Healing Path
Holistic Medicine Clinic, LLC

Anja Middelveld, L.Ac., MAOM, NTP

Health History Intake

PERSONAL & WORK INFORMATION

Patient Name: ____ Date: ____________ Date of Injury/Accident: ______________

Address: ____ City: ______________ State: ______ Zip: _________________

Home Phone: ______________________ Cell Phone: _____________________ Work Phone: ____________________________

Email: ____
(by providing my email address I agree to receive occasional emails from Healing Path)

Birth date: _______/______/_________ Sex: M F

☐ Married ☐ Partner ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ______________________________ Employed By: ____

Business Address: ____ City: _______________ State: ______ Zip: ____________

Emergency Contact: _______________________ Emergency #: _______________________

How did you learn about our practice? ☐ friend ☐ ad ☐ internet ☐ drive-by ☐ health professional ☐ other: _______________

FINANCIAL & INSURANCE INFORMATION

Do you have Medical Insurance that covers Acupuncture? ____Yes ____No If yes, please check type:

☐ Private Health Insurance ☐ Personal Injury (please complete other personal injury forms)

Health Insurance Company ____

Insurance Address: ____ City: _______________ State: ____ Zip: ___________

Phone: ________________________ Adjuster Name: ____

Policy or ID #: _____________________________ Group, Plan or Program: __________________ Claim #:___________________

Insured Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Partner

Insured Name : ____ Insured: ☐ M ☐ F

Insured Social Security #: ________________________ Insured Birth date: _____/______/______

Insured Address: ____ City: _______________ State: ____ Zip: _____________

Insured Phone #: ________________________

Insured Employer & Address: ____

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted. I further agree and authorize Anja Middelveld, L.Ac. of Healing Path Holistic Medicine Clinic, LLC to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I, (patient name) ______________________________, hereby authorize (Insurance Co.) ________________________________ to pay and hereby assign directly to Anja Middelveld. L.Ac., of Healing Path Holistic Medicine Clinic, LLC all owed benefits. I understand that I am financially responsible for all charges incurred, whether of not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of Patient ____ Date ____________________________________

Adult Health History Intake (continued)

Name: ____ Birth date: _____/______/______

Primary Complaint ____

History of present illness:

Where does it hurt? ____

How long have you had this problem? ____

What does it feel like when it hurts? ____

Does the pain/problem occur at a specific time? ____

What other associated problems have you been having? ____

What makes the pain/problem worse or better? ____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State

Medications (include non-prescription, vitamins, supplements, etc.)____
____

Family Medical History

Family Member	Age	Diseases	If deceased, cause of death
Father			
Mother			
Sibling(s)			
Spouse			
Children			

Please mark an "x" next to any conditions you have had in the past, and a "check" after conditions you currently have.

MENTAL/EMOTIONAL
____ Mood swings/depression
____ Eating disorder
____ History of counseling
____ Anxiety or nervousness
____ Considered/attempted suicide

NEUROLOGIC
____ Seizures
____ Vertigo or dizziness
____ Paralysis
____ Muscle weakness
____ Numbness or tingling
____ Loss of balance
____ Loss of memory

HEAD
____ Headaches
____ Migraines
____ Head Injury
____ Jaw/TMJ problems

ENDOCRINE
____ Thyroid problems
____ Heat or cold intolerance
____ Fatigue
____ Hypoglycemia
____ Excess thirst or hunger
____ Diabetes
____ Seasonal depression

SKIN
____ Rashes
____ Color change
____ Eczema
____ Fungus
____ Itching
____ Acne or boils

EARS
____ Impaired hearing
____ Earaches
____ Ringing

IMMUNE
____ Chronic fatigue syndrome
____ Chronically swollen glands
____ Chronic infections
____ Frequent colds
____ Autoimmune disease
____ Allergies or hay fever

RESPIRATORY
____ Cough
____ Pain on breathing
____ Wheezing or asthma
____ Shortness of breath
____ Bronchitis
____ Spitting up blood

NOSE AND SINUSES
____ Stuffiness
____ Nosebleeds
____ Hay fever
____ Sinus problems
____ Loss of smell
____ Sinus headaches

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Adult Health History Intake (continued)

Name: ____ Birth date: _____/______/______

MOUTH AND THROAT
____ Teeth grinding
____ Hoarseness
____ Copious saliva
____ Dry mouth
____ Gum problems
____ Sore tongue or lips
____ Mouth sores

EYES
____ Floaters or 'spots'
____ Cataracts
____ Blurriness
____ Double vision
____ Glaucoma
____ Near/Far sightedness
____ Tearing or dryness
____ Eye pain/strain
____ Impaired vision

