Joanna Donnelly, LAc

www.joannadonnelly.com

INTAKE INFORMATION

Client Name: _____ Date: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Office Phone: _____

Age: _____ Date of Birth: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Address: _____

Weight: _____ Sex: M ____ F ____ Referred by: _____

Doctor's Name: _____ Phone: _____

Married ___ Single ___ Widowed ___ Divorced ___ Partnered ___ Children ___

Emergency Contact: _____ Phone: _____

Name of parent if client is a minor: _____

Have you ever had chiropractic, physical therapy, massage therapy or alternative health care before? If yes, for what problem? _____

_____

SYMPTOMS & COMPLAINTS

Please list your major complaints and symptoms – be as specific as you can: _____

_____

_____

How do you believe your problem (pain) began? _____

_____

Have you lost any work because of this problem? _____ Date you last worked: _____

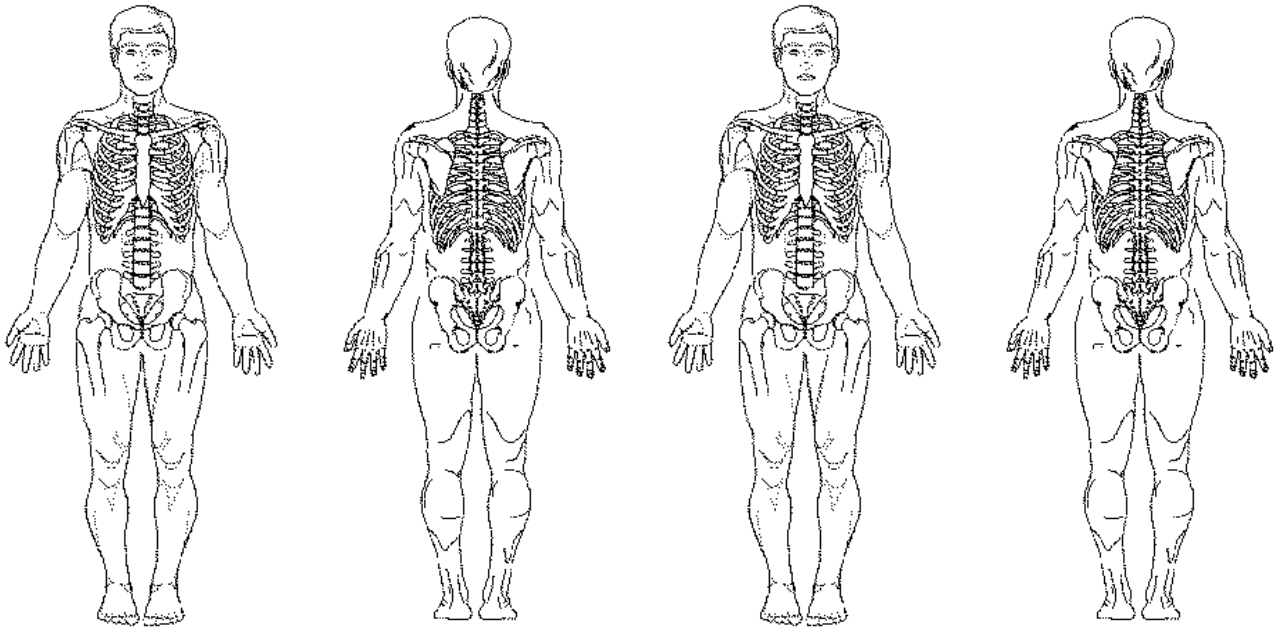
What is your official diagnosis? _____

PAIN DIAGRAM

Please shade in all areas

PARAESTHESIA DIAGRAM

Place of pain. Indicate the severity of pain and shade in all areas of "funny feelings" a scale of: 0 (none) to 10 (excruciating), & (tingling, burning, pins and needles, etc.) type of pain (sharp, aching, dull, knifelike)



SYMPTOMS	NEVER	OCCASIONAL	OFTEN	CONSTANT
Dizziness/Lightheadedness	_____	_____	_____	_____
Nausea	_____	_____	_____	_____
Ringing, stuffy or painful ears	_____	_____	_____	_____
Vision problems	_____	_____	_____	_____
Balance/coordination problems	_____	_____	_____	_____
Chest pain	_____	_____	_____	_____
Decreased concentration	_____	_____	_____	_____
Memory problems	_____	_____	_____	_____
Bowel problems	_____	_____	_____	_____
Bladder problems	_____	_____	_____	_____
Unusual bleeding or discharge	_____	_____	_____	_____
Difficulty sleeping	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Fever, chills	_____	_____	_____	_____

What was the date of onset of your last menses? _____

MEDICAL HISTORY

Please indicate your present medical status (illnesses, diseases, fractures): _____

_____

_____

Indicate your past history of health (illnesses, diseases, fractures): _____

_____

_____

List operations you have undergone and dates: _____

_____

List all trauma and when it occurred (All trauma in the past – accidents, falls, injuries are important):

_____

_____

_____

List all medications (including vitamins, herbs or over the counter drugs) you are presently taking:

