Traci Kanzawa, L.Ac.
220 Montgomery Street, Suite 305
San Francisco, CA 94104

Patient Intake Form

Name: _____ Birthdate: _____

Street Address: _____ City: _____ Zip: _____

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

Sex: _____ Social Security: _____ Email Address: _____

Patient Status: ☐ Married ☐ Single ☐ Domestic Partnership ☐ Divorced ☐ Other_____

Emergency Contact: _____ Relationship: _____ Tel #: _____

Referred to our clinic by: _____

✧ ✧ ✧ ✧ ✧

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student

Occupation: _____ Employer: _____

Employer's Address: _____

Spouse's Name: _____ Tel #: _____

Primary Care Physician's Name: _____ Tel #: _____

✧ ✧ ✧ ✧ ✧

Primary Insurance Company: _____ Tel #: _____

Policy #: _____ Group #: _____

Secondary Insurance Company: _____ Tel #: _____

Policy #: _____ Group #: _____

✧ ✧ ✧ ✧ ✧

Insurance Responsibility Statement:
Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our clinic. It is your responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance. We will assist you in billing your insurance company as much as possible. However, you are responsible for your bill.

Assignment and Release:
I hereby assign my insurance benefits to be paid directly to the Traci Kanzawa, L.Ac. I understand that I am financially responsible for any non-covered services. I also authorize Traci Kanzawa, L.Ac. to release any information required to process any claims.

Cancellation Policy:
There is a 24-hour late cancellation policy for acupuncture appointments. The late cancellation fee is $70.

Signed: _____ Date: _____

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Patient Health History

Name: _____ Date: _____

General

Past	Current	
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Nightsweats
☐	☐	Sweats easily
☐	☐	Chills
☐	☐	Localized weakness
☐	☐	Strong thirst
☐	☐	Other: _____

Skin and Hair

Past	Current	
☐	☐	Rashes/Hives/Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors or Lumps
☐	☐	Other: _____

Head and Neck

Past	Current	
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck stiffness
☐	☐	Enlarged lymph
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Other: _____

Ears

Past	Current	
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other: _____

Eyes

Past	Current	
☐	☐	Blurred vision
☐	☐	Poor night vision
☐	☐	Floaters/spots
☐	☐	Cataracts
☐	☐	Other: _____

Male

Past	Current	
☐	☐	Impotence
☐	☐	Benign Prostatic Hyperplasia
☐	☐	Weak urinary stream
☐	☐	Other: _____

Cardiovascular

Past	Current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Fainting
☐	☐	Phlebitis
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Swelling of hands/feet
☐	☐	Other: _____

Respiratory

Past	Current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Chronic Obstructive Pulmonary Dz
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other: _____

Gastrointestinal

Past	Current	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/Black stools
☐	☐	Bad breath
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gallbladder disorder
☐	☐	Gas
☐	☐	Other: _____

Genito-urinary

Past	Current	
☐	☐	Kidney stones
☐	☐	Pain with urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other: _____

Female

Past	Current	
☐	☐	Urinary tract infections
☐	☐	Vaginal infections
☐	☐	Pain/Itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Abnormal Pap smear
☐	☐	Irregular periods
☐	☐	Painful menses
☐	☐	Premenstrual Syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Other: _____

Neurological

Past	Current	
☐	☐	Seizures or Tremors
☐	☐	Numbness or tingling
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Breast lumps
☐	☐	Other: _____

Psychological

Past	Current	
☐	☐	Depression
☐	☐	Anxiety/Stress
☐	☐	Irritability
☐	☐	Treated for emotional/ psychological problems
☐	☐	Other: _____

Infection Screening (Positive Test)

Past	Current	
☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Syphillis
☐	☐	Genital warts or HPV
☐	☐	Herpes: Oral/Genital
☐	☐	Other: _____

Nose, Throat, and Mouth

Past	Current	
☐	☐	Nosebleeds
☐	☐	Sinus infection
☐	☐	Hay fever/Allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing

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Patient Health History (continued)

Name: _____ Date: _____

Family History: Complete for each family member by placing an X in the appropriate box.

	Self	Mother	Father	Sister/Brother	Spouse	Child
Allergies						
Blood Disorder/Anemia						
Diabetes						
Cancer or Tumors						
Seizures						
High Blood Pressure						
Kidney or Bladder Disorder						
Stomach or Intestinal Disorder						
Drug Abuse						
Tuberculosis						
Heart Disease						
Stroke						
Depression/Mental Illness						
Other						
Age at Death						

Major Hospitalizations: Detail your most recent hospitalizations below.

Year	Operation or Illness	Name of Hospital	City and State

Previous Pregnancies:
Total # of Pregnancies: # of Living: # of Ectopic: # Induced of Abortions: # of Miscarriages:

Medication: Mark an "X" in the box and write down the name of the medication that you are now taking.

