Root Health-Acupuncture & Chinese Herbs

Kameron Schott, LAc, MAOM, DiplOM
414 S. Jefferson, Moscow, ID 83843
ks@roothealthclinic.com
541-791-6878

Patient Health History

Please complete this questionnaire as thoroughly as possible - the information will greatly aid your practitioner. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional states. Print all information and indicate areas of confusion with a question mark. Along with all your medical information, this form will be kept completely confidential. Thank you.

Date: _____/_____/_____

Name: _____
(first) (middle initial) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F Social Security #: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

May we contact you by phone and leave a message if necessary? Y / N If yes, at which phone #? _____

Email Address: _____ May we email you appointment reminders? Y / N

May we send you a monthly email message with coupons, updates and info about classes & events? Y / N

Do you have a: Partner? Y / N Spouse? Y / N Have you been widowed? Y / N

Do you have children? Y / N If so, what are their ages? _____

Emergency Contact's Name, Phone #, and relationship to you: _____

Educational Background: _____ Occupation: _____

Employer: _____ Hours of work per week: _____

Do you enjoy work? Y / N Why or why not? _____

How did you hear about us? _____

Can we thank someone for referring you? _____

When and where have you recently received health care [with any type of practitioner(s)]? _____

For what reason did you receive health care? _____

Are your current health concerns the result of: an automobile accident? Y / N a work-related injury? Y / N

Has your case been referred to an attorney? Y / N

Please identify below the health concerns that have brought you to Root Health (in order of importance):

Condition **Past Treatment**

1. _____

How does this condition affect you? _____

2. _____

How does this condition affect you? _____

3. _____

How does this condition affect you? _____

4. _____

How does this condition affect you? _____

Please list any medications (prescribed and/or over-the-counter), vitamins, herbs, and/or supplements you are currently taking (including dosages):

_____

_____

_____

History of Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

History of X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Family History (Check all that are applicable):

	Father	Mother	Sibling(s)	Grandparents	Children	Spouse/Partner
Age (if living)	_____	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____
Health (G)good, (P)poor	_____	_____	_____	_____	_____	_____
Cancer (specify type)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma or Allergies	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____	_____
Endocrine Disorder (thyroid, etc)	_____	_____	_____	_____	_____	_____
Gastrointestinal Disorder	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

Your Height: _____ Current Weight: _____ Past Maximum Weight: _____ When? _____

What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Do you have any infectious diseases? Y / N If yes, please list: _____

Childhood Illness (please circle any that you have had): Scarlet Fever Diphtheria Rheumatic Fever Mumps

Measles German Measles Chicken Pox Other(s): _____

Immunizations (please circle any that you have had): Polio Tetanus Measles/Mumps/Rubella Pertussis

Diphtheria Hib Hepatitis B Chicken Pox Other(s):_____

Please list any foods, drugs, or substances you are hypersensitive or allergic to (please include reaction): _____

_____

_____

For the following sections, please **circle** any symptoms or illnesses you experience **now** and underline any that you have experienced in the past:

Mental/Emotional: Mood Swings Nervousness/Anxiety Mental Tension Depression Phobias Panic Attacks Bi-Polar Disorder Obsessive Compulsive Disorder Schizophrenia Post Traumatic Stress Disorder (PTSD) Other(s): _____

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Frequent Colds/Flu Other(s): _____

Skin: Dry or Oily Skin Itching Rashes Hives Eczema Psoriasis Acne Unusual or Excessive Sweating Other(s): _____

Head, Eye, Ear, Nose, and Throat: Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Hay Fever/Allergies Frequent Nasal Congestion Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Other(s): _____

Musculoskeletal: Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain Upper Back Pain Mid Back Pain Low Back Pain Sensation of Heaviness in Limbs Joint Pain (if so, where?): _____ Other(s): _____

Neurological: Vertigo/Dizziness Paralysis Numbness/Tingling Muscle Weakness Loss of Balance Stroke Poor Memory Seizures/Epilepsy Multiple Sclerosis Other(s): _____

Respiratory: Pneumonia Chronic Cough Difficulty Breathing Emphysema Pleurisy Asthma Tuberculosis Shortness of Breath Other(s): _____

Cardiovascular: Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering Heart Attack Heart Murmurs Rheumatic Fever Varicose Veins Other(s): _____

Gastrointestinal: Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain Frequent Passing of Gas Heartburn Frequent Belching Gall Bladder Disease Liver Disease Hepatitis B or C Jaundice Hemorrhoids Bloating Diarrhea Constipation Blood or Mucus in Stool Undigested Food in Stool Fatigue After Eating High Cholesterol Other(s): _____

Endocrine: Hypothyroid Hyperthyroid Hypoglycemia Diabetes Unusual Sensations of Hot or Cold Cold Hands and/or Feet Night Sweats Other(s): _____

For the following sections, please **circle** any symptoms or illnesses you experience **now** and underline any that you have experienced in the past):

Urinary: Kidney Disease or Stones Painful Urination Frequent Urination Impaired Urination Blood in Urine

Frequent Urination at Night Frequent Urinary Tract Infections (UTI) Incontinence Other(s): _____

Male Reproductive: Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Sexually Transmitted Disease(s) Other(s): _____

Female Reproductive/Breasts: Irregular Cycles Heavy Flow Bleeding Between Cycles Painful Periods

Premenstrual Problems/Symptoms Menopausal Symptoms Vaginal Dryness Unusual Vaginal Discharge

Breast Lumps Breast Tenderness Nipple Discharge Difficulty Conceiving Endometriosis

Sexually Transmitted Disease(s) Other(s): _____

Do you have **any** reason to believe you may be pregnant? Y / N If yes, how far along are you? _____
(Please remember to inform your practitioner in the future if you have any reason to believe you might be pregnant.)

