INNER GATE
HEALTH & WELLNESS

6230 NE Halsey St, Portland OR 97213
Tel: 971.279.2294 Fax: 971.339.2971

Personal Information

Name: _____

Date of Birth: _____ Social Security #:_____(required if services not paid in full)

Sex assigned at birth: _____ Gender:_____ Pronouns: _____ Sexual Orientation: _____

Marital Status: ☐ Single ☐ Married ☐ Other Parent/Partner's Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____Ok to leave messages? ☐ Yes ☐ No

Work Phone: _____Ok to leave messages? ☐ Yes ☐ No

Cell Phone: _____Ok to leave messages? ☐ Yes ☐ No

Fax: _____ Email:_____

Preferred Reminder Communication Method: ☐ Home Phone ☐ Cell ☐ Email ☐ Please Do not call

Employer: _____ Occupation: _____

How were you referred to An Hao Clinic? _____

Emergency Contact

Name: _____ Relationship to you: _____

Address: _____

Home #: _____ Cell #: _____ Work #:_____

Insurance Information

Copy of Insurance Card Required

Primary Insurance Company: _____

Phone Number: _____Group or Individual Plan? _____

Subscriber ID #: _____ Group #: _____

Who are you in relation to the **primary subscriber**? ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Subscriber's Name: _____Date of Birth: _____

Primary Subscriber's Policy #: _____

Primary Subscriber's address (if different than your address): _____

_____

If you have a secondary insurance, please give us a copy of the insurance card. Thank you.

Office Policies and Statement of Financial Responsibility

Insurance:

- Please call your insurance provider prior to your visit to verify your benefits.
- We only bill your primary insurance company.
- Please bring a copy of your insurance card so that we can make a photocopy for our records.
- Payment is expected at the time of service.
- A Social Security Number is required if charges are not paid in full at the time of service.
- As Health Care Providers we must emphasize our relationship is with you, not your insurance company. Therefore, although we will file a claim for you, **all charges are your responsibility from the date services are rendered.**
- As a courtesy to you, we will carry your claim for 90 days from the date of service. **If your insurance company has not paid in full within 90 days, full payment is expected from you.**
- All expenses for supplements and herbs are in addition to the cost of the visit/treatment and are to be paid in full at the time of service.

Billing:

- We require payment in full for all services rendered and pharmacy prescribed at the time of visit, unless payment arrangements have been approved in advance by our staff.

Appointments:

- If you are unable to keep your appointment, **PLEASE GIVE US AT LEAST 24 HOURS NOTICE.**
- ***If you fail to keep your appointment or cancel without prior notice, you will be billed a late cancellation fee of $60 for Acupuncture appointments, $75 for a 30 minute Naturopathic Consultation and $150 for Naturopathic Consultation.***

I have read and understand all of the above

My signature is an acknowledgment that I voluntarily consent to receive treatment and that I have read the policies listed above and agree to abide by the same.

_____

Patient/Guardian Signature Date

Assignment of Insurance Benefits

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practitioner to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

_____

Responsible Party Signature Relationship Date

Disclosure of Health Information

I consent to the use or disclosure of my protected health information by the An Hao Natural Health Care Clinic for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

I understand that diagnosis or treatment of me by the An Hao Natural Health Care Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. An Hao Natural Health Care Clinic is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time.

My "protected health information" means health information, including demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical and/or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the An Hao Natural Health Care Clinic Notice of Privacy Practices prior to signing this document.

The An Hao Natural Health Care Clinic's Notice of Privacy Practices has been given to me.

The An Hao Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling An Hao Natural Health Care Clinic and requesting a revised copy to be sent or by requesting one at my next appointment.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative Date

Description of Personal Representative's Authority Date

Consent for Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation and cupping are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion are burns, blistering or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I will notify the practitioner should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my practitioner are safe in the recommended doses. Large doses of herbs or vitamins taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that I must stop taking any supplements and notify my practitioner as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risk and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her best judgment in my interest during the course of treatment based upon the facts then known.