- ☐ Aspirin _____ ☐ Ibuprofen _____ ☐ Acetaminophen _____
- ☐ Antacids _____ ☐ Laxatives _____ ☐ Cold tablets _____
- ☐ Diet pills _____ ☐ Tranquilizers _____ ☐ Oral contraceptives _____
- ☐ Sleeping pills _____ ☐ Hay fever tablets _____ ☐ Fiber supplements _____
- ☐ Blood thinning _____ ☐ Blood pressure pills _____ ☐ Insulin, Diabetic pills _____
- ☐ Other _____ ☐ Other _____ ☐ Other _____

Vitamins (please list):
_____ _____ _____

Herbs (please list):
_____ _____ _____

Drug Allergies:

Habits: Please check any of the habits listed below which apply to you now or in the past.

Coffee	☐ yes ☐ no	Cups per day/week:	Age started:	Age quit:
Alcohol	☐ yes ☐ no	Drinks per day/week:	Age started:	Age quit:
Tobacco	☐ yes ☐ no	Cigarettes per day/week:	Age started:	Age quit:
Marijuana	☐ yes ☐ no	Use per day/week:	Age started:	Age quit:
Crack/Cocaine	☐ yes ☐ no	Use per day/week:	Age started:	Age quit:
Heroin	☐ yes ☐ no	Use per day/week:	Age started:	Age quit:
Other			Age started:	Age quit:

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Patient Health History (continued)

Have you ever had an acupuncture treatment? When and for what reason? _____

_____

Are you presently being treated for a medical condition? Please describe: _____

_____

Please briefly describe any chronic pain: _____

_____

What health issue do you want to be treated for? Please describe as fully as possible. _____

_____

_____

What treatment have you been using for relief of this issue? _____

_____

Do you have other health concerns? Please describe. _____

_____

Please describe your diet and what types of food you eat regularly at each meal.

Breakfast		% of Vegetables in diet	
Morning snack		% of Fruits in diet	
Lunch		% of Grains and Carbohydrates in diet	
Afternoon snack		% of Protein in diet	
Dinner		% of Dairy in diet	
Evening snack		% of Fats, Oils, and Sweets in diet	

Do you exercise regularly? ☐Yes ☐ No How frequently? _____ times per day/week

What type of exercise do you do? _____

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Informed Consent to Treatment Policies

I, _____, give consent to receive acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Traci Kanzawa, L.Ac. and/or any guest acupuncturist working under her supervision. I understand that the methods of treatment may include, but are not limited to: acupuncture, electrical stimulation, cupping, Tui Na massage, herbal medicine, nutritional counseling, and moxa.

I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including, but not limited to: bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Other risks of acupuncture treatment could include (although unusual and extremely rare) spontaneous miscarriage, nerve damage, and organ puncture (including lung puncture – pneumothorax).

Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is Another possible risk of treatment. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to be able to exercise judgment during the course of treatment which is based upon the facts known and my condition, is in my best interests.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are safe in the practice of Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatments are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify my practitioner of any unpleasant effects associated with the consumption of herbal teas or products.

- **I will notify my practitioner if I am or become pregnant.**
- **I agree to follow all treatments only as recommended/prescribed. If I am experiencing any side effects or difficulties I will notify the practitioner as soon as possible.**
- **I understand the practitioner and clinic staff may review my lab reports, but all my records will be kept strictly confidential and will not be released without my consent.**

By voluntarily signing below, I am demonstrating that I have read (or have read to me) this consent to treatment and treatment policies, have been told about the risks of acupuncture and other procedures, and have had the opportunity to ask questions. I understand this consent is intended to cover my entire course of treatment for my present and future conditions for which I seek treatment at this office.

Patient's Name: _____ Date: _____

Patient's/Representative's Signature: _____

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Summary and Acknowledgement of Receipt of Notice of Privacy Practices

1. Traci Kanzawa, L.Ac.'s (the Practice) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, obtain payment for that treatment, and to carry out its healthcare operation. The Practice explained to me that the Privacy Notice will be available to me at any future appointment and at my request at any other time.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.
3. I understand, and consent to, the following communication that may be used by the Practice.
    a. Cards, letters, or other written information mailed to me at the address provided by me.
    b. Telephoning and leaving a message on my answering machine, voicemail, or with the individual answering the phone.
    c. Sending electronic mail to the email address provided by me.
4. The Practice may maintain a directory of and a sign-in log for individuals seeking care and treatment in the office. This information may be seen by, and is accessible to others who are seeking or services in the Practice's office.
5. The Practice may use and/or disclose my PHI for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.
6. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.
7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Traci Kanzawa, L.Ac., by phone at (415)677.9900. Signature below is acknowledgement that you have received this Notice of Privacy Practice and that you have read and understood the foregoing notice, Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

_____ _____
Name (Printed) Date Signed

_____
Signature