may not appear on card)**

**PRIMARY INSURANCE**

Insurance Company \_\_\_\_\_

Primary Cardholder's Information: **please check box if information is the same as above**

Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Relation to Primary Cardholder \_\_\_\_\_

**Secondary Insurance**

Insurance Company \_\_\_\_\_

Primary Cardholder's Information: **please check box if information is the same as above**

Name \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB \_\_\_\_\_

Relation to Primary Cardholder \_\_\_\_\_

---

I, THE UNDERSIGNED, GIVE AUTHORIZATION TO TREAT AND ASSIGN DIRECTLY TO THE CENTER FOR INTEGRATIVE MEDICINE, ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Center for Integrative Medicine**  
1100 East 3rd Street, Suite G100  
Chattanooga, TN 37403  
Telephone: (423) 643-2246 ÉFax (423) 643-2030

### **Notifications and Releases**

We want to make your experience with every aspect of our service, meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

Listed below are several notices that outline certain responsibilities of ours, and yours. ***Please read them carefully and sign where indicated that you have read each statement.***

**\*\*General Consent for Treatment**

*We look forward to treating you as a patient, however, we need your permission for our physicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.*

**I give general consent to be treated.**

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

### **Patient / Patient's representative**

**\*\*Financial Policy / Assignment of Benefits**

*As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services.*

***A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee.*** \_\_\_\_\_ (patient initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. Balances not paid within 30 days after your first treatment will be subject to a 1½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorney's fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

**I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.**

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

Patient / Patient's representative

*New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.*

**\*\*Privacy Policy**

**I acknowledge that I have been informed about the privacy of my medical record, and the practice's Privacy Policy has been made available to me.**

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

CENTER FOR INTEGRATIVE MEDICINE  
Jeffrey S. Jump. M.D.  
1100 E. Third Street. Suite G-100  
Chattanooga, TN 37403 Phone: (423) 643-2246 Fax: (423) 643-2030

## PRIVACY RESTRICTION

As your healthcare provider, I want you to understand that everything you tell me is confidential. New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e., parents/guardians, spouses) without your approval in writing.

**I understand the above statement and (check one box below):**

- I do not mind that my medical information is shared with my parent/guardian or spouse at anytime.
- I want my medical information to remain confidential. My protected health information should *NOT* be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may release information to the person(s) paying for my medical insurance. I also realize that this restriction must be approved by Center for Integrative Medicine Privacy Officer, who may deny my request.

---

Patient Signature

---

Date

**Emergency Treatment EXCEPTION:** If the Privacy Office agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or physician to use and disclose necessary information to treat the patient.

Created on 03/25/03