_____

_____

List all medications you have taken in the last 5 years: _____

_____

List any diagnostic tests (X-ray, MRI, etc.) you have had, as well as the results: _____

_____

_____

Circle if you have any of the following: IUD pacemaker stints breast implants

FUNCTION

List your present hobbies: _____

_____

Describe any regular exercise or sports you presently do: _____

_____

Please indicate your ability to do the following activities:

	DIFFICULT	PAINFUL	UNABLE	NOT APPLICABLE
Lying on back	_____	_____	_____	_____
Lying on stomach	_____	_____	_____	_____
Lying on right side	_____	_____	_____	_____
Lying on left side	_____	_____	_____	_____
Turning over back-stomach	_____	_____	_____	_____

Please indicate your ability to do the following activities:

	DIFFICULT	PAINFUL	UNABLE	NOT APPLICABLE
Turning over stomach-back	_____	_____	_____	_____
Kneeling on knees	_____	_____	_____	_____
Sitting up from lying down	_____	_____	_____	_____
Lying down from sitting up	_____	_____	_____	_____
Sitting on a chair	_____	_____	_____	_____
Sitting in a car	_____	_____	_____	_____
Driving	_____	_____	_____	_____
Standing up from the floor	_____	_____	_____	_____
Standing up from the chair	_____	_____	_____	_____
Standing up straight	_____	_____	_____	_____
Walking	_____	_____	_____	_____
Bending (vacuuming)	_____	_____	_____	_____
Lifting objects from the floor	_____	_____	_____	_____
Lifting objects from the table	_____	_____	_____	_____
Reaching arms above head	_____	_____	_____	_____
Dressing/undressing	_____	_____	_____	_____
Bathroom and hygiene	_____	_____	_____	_____
Other: Sports & leisure activities	_____	_____	_____	_____
Work	_____	_____	_____	_____

Are you involved in any lawsuits related to your pain? Check below if appropriate:

____ I have no lawsuit pending

____ I am in the process of suing the State or an insurance company to receive compensation benefits for my pain.

____ I am in the process of suing an individual who is partly/totally responsible for my pain problems.

CLIENT AGREEMENT AND RELEASE FROM LIABILITY

I, _____ agree to the following during and after the course of my therapy.
Name

(Initials)

1) I will not use any mood-altering substance (drug and alcohol) before coming to a session. _____
2) At any time during a session, I have the right to stop the therapy if I feel uncomfortable or unsafe. _____
3) I understand that I am responsible for my well-being and healing process and that the therapist cannot "fix" or cure me. _____
4) I understand that the therapist is committed in assisting me to heal myself in the shortest time possible. _____
5) I understand that there may be reactions to treatment, anticipated or unanticipated, and that it is my responsibility to discuss any symptoms of concern with the therapist. _____
6) If I need to cancel an appointment, I will do so 24 hours prior to the appointment. I understand that a late fee will be charged if I cancel less than 24 hours prior to the appointment. _____

ACKNOWLEDGEMENT AND CONSENT

I understand that Joanna Donnelly, L.Ac. P.C. (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information within the practice of Joanna Donnelly, L.Ac. P.C. in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers within Joanna Donnelly, L.Ac. P.C. for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some of all of my health information not be used or disclosed in the manner described in the Notice of privacy Practices and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that a copy of the Notice of Privacy Practices is available to me should I want it.

By: _____ Date: _____
Patient

By: _____ Date: _____
Patient Representative

Description of Representative's Authority: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Joanna Donnelly, L.Ac. P.C. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact:

Joanna Donnelly, LAc

www.joannadonnelly.com

I also understand that I am entitled to receive updates upon request if Joanna Donnelly, L.Ac. P.C. amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature and Relationship to Patient (if signed by someone other than Patient) Date

THIS SECTION TO BE COMPLETED BY JOANNA DONNELLY, L.AC. P.C. IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named Patient, but was unable to because:

____ Patient declined to sign this Written Acknowledgement

____ Other (specify):

_____
Employee signature

_____ _____
Name and title of employee Date

TREATMENT CONSENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Joanna Donnelly, L.Ac. P.C. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed M.D. or D.O. is an important choice that Joanna Donnelly, L.Ac. P.C. strongly recommend.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) 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 have been made aware that certain adverse side effects may result. These 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. I understand that there are no guarantees concerning its use and effects that I am free to stop acupuncture treatment at any time.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I have been made aware that certain adverse side effects may result, which may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

Chinese Herbs/Supplements: 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 have been made aware that certain side effects may result from taking these substances. These could include, but are not limited to: chances in bowel movements, slight abdominal cramping or discomfort and possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems that I associate with these substances, I should suspend taking them and call the practitioner who prescribed them to me as soon as possible.

Visceral/Neural/Vascular Manipulation, Joint Articulation & Shiatsu: I understand I may be given manual therapy as part of my treatment to mobilize restricted tissues and to promote the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: soreness or aching and the possible aggravation of symptoms existing prior to the treatment. I understand that I may stop this therapy if it is uncomfortable.

I understand that there may be other treatment alternatives, including treatment that might be offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I gave my permission and consent to treatment.

_____

Printed Name

_____ _____

Signature Date

Joanna Donnelly, LAc

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