Many Lives Chinese Medicine

Client Intake Form

Date: **Phone:**

Name: Birthdate: Age:

Address: City: Zip:

Email Address:

Emergency Contact: Phone:

Referred by:

Please be respectful of our time and yours.

Missed or cancelled appointments:

- **There will be NO Appointment Cancellations acknowledged on SUNDAY.**
- **Please give twenty-four (24) hour notice or you will be charged in full for the missed appointment.**

Client Signature: Date:

Confidential

Many Lives Chinese Medicine

beth.schiffman@gmail.com **650.366.4299**

Name: _____

Chief complaint: _____

Date of onset (when you first noticed the problem): _____

How long have you had this condition: _____

Have you had this in the past? ☐ No ☐ Yes When: _____

Pain is: ☐ Minimal ☐ Moderate

☐ Slight ☐ Severe Scale of 1 to 10: _____

What makes it better? _____

What makes it worse? _____

Your condition is: ☐ Getting worse ☐ Constant ☐ Comes and goes

Medications/drugs/herbs you are currently taking: _____

List surgeries/operations you have undergone, with dates: _____

_____

Family History

	Father	Mother	Sibling	Children	Self
Arthritis					
Asthma					
Cancer					
Allergies					
Heart trouble					
High blood pressure					
Stroke					
Diabetes					

General		
☐ Chills	☐ Fatigue	☐ Aversion to heat/cold
☐ Frequent colds	☐ Excess thirst	☐ Low-back pain
☐ Catch colds easily	☐ Weight loss/gain	☐ Joint disorders
☐ Allergies	☐ Dizziness	

Energy level	**Stress**
☐ High (time of day) _____	☐ None
☐ Low (time of day) _____	☐ Moderate
	☐ Severe
	What causes it? _____

Sleep problems		
☐ Trouble falling asleep	☐ Trouble staying awake	☐ Other: _____
☐ Trouble staying asleep	☐ Excess dreaming	
☐ How many hours do you sleep each night? _____		

Sweating	Circulation
☐ Rarely sweat	Feelings of: ☐ Hot
☐ Night sweats	☐ Cold What area? _____
☐ Excess sweating	
☐ Spontaneous sweating	Hands and feet get cold easily: ☐ Yes ☐ No

Skin		
☐ Dry	☐ Changing moles/lumps (cysts/tumors)	☐ Dry scalp
☐ Itchy	☐ Boils	☐ Skin puffy/wrinkled
☐ Moist, clammy	☐ Frequent rashes	☐ Dark circles under eyes
☐ Burning	☐ Acne	☐ Other: _____
☐ Blood not clotting	☐ Bruise easily (black-and-blue spots)	
☐ Hives	☐ Hair loss/thinning	

Head & neck		
☐ Memory loss	☐ Double vision	☐ Headaches (list where):
☐ Eye pain	☐ "Floaters" (spots in vision)	_____
☐ Dry eyes	☐ Loss of balance	☐ Other: _____
☐ Blurred vision	☐ Burning eyes	

Ears & nose		
☐ Poor hearing	☐ Ringing/buzzing in ears	☐ Congestion/allegeries
☐ Ear aches	☐ Frequent nose bleeds	☐ Frequent colds
☐ Ear discharge/infections	☐ Sinus problems	☐ Other: _____

Chest		
☐ Trouble breathing	☐ Mucous rattle when breathing	☐ Swollen ankles
☐ Trouble breathing at night	☐ Wheezing	☐ Coughing phlegm
☐ Shortness of breath	☐ Persistent cough	Color: _____
☐ Pain/pressure in chest	☐ Chest pain	☐ Other: _____
☐ Palpitations	☐ Coughing blood	

Genito-urinary		
☐ Frequent urination	☐ Strong-smelling urine	☐ Water retention
☐ Day	☐ Pain or burning on urination	☐ Abnormal color
☐ Night	☐ Blood in urine	☐ Other: _____
☐ Difficult to urinate	☐ Frequent infections/dysfunction	

Neurological		
☐ Tremors	☐ Pain; where: _____	☐ Poor coordination
☐ Numbness; where: _____	☐ Paralysis; where: _____	☐ Stroke
☐ Tingling; where: _____	☐ Seizures	☐ Other: _____

Emotional & mental		
☐ Nervousness	☐ Moody	☐ Fearful
☐ Depressed	☐ Mind not clear	☐ Terrors
☐ Easily angered	☐ Manic	☐ Difficulty expressing emotions
☐ Easily irritated	☐ Obsessive	☐ Other: _____
☐ Frequent crying	☐ Compulsive	
☐ Disoriented	☐ Anxiety	

Gastro-intestinal (check all that apply)

	Often	**Seldom**	**Severe**	**Mild**	**None**
Poor appetite					
Excessive appetite					
Nausea					
Vomiting					
Belching					
Indigestion					
Stomach pain					
Lower-abdominal pain					
Bloody stools					
Black stools					
Mucus in stools					
Stools have foul odor					
Hemorrhoids					
Lower bowel gas					
Colon problems					
Diarrhea					
Constipation					

