Lafayette Acupuncture & Functional Medicine - Benjamin Dierauf, LAc

2920 Camino Diablo #210-C, Walnut Creek CA 94597 (925) 297-4785 bdierauf@gmail.com

Confidential Patient Intake Form - *Please use back of page for more space.* Date: _____

Patient Name: _____ Date of Birth: _____
First Middle Last

Address: _____
Number Street City State Zip

Telephone Home: _____ Cell: _____ Work: _____

Email: _____ May we add you to our email list? _____

Gender: _____ Lives with: _____Children? _____

Emergency Contact: _____
Name Phone Relationship

Primary Care Physician: _____
Name Address

Doctor's Phone: _____ May we confer with your Doctor? Y N Initials: _____

Who can we thank for referring you? _____
Name Phone/Address

Have you had acupuncture before? Y N When? _____ Where? _____

What are you here to work on? _____

What makes it better or worse? _____

Have you seen an MD for this? _____ When? _____ Diagnosis? _____

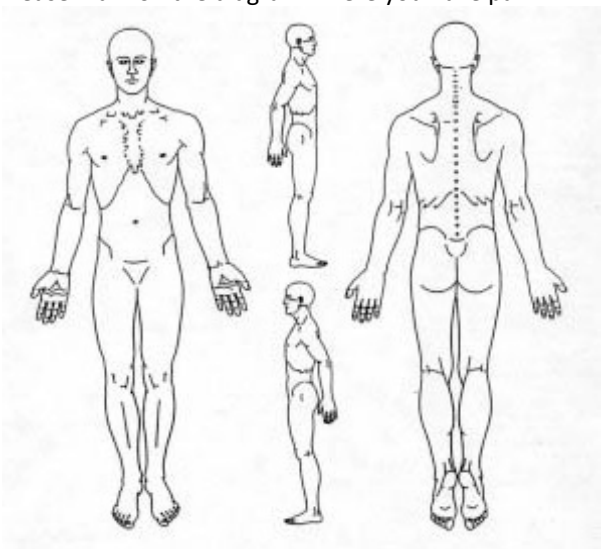
Please describe any major illnesses or surgeries and when they occurred:_____

Please list all known Allergies (use the back if you need more space):_____

Please list all medications and supplements are you taking, use the back if you need more space:

Medication/Supplement Name	Reason Taking / Dx.	How Long	Dose & Freq.	Last Dose

Please mark on the diagram where you have pain:



Describe the pain: _____

_____

Does it travel? _____

What makes it worse? _____

_____

What makes it better? _____

_____

Do you have any particular food cravings? _____

Do you use: Tobacco? _____ Alcohol? _____ Caffeine? _____ Recreational drugs? _____

Do you exercise? _____ How often? _____ What activities? _____

Sleep: Do you sleep well? _____ If you wake up, why? _____

Do you go back to sleep easily? _____ How are your dreams? _____

How is your energy level? _____ Work/Occupation: _____

Women: Are you pregnant? ____ When was your most recent period? _____ Regular periods? _____

How many days between periods? _____How old when first period? _____ Final Period? _____

Do you have PMS? _____ Moodiness/Emotional? _____ Bloating? _____ Breast Swelling? _____

During your period: Cramps? _____ Clots? _____ Heavy flow? _____ Scanty flow? _____ # of days: _____

Are you sexually active? _____ What form of birth control do you use? _____

Have you ever been pregnant? _____ Number of: Live births: _____ Miscarriages: _____ Abortions: _____

How old are your children? _____ Last Birth/Miscarriage/Abortion: _____

Are you trying to get pregnant? _____ For how Long? _____ Interventions: _____

Date of last gynecological exam: _____ Breast Imaging: _____ Type: _____

Men: Last Prostate exam: _____ Enlarged Prostate? _____ Prostate cancer? _____

Urinary problems: Dribbling urine? _____ Slow start of stream? _____ Burning? _____

Erectile difficulty? _____ Testicular pain/swelling? _____ Night time frequency? _____

MEDICAL HISTORY – ***Circle*** *any problem you have now, and* ***check*** *any problem you've had in the past.*
Please write any details on the back of the page.

___ADD/ADHD
___Anxiety/ Nervousness
___Bi-Polar Disorder
___Dementia
___Depression
___Dizziness/Vertigo
___Emotional Problems
___Insomnia
___Panic Attacks
___Schizophrenia/
Schizoaffective Disorder
___Sleep Disturbances
___Tooth Grinding/TMJ

___Epilepsy/Seizures
___Migraine
___Neuritis
___Paralysis
___Stroke

___Dry Eyes/Excess Tearing
___Earaches
___Eye/Visual Problems
___Glaucoma
___Ringing in the Ears

___Allergies/Hay Fever
___Asthma
___Bronchitis
___Cough
___Eczema
___Emphysema
___Hives
___Pleurisy
___Pneumonia
___Rashes
___Shortness of Breath
___Sinus Congestion
___Tuberculosis

___Blood in Urine
___Dribbling Urination
___Frequent Urination
___Incontinence
___Kidney Disease
___Kidney Stones
___Painful Urination
___Urinary Tract Infections

___Anemia
___Aneurism
___Angina Pectoris
___Bruise Easily
___Chest Pain
___Heart Disease
___Hemophilia
___High/Low Blood Pressure
___Nose Bleeds
___Pacemaker
___Palpitations
___Varicose Veins

___Arm Pain
___Arthritis
___Back Pain upper/mid/lower
___Bursitis
___Disc Problems
___Fibromyalgia
___Headaches
___Joint Pain
___Leg Pain
___Muscle Spasms or Cramps
___Neck Pain
___Osteoporosis/Bone Loss
___Pinched Nerves
___Scoliosis
___Shoulder Pain

___Cirrhosis
___Gall Stones
___Hepatitis A/B/C
___Liver Problems
___Breast/Nipple Discharge
___Breast Pain
___Hot Flashes
___Hysterectomy
___Impotence
___Menopause Symptoms
___Menstrual Problems
___Night Sweats
___Ovarian Cysts
___PMS
___Painful Intercourse
___Prostate Problems
___Testicular Pain/Swelling
___Vaginal Dryness
___Vasectomy/Tubal Ligation

___Constipation
___Crohns Disease
___Excess Appetite
___Frequent Hunger
___Gas/Belching
___Heartburn/Reflux
___Hemorrhoids
___Hernia
___Irritable Bowel Syndrome
___Loss of Appetite
___Nausea/Vomiting
___Stomach Ulcers

___Cancer _____
___Candida
___Chronic Fatigue Syndrome
___Diabetes Type 1 or 2
___Edema
___Fatigue
___Get Sick Easily
___HIV/AIDS
___Hypoglycemia
___Hyper/Hypo Thyroid
___Lupus
___Obesity
___Poor/Slow Wound Healing
___Unexplained Weight Loss

Lafayette Acupuncture & Functional Medicine - Benjamin Dierauf, LAc

2920 Camino Diablo #210-C, Walnut Creek CA 94597 (925) 297-4785 bdierauf@gmail.com

Fee Schedule:	Same day discount	Regular Fee
Patient visit (1-sided acupuncture)	$105	$145
Patient visit (2-sided acupuncture)	$145	$200
Initial visit evaluation	$55 - 95	$95-135
Massage	$45	$70
Electro-stimulation	$25	$35

Cancellation Policy:
Less than 24 hours cancellation notice and/or missed appointments will be billed at $85. If an emergency prevents you from keeping your appointment, arrangements can be made. PLEASE BE ON TIME. If you know you will be late, please call. Every effort will be made to reschedule you for a later time. Fees for missed appointments are NOT covered by insurance.

I have read this cancellation policy and agree to its terms.

Patient Signature: _____ Date: _____

Benefit Assignment and Release of Information:

I _____, hereby assign all medical benefits to which I am entitled, as covered by private insurance or any other qualifying health plan, to Benjamin Dierauf, LAc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Benjamin E. Dierauf, LAc, to release all information necessary, including medical records, to secure payment.

Patient Signature: _____ Date: _____

Financial Policy Statement:
As a courtesy to you, it is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill for services rendered. Arrangements for payment of your estimated share must be made at the date of service. If your insurance carrier does not remit within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to us.

Patient Signature: _____ Date: _____

2920 Camino Diablo #210-C, Walnut Creek CA 94597 (925) 297-4785 bdierauf@gmail.com

Notice of Patient Privacy Effective Date: March 3, 2013

Health Insurance Portability and Accountability Act (HIPAA)

Benjamin Dierauf, LAc, is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that I communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right-hand side of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Benjamin Dierauf, LAc. You may also send a written complaint to the US Department of Health and Human Services.

I have read, understand and agree to the above conditions:

Patient Signature: _____ Date: _____

2920 Camino Diablo #210-C, Walnut Creek CA 94597 (925) 297-4785 bdierauf@gmail.com

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Benjamin Dierauf, LAc, a licensed acupuncturist, or other members of his office.

I understand the methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Suction Cupping, Electrical Stimulation, Spooning (Guasha), Acupressure, Tui-Na (Chinese massage), Manual Therapy, Chinese or Western Herbal Medicine, and Nutritional & Lifestyle Counseling.

I have had the opportunity to discuss with the above named Benjamin Dierauf and/or with other office personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping and spooning.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. I will notify my acupuncturist should I become pregnant or if I am trying to become pregnant (for which Oriental medicine can be very helpful). If I experience any gastro-intestinal upset or allergic reactions to the herbs I will stop taking the herbs and immediately inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____

Signature _____ Date Signed _____