By signing this form I acknowledge any inherent risks and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Print name Date

Signature Date

Current Health History

Main purpose of this appointment:

Medications you now take with dosage information:

Herbs, home remedies, vitamins with dosage information:

Major complaints:

Other treatments you have received for this/these conditions (check the box):

☐ Acupuncture ☐ Chiropractic ☐ Homeopathy ☐ MD
☐ Massage ☐ Naturopathic ☐ Osteopathy ☐ Shiatsu

Primary Care Physician _____ Specialists _____

When did symptoms begin?

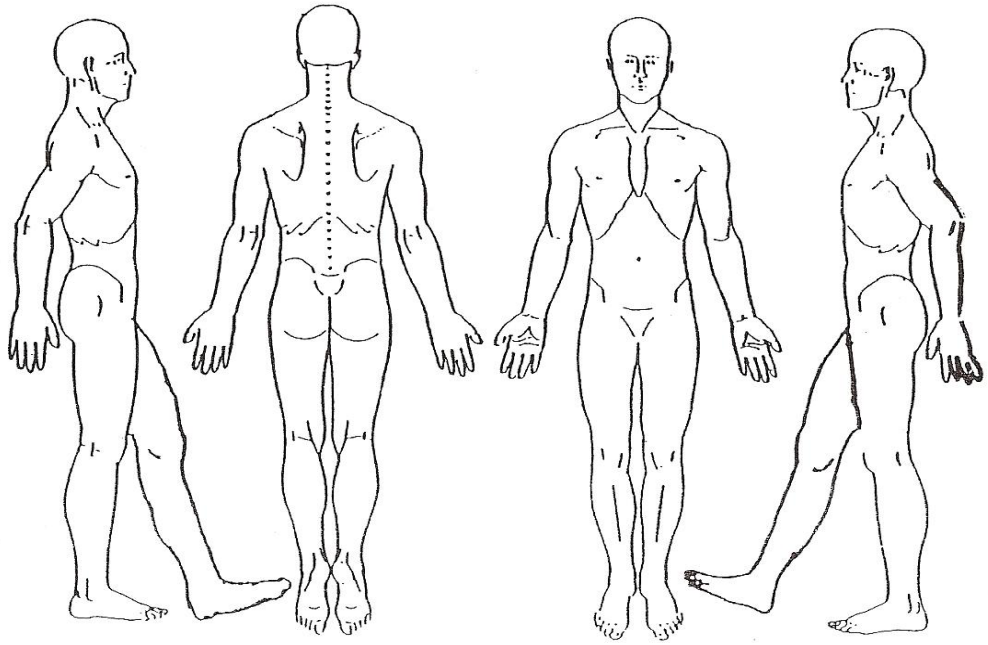
Are there others in your family with the same condition?

To what extent does this problem interfere with your daily activities? (sleep, sex, work, etc.)

Do some circumstances make your condition better or worse (time of day, hot/cold, season, emotions, motion, position)?

Is your condition worse on one side of the body?

Please Indicate Areas of Your Discomfort/Pain



Health History

Have you been treated for any health conditions in the past year? ☐ Yes ☐ No
If yes, please explain:

_____

_____

_____

Major Illness/Injuries/Trauma: (include dates & detail):
☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Osteoporosis ☐ Thyroid ☐ Other: _____
☐ Hospitalizations: _____ ☐ Surgeries: _____

_____

_____

_____

Is there anything we should know about your birth history or childhood illnesses?