Lifestyle habits (please indicate how much, how many, how often)

Cigarettes (packs): _____ Coffee/tea (cups): _____

Alcohol (type/amount per week): _____

Prescription drugs: _____

Over-the-counter drugs: _____

Recreational drugs: _____

Vitamins/herbs: _____

Dietary restrictions: _____

Food cravings: _____

Exercise (type and frequency): _____

Briefly describe your diet: _____

Many Lives
Chinese Medicine

Insurance Information

At Many Lives, we provide insurance billing as a courtesy to our patients. Currently, we accept most PPO insurance plans, and are not currently “in-network” with any of them. Depending on your plan, you may still be covered, but this may result in a lower percentage of your claim being paid. Your financial responsibility depends on your specific health insurance plan.

If we are not able to verify your coverage before your first visit, you are responsible for the full payment at time of service. (Don’t worry) We will issue a refund for your acupuncture charge when we receive payment from your insurance company. When we are able to verify coverage and get an estimate of what they will cover, you will be expected to pay a co-pay at time of service. Amount due at time of service may need to be adjusted once we receive payments from your insurance company.

Please remember, the ultimate financial responsibility for payment lies with the patient, not the insurance company.

Release of Information

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release medical information necessary to process your claim:

Your signature below acknowledges that you have read and agreed to these terms.

Signature_____ Date_____

Thank you very much. We look forward to working with you.

Many Lives Chinese Medicine

Informed Consent to Treatment

I, _____ consent to acupuncture treatment(s) and other procedures associated with Traditional Chinese Medicine by Beth Schiffman, L.Ac. I have discussed the nature and purpose of my treatment, and understand that methods of treatment may include, but are not limited to acupuncture, herbal medicine, nutritional counseling, moxibustion, cupping and electrical stimulation.

I have been informed that acupuncture utilizes sterile needles and is done in a clean, safe environment; but that it may have side effects, including: bruising, numbness or tingling near acupuncture, dizziness and fainting. Some unusual risks of acupuncture include lung puncture (pneumothorax) and infection. Burns and/or scarring are a potential risk of indirect moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify Beth Schiffman if I am or become pregnant.

Herbs and nutritional supplements (from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs are 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 immediately notify Beth Schiffman of any unanticipated or unpleasant effects associated with the consumption of herbal teas, or patent (pill form) medicines.

By signing below I show that I have read this consent to treatment, and understand the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present and any future conditions for which I seek treatment.

Client	Date	Practitioner	Date

Directions to Many Lives Chinese Medicine
499 Seaport Ct. #101
Redwood City CA 94063
650-366-4299

Signage is not well marked

From the North:

101 South
Exit to Seaport Blvd. (Woodside Road)
Heading East
Go ¾ mile turn Left on Seaport Ct.
Go to Stop sign, go slight Right
Count 3 light posts (on center strip)
Park. Walk straight, pass the California Overnight box
Door is behind the octagonal planter box!

From the South:

101 north
Exit to Seaport Blvd. (Woodside Road)
Heading East
Go ¾ mile turn Left on Seaport Ct.
Go to Stop sign, go slight Right
Count 3 light posts (on center strip)
Park. Walk straight, pass the California Overnight box
Door is behind the octagonal planter box!

Privacy Policy (1/2019)

This notice describes how health care information about you may be used and shared, and how you can get access to this information. Please review this carefully.

We are required by law to inform you of how your health information will be protected, used, or shared by Many Lives Chinese Medicine and its staff. If you have any questions please contact MLCM at 650-366-4299.

MLCM practitioners and staff consider your health information to be private and confidential. All information you provide, and information obtained during the course of treatment is used solely for the purpose of you and your individual treatment.

Your personal health information will only be disclosed between practitioners in order to provide you the best possible care, all MLCM practitioners work as a group.

Your information will only be provided to a third party with your written consent for the purposes of payment, insurance payment, or another practitioner outside of MLCM involved in your care.

Your information can and will be provided without your consent when it is required by law. This includes but is not limited to:

Cases of suspected abuse or neglect
Information demanded by legal subpoena
Public Health authorities where required by law to control disease or injury
Health and safety of yourself or another person to prevent serious threat

You have the right to request in writing any of the following:
To be informed of any disclosure of your health information
To change or modify your health information
A copy of your health information (fee for copies made)
Confidential communications made with our office (inform us of how to contact you)
Limitation of how your health information is shared or disclosed

You have the right to file a complaint if you believe your health privacy has been violated. U.S. Department of Health and Human Services Office for Civil Rights.

Any Changes made to this policy will be provided to you in writing as soon as possible following changes

Signature _____ Date _____

As part of keeping in touch with our clients, we send out a monthly newsletter which includes recommendations for keeping healthy, new offerings at MLCM and other fun and useful updates. If you would like to opt out of this email, please check the opt out space below. We always respect your privacy, and will never share your information with anyone else. OPT OUT _____