Age of First Menses: _____ Average # of Days of Menses Flow: _____ Length of Cycle (between flows): _____

Birth Control Use – Current and in Past (if applicable): _____

If applicable: # of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Any complications during pregnancy, birth and/or postpartum? _____

Other: Anemia or Other Blood Disorders Cancer Fibromyalgia Sensation of "Foggy" or "Heavy" Head

Eating Disorder(s) Lyme's Disease Problems with teeth and/or gums Other(s): _____

_____

Is there anything else we should know (including other symptoms not listed above)? _____

_____

_____

Lifestyle:

Number of meals eaten per day: _____ Number of snacks eaten per day: _____

Types and amount of beverages per day: _____

For the following substances please indicate types and average amount of current and/or past use (if applicable):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Recreational Drugs: _____

Type(s) and amount(s) of exercise each week: _____

_____

Religious and/or spiritual practice: _____

Average hours of sleep per night _____ Do you wake rested? Y / N

Any problems falling asleep or staying asleep? Y / N If so, please describe: _____

Please rate you stress level (circle): low medium high

What are your primary sources of stress? _____

Have you experienced any major traumas (ie abuse, major accidents, homelessness, death of spouse/partner, etc)? Y / N

If so, please describe: _____

_____

Interests and hobbies: _____

Anything else you would like us to know: _____

Thank you for taking the time to fill out this form.
It will greatly help us to assess and treat you in our clinic.

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated by practitioners at Root Health, LLC. Further, I understand all of the following:

- Acupuncturists practicing in the state of Idaho are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.
- There is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. There may be other treatment alternatives, including treatment offered by a licensed physician.
- I am free to refuse any specific treatment modality and to stop treatment at any time.
- **It is my obligation to notify the acupuncturist 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 potentially induce miscarriage**. With the proper precautions Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that the methods of treatment used in this clinic may include, but are not limited to, those listed below and that these are all safe methods of treatment. However, their potential risks (outlined below) have been explained to me.

- **Acupuncture:** I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.
- **Electro-Acupuncture:** I understand that I may be given electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.
- **Indirect and Direct Moxibustion/TDP lamp:** I understand that moxibustion is performed by applying heat (indirectly or directly) to the skin at certain points of the body. The heat is achieved by burning of the mugwort herb and/or a TDP lamp placed above the skin. I understand there is a risk of burning or scarring from their use as well as the possible aggravation of symptoms existing prior to treatment.
- **Adjunct Chinese Medicine Therapies (Cupping, Gua Sha, and Pricking):** I understand that cupping involves suctioning a glass "cup" to the skin in order to pull out waste products from the fascial and muscle layers. Gua Sha accomplishes the same result via scraping the skin after a liniment has been applied. I am aware that discomfort during the procedure as well as temporary bruising or redness that lasts a few days is a side effect of these two therapies. I further understand that pricking involves drawing small amounts of blood at certain points. It is used to release heat and stagnation. Side effects include discomfort, bruising and soreness.
- **Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*
- **Acupressure/Tui-Na/Shiatsu Massage:** I understand that I may also be given acupressure/tui-na or shiatsu massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. In certain situations a liniment may be applied to the skin during these procedures. I am aware that certain adverse side effects may result which include but are not limited to: bruising, sore muscles or aches, reaction of the skin to the liniment and the possible aggravation of symptoms existing prior to treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of any of these procedures or techniques at any time (now or in the future). I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: ____ Date of Birth: _________________

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Financial Policy Form

Aside from the exception (insurance) stated below, payment is due at time of services rendered / time of purchase of products and herbs. This clinic accepts payment in the form of: cash, check, debit card, VISA or MASTERCARD.

Our office ONLY bills insurance companies with whom we are contracted. If you are covered by one of these companies, please understand that by signing below, you are authorizing Root Health, LLC to charge you directly for any co-payments, co-insurance and/or deductibles due to you as stated in your insurance agreement and these are due at the time of service. You also agree to pay for any and all charges that are NOT covered by your insurance plan. Furthermore, payment of medical benefits will be distributed directly to Root Health, LLC.

If you have a health insurance plan from a company with whom we are NOT contracted, you must pay in full at time of service. We are happy to provide you with a specialized receipt to submit for reimbursement.

The low-cost group acupuncture treatments are NOT reimbursable by insurance due to coding issues.

We reserve the right to charge for appointments cancelled or broken without a minimum of 24 hours notice. No refunds are provided for any reason.

There is a $25 charge, above and beyond the charges for services rendered, for all returned checks.

An outstanding balance due on an account will accrue interest of 1.5% per month (18% annual rate) after a ninety-day grace period. Any unpaid balance must be paid for before another appointment can be scheduled. If the payment is made with a check, the check must clear before additional scheduling can occur.

All prices and discounts are subject to change.

By signing below, I state that I understand and agree to all of the above terms of payment:

Printed Name: _____Date of Birth: _____

Signature: _____Date: _____

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HIPAA FORM

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize. Additionally, the practitioners in this clinic may consult with one another regarding your case.

Safeguards in place at our office include:

- Limited access to areas where information is stored (only authorized staff can access these locked areas).
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us at (541) 791-6878.

Yours truly,

Root Health, LLC
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Our Clinic Protects Your Health Information and Privacy

By signing below, I verify that I have received and read the privacy policy of Root Health, LLC. I have had the opportunity to ask any questions I may have. Additionally, I am aware that I have the right to read this policy at any time in the future if I so desire.

Furthermore, I authorize Root Health, LLC to release all pertinent medical information/records requested by my insurance company(s). I also give practitioners at Root Health, LLC consent to confer with and/or send any reports to the referring health care practitioner.

_____
Print Name

_____ _____
Signature Date

_____ _____
Witness Date