_____

_____

Allergies (drug, chemical, foods):

_____

_____

Family history: Please include age of onset and death if known

	Cancer (specify type)	Diabetes	Heart Disease	Osteoporosis	Autoimmunity (specify type)	Thyroid disease (specify type)	Addiction/ Mental Health	Other	Other
Mother									
Father									
Brother									
Sister									
MGM									
MGF									
PGM									
PGF									
Children									

Lifestyle

Height: _____

Weight: _____

Weight one year ago: _____

Max weight: _____ When? _____

How much water drank per day? _____

Hours of TV watched per week? _____

Hours of sleep per night? _____

Is your sleep restful? ☐ Yes ☐ No ☐ Sometimes

Minutes of exercise per week? _____

Energy levels throughout the day: _____

Do you use tobacco? ☐ Yes ☐ No ☐ Sometimes

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week:_____

Do you take recreational drugs? ☐ Yes ☐ No ☐ Sometimes What Type:_____

Describe your libido: ☐ High ☐ Moderate ☐ Low ☐ None

Have you ever had STD? ☐ Yes ☐ No When/Type: _____

Do you have a history of sexual or physical abuse? ☐ Yes ☐ No

Check any of the following symptoms which apply to you (now or recent past):

Musculoskeletal

- ☐ Headaches
- ☐ Difficult chewing

Nervous System

- ☐ Cold/tingling extremities
- ☐ Fainting

Cardiovascular

- ☐ Ankle swelling
- ☐ Lung congestion

- ☐ Jaw pain/clicking/popping
- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Muscle pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Arthritis
- ☐ Convulsions
- ☐ Dizziness
- ☐ Paralysis
- ☐ Numbness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Vertigo
- ☐ Varicose veins
- ☐ Blood pressure High or Low
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Heart problems
- ☐ Lung problems
- ☐ Cough

Genito-Urinary

- ☐ Bladder trouble
- ☐ Painful/excessive urine
- ☐ Discolored urine
- ☐ Urine leakage
- ☐ Urine flow problem
- ☐ Urgency
- ☐ Frequency

ENT

- ☐ Seasonal allergies
- ☐ Dental problems
- ☐ Sore throat
- ☐ Earaches
- ☐ Hearing difficulties
- ☐ Bad breath / Dry mouth
- ☐ Sinus problems

Male

- ☐ Prostate concerns
- ☐ Discolored urine
- ☐ Impotence
- ☐ Painful/excessive/ decreasing urination

Date of last Prostate Exam/PSA: _____

Skin

- ☐ Rashes
- ☐ Dryness
- ☐ Itchiness

Eyes

- ☐ Vision problems
- ☐ Cataracts / Glaucoma
- ☐ Eye pain

Immune

- ☐ Frequent colds
- ☐ Up to date on vaccinations

Gastrointestinal

- ☐ Poor/excessive appetite
- ☐ Vomiting
- ☐ Hemorrhoids
- ☐ Weight problems
- ☐ Gas/Bloating after meals
- ☐ Irregular bowel movements
- ☐ Excessive thirst
- ☐ Diarrhea
- ☐ Liver trouble
- ☐ Abdominal cramps
- ☐ Heartburn/indigestion
- ☐ Tiredness after eating
- ☐ Nausea
- ☐ Constipation
- ☐ Mucus in stools
- ☐ Bloody stools
- ☐ Colitis

Number bowel movements per day: _____ Date of last Colonoscopy: _____

Bio-Female

- ☐ Menstrual irregularity
- ☐ Breast lumps/pain
- ☐ Hot flash / Night sweats
- ☐ Menstrual cramping
- ☐ Abnormal vaginal discharge
- ☐ Menopause symptoms
- ☐ Vaginal pain/infections
- ☐ Sexual dysfunction
- ☐ Vaginal dryness

Date of last PAP: _____ Was it normal? ☐ Yes ☐ No

Date of last mammogram: _____ Was it normal? ☐ Yes ☐ No

Date of last menstruation: _____

Contraception methods used: _____

Age menstruation started: _____

Days between cycles: _____

Usual days of flow: _____ Light / Medium / Heavy

Ever use birth control pills? ☐ Yes ☐ No

PMS? _____

Discharge between cycles? _____

Number of pregnancies: _____

Number of live births: _____

Number of abortions: _____

Number of D&C's: _____

Number of caesareans: _____

Hysterectomy? ☐ Yes ☐ No When? _____

Diet : Typical foods eaten throughout a normal day.

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

_____