NORTHWESTERN HEALTH SCIENCES UNIVERSITY Clinics

PATIENT ACKNOWLEDGEMENT FORM

PLEASE READ THOROUGHLY. INITIAL YOUR ACKNOWLEDGEMENT, THEN SIGN AND PRINT YOUR NAME AND DATE.

ASSIGNMENT OF BENEFITS

I assign all benefits payable to me for my care at Northwestern Health Sciences University. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.
_________(please initial)

GUARANTEE OF PAYMENT

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility**. _________(please initial)**

CANCELLATION POLICY

To maintain our excellence in customer service and to acknowledge the student intern's time and patient requirement, we request a 24-hour cancellation notification for our student and professional acupuncture, chiropractic, massage, naturopath, nutrition, physical therapy and Chinese medicine appointments. I understand that I am to notify the clinic of a cancellation within 24 hours prior to my appointment. **_________(please initial)**

MEDICARE

☐ I am not currently enrolled in Medicare
☐ I am currently enrolled in Medicare

For office use only:
☐ Health Plan Restriction form completed

AUTO/WORKER'S COMPENSATION

☐ No I do not currently have an open auto or work comp claim
☐ Yes I currently have an open auto or work comp claim

MARKETING

I allow NWHSU Clinics to send me information electronically or via printed materials (i.e. additional services, appointment openings and events (used for internal purposes only – we will not share your information with third parties))

☐ **Yes, I would like to receive marketing materials from NWHSU**
Current email address____
☐ **No, thank you**

Print Name____Date____________________________________

Patient Signature____

NORTHWESTERN HEALTH SCIENCES UNIVERSITY Clinics

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

The Northwestern Health Sciences University (NWHSU) Care Delivery System is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial here [ ] ***I acknowledge receipt of the NWHSU-Notice of Privacy Practices***

By signing below, I give consent to the NWHSU-clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

______________________	______________________
Printed Name	**Authorized Provider Representative**
______________________	______________________
Signature	**Date**
______________________	
Date	

NORTHWESTERN HEALTH SCIENCES UNIVERSITY Clinics

Patient Intake Form

Patient Legal Name: ____

(Last Name, First Name , Middle Initial)

Preferred Name in Clinic: ______________________________ Date of Birth: __________

Guardian Name (if applicable): ____

Address: ____

Phone: ________________________ Email: ______________________________

Primary Healthcare Provider and/or Clinic: ____

Are you being seen for injuries related to: □ Motor Vehicle Accident □ Workers Compensation Accident □ Neither

Healthcare Goals

In working to make sure our providers and patients are working together for similar goals, please provide us with your top three healthcare goals you would like to address.

1. ____
2. ____
3. ____

History of What Brings You In

Please describe what primarily brings you in today? ______________________________

____

____

When did you start experiencing your symptoms? ______________________________

How did your symptoms begin? ______________________________

How often do you experience your symptoms?

- □ Constantly (76-100% of the day)
- □ Frequently (51-75% of the day)
- □ Occasionally (26-50% of the day)
- □ Intermittently (0-25% of the day)

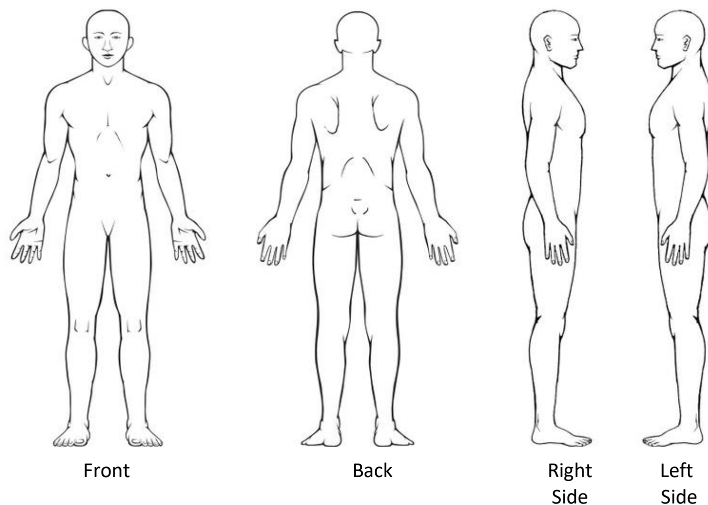
What describes the nature of your symptoms?