MUSCULOSKELETAL
____ Joint pain
____ Joint stiffness
____ Arthritis
____ Weakness
____ Sciatica
____ Broken bones
____ Muscle pain
____ Muscle spasm
____ Osteoporosis

URINARY/KIDNEY
____ Pain on urination
____ Increased frequency
____ Frequency at night
____ Kidney stones
____ Infections
____ Urine leakage

CARDIOVASCULAR
____ Heart disease
____ Murmurs
____ Chest pain
____ Poor circulation
____ Blood clots
____ Deep leg pain
____ Valvular problems
____ Palpitations
____ Easy brusing
____ Anemia
____ Varicose veins
____ Fainting
____ Swelling in ankles

GASTROINTESTINAL
____ Trouble swallowing
____ Nausea
____ Vomiting
____ Diarrhea
____ Belching
____ Passing gas
____ Change in appetite
____ Heartburn
____ Ulcer
____ Change in thirst
____ Hemorrhoids
____ Pain or cramps
____ Black stool
____ Blood in toilet

REPRODUCTIVE
____ Pain with intercourse
____ Chlamydia
____ Herpes
____ Genital warts
____ Discharge or sores
____ Sexual difficulties
____ Trouble conceiving

FEMALE ONLY
____ # of days of bleeding per cycle
____ Are cycles regular?
____ PMS
____ Length of cycle (# of days)
____ Bleeding between cycles
____ Painful menses
____ Endometriosis
____ Menopause symptoms
____ Breast lumps or pain
____ Nipple discharge
____ Do you do self breast exams?
____ Age of first menses
____ Clotting
____ Heavy cycles
____ Abnormal pap smears
____ Ovarian cysts
____ # of pregnancies
____ # of miscarriages
____ # of live births

MALE ONLY
____ Hernias
____ Testicular mass
____ Prostate disease
____ Impotence
____ Testicular pain
____ Premature ejaculation

HABITS
Do you exercise? Y N If yes, what kind and how often? ____
How many hours do you sleep? ______ Do you sleep well? ______ Use recreational drugs? ______ Drink coffee? ______
Drink cola? ______ Eat 3 meals a day? ______ Use tobacco? _______ Use alcoholic beverages? _______
How much water do you drink daily? ______ Food intolerances (if known) _____________________________________

1. How does your health condition affect your life on an ongoing basis? ________________________________
2. How would your life be different if you didn't have this condition? __________________________________
3. On a scale of 1-10, how committed are you to improving your state of health? ___________________________
4. On a scale of 1-10, how much change are you willing to make at this time for improving your state of health? ___________

OFFICE POLICIES & FINANCIAL AGREEMENT

Dear New Patient,

Welcome to our clinic. We, the healthcare providers at Healing Path Holistic Medicine Clinic (HPHMC), look forward to addressing all of your health needs. We encourage your questions and participation in all aspects of your health care.

Please read and initial the following:

Office hours & Appointments:

_________ **Initials** The office is open Monday through Saturday, by appointment only.

_________ **Initials** Payment for all services and dispensary items are due at the time of the visit.

_________ **Initials** You will be charged a Missed Appointment fee of $50.00 for any missed appointments or late cancellations (less than 24 hours notice).

_________ **Initials** I give permission for the staff at HPHMC to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.

_________ **Initials** Unless a specific payment plan has been agreed upon and put into writing, we reserve the right to charge interest on any outstanding balance on the account. After 2 months, a 5% compounded interest will accrue, after 6 months, 8% compounded interest will accrue.

Health Insurance & Acupuncture Services (*please read carefully*):

_________ **Initials** For acupuncture and traditional Chinese medicine services we will directly bill your insurance company for payment only after your insurance coverage has been verified. If your insurance benefits have not been verified at the time of your first visit, you are required to pay for you office visit in full at the time services are rendered. Anja Middelveld, L.Ac. is a preferred or in-network provider for some insurance plans, which means that you may be responsible for full payment of all fees, should your insurance company deny part of or all of your claims. You will be billed and are expected to pay any outstanding balance. Your insurance policy is a contract between you and your insurance company and we cannot guarantee payment of your claims.

_________ **Initials** All patients with health insurance coverage of acupuncture services should note that the following items are not covered by most health insurance plans and you will be directly responsible for payment of these services or products:

- Late cancellation fees
- Telephone consultations
- Herbal medicine
- Supplements
- Massage

I have read and understand the above-stated policies of Anja Middelveld, L.Ac. of Healing Path Holistic Medicine Clinic, LLC and will comply with them in all respects.

____
Your Signature (parent of guardian if minor)

____ __________
Print your name (parent or guardian if minor & patient name) Date