- □ Sharp □ Shooting
- □ Dull Ache □ Burning
- □ Numb □ Tingling
- □ Other ______________

How are your symptoms changing?

- □ Getting Better
- □ Not Changing
- □ Getting Worse

Indicate where your symptoms are located



History of What Brings You In Continued

During the **past 4 weeks**:

Indicate the average intensity of your symptoms or pain (please circle): 0 1 2 3 4 5 6 7 8 9 10

How much have the symptoms interfered with your **normal work** (including both work outside the home and housework): □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much of the time has your condition interfered with your **social activities?**

□ None of the time □ A little bit of the time □ Some of the time □ Most of the time □ All of the time

Who have you seen for your symptoms? □ No One □ Medical Doctor □ Acupuncture □ Massage Therapy □ Chiropractic □ Physical Therapy □ Other ________________________

What treatment did you receive and when? ____

What tests have you had for your symptoms and when were they performed?

□ X-rays date:_________ □ CT Scan date: _________ □ MRI date: ________ □ Other date: ___________

Overall Health Review

Review of Systems

In the past year , have you ever experienced any of the following? Please check all that apply.

General

- □ Fever
- □ Chills
- □ Sweats
- □ Anorexia
- □ Fatigue
- □ Weakness
- □ Sleep disorder
- □ Diabetes

Eyes

- □ Vision loss
- □ Double vision
- □ Eye irritation
- □ Blurring
- □ Eye pain
- □ Halos
- □ Discharge
- □ Light Sensitivity
- □ Cataracts

Ears/Nose/Throat/Mouth

- □ Ringing in the ears
- □ Ear discharge
- □ Earache
- □ Decreased hearing
- □ Nasal Congestion
- □ Nosebleeds
- □ Difficulty swallowing
- □ Hoarseness
- □ Sore throat

Cardiovascular

- □ Difficulty breathing at night
- □ Near fainting
- □ Chest pain or discomfort
- □ Racing/skipping heart beats
- □ Lightheadedness
- □ Shortness of breath with exertion
- □ Palpitations
- □ Swelling of hands/feet
- □ Difficulty breathing while lying down
- □ Fainting
- □ Leg cramps with exertion
- □ Bluish discoloration of lips or nails
- □ Weight gain

Respiratory

- □ Sleep disturbances due to breathing
- □ Cough
- □ Shortness of breath
- □ Coughing up blood
- □ Wheezing
- □ Excessive sputum
- □ Excessive snoring

Gastrointestinal

- □ Excessive appetite
- □ Loss of appetite
- □ Indigestion
- □ Vomiting blood
- □ Nausea
- □ Vomiting
- □ Yellowish color skin
- □ Gas
- □ Abdominal pain or bloating
- □ Hemorrhoids
- □ Diarrhea
- □ Change in bowel habits
- □ Constipation
- □ Dark tarry stools

Please provide any additional information regarding symptoms you marked as yes above.

____

____

____

Review of Systems Continued

In the past year, have you ever experienced any of the following? Please check all that apply.

Genitourinary

- □ Foul urinary discharge
- □ Blood in urine
- □ discharge
- □ Urinary frequency
- □ Urinary hesitancy
- □ Night time urination
- □ Inability to control bladder
- □ Genital sores
- □ Lack of sex drive
- □ Erectile dysfunction
- □ Excessive heavy periods
- □ Missed periods
- □ Unusual urinary color
- □ Kidney stones
- □ Pain or discomfort urinating

Musculoskeletal

- □ Muscle cramps
- □ Joint pain
- □ Joint swelling
- □ Presence of joint fluid
- □ Stiffness
- □ Muscle weakness
- □ Arthritis
- □ Gout
- □ Muscle aches
- □ Osteoporosis
- □ Facture or Dislocation
- □ Deformity

Dermatology

- □ Excessive perspiration
- □ Night sweats
- □ Suspicious lesions
- □ Changes in nail beds
- □ Dryness
- □ Poor wound healing
- □ Unusual hair distribution
- □ Skin cancer
- □ Itching
- □ Changes in color of skin
- □ Flushing
- □ Rash

Neurology

- □ Difficulty with concentration
- □ Poor balance
- □ Headaches
- □ Disturbances in concentration
- □ Numbness
- □ Inability to speak
- □ Falling down
- □ Tingling
- □ Brief paralysis
- □ Visual disturbances
- □ Sensation of room spinning
- □ Tremors
- □ Fainting
- □ Excessive daytime sleeping
- □ Memory loss

Psychological

- □ Sense of great danger
- □ Anxiety
- □ Thoughts of suicide
- □ Mental health problems
- □ Depression
- □ Thoughts of violence
- □ Frightening visions or sounds

Endocrine

- □ Excessive hunger
- □ Cold intolerance
- □ Heat intolerance
- □ Excessive urination
- □ Excessive thirst
- □ Weight change

Hematology

- □ Enlarged lymph nodes
- □ Bleeding
- □ Skin discoloration
- □ Abnormal bruising
- □ Fevers

Allergy

- □ Persistent infections
- □ Hives or rash
- □ Seasonal allergies
- □ HIV exposure

Please provide any additional information regarding symptoms you marked as yes above.

____

____

____

Past History

Have you had any hospitalizations? □ Yes □ No

In the past 5 years have you had any minor surgical procedures? □ Yes □ No

Have you ever had any major injuries or accidents? □ Yes □ No

Have you ever had any major surgical procedures? □ Yes □ No

Have you ever had any head trauma? □ Yes □ No

Have you ever had any orthodontic work or teeth extractions? □ Yes □ No

Do you have a history of cancer? □ Yes □ No

If yes, what type of treatments have your received for it? ____

If you marked yes to any of the past history question please provide the reason and the dates the event occurred.

____

____

Family History

Please review the conditions below and indicate if the family member listed have or had any of them.
If they have please place a check mark in the box.

	Mother	Father	Child	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Cancer									
Diabetes									
Heart Disease									
Thyroid									
Arthritis									
Mental Health									
Digestive Issues									
Autoimmune Disorder									
Other									

□ No Known Family History

Social/Current History

On average many glasses of water do you consume per day? □ None □ 1 - 2 □ 3 - 5 □ 6 - 8 □ 9 - 11

On average how many cups of caffeine do you consume per day? □ None □ 1 - 2 □ 3 - 5 □ 6 - 8 □ 9 - 11

How frequently do you consume alcohol? □ Never/Rarely □ Once a week □ 2 - 3x/week □ 5+ x/week

Do you or have you ever used nicotine or tobacco products? □ Current □ Former □ Never

How many hours of restful sleep do you get per night? □ <3 Hours □ 4-6 hours □ 7-9 hours □ 10+ hours

Do you regularly exercise? □ Yes □ No

If yes, what do you like to do and how frequently? ____

What do you currently do for a living? □ Retired □ Caretaker □ Disabled

□ Work Part Time □ Work Full Time What is your job? ________________________________

What are some of your hobbies? ____

Discipline Specific Questions

Please complete the below section if your visit today is with one of the following providers types.

□ Not applicable today

Acupuncture and Chinese Medicine or Naturopathic Medicine

Urination

Frequency: ______________ Quantity: ______________ Color: _____________

Do you have to get up in the middle of the night to urinate? □ Yes □ No How many times on average? _____

Bowel Habits/Stool

Frequency: □ less than once per day □ 1 - 2 times a day □ 3 - 4 times a day □ 5+ times a day

Quality:________________ Quantity: ______________ Color: _____________

Menstrual Cycle

Days between Menses: ___________________________

Do your cycles tend to be regular? □ Yes □ No

Diet

How would you describe your typical diet? ____

How frequently in a 24 hour period do you eat? ____

Additional Information to Help Us Better Serve Your Needs

Current Legal sex: □ M □ F What sex were you assigned on your original birth certificate? □ M □ F

Gender identity/expression: □ Male □ Female □ M to F □ F to M □ Choose not to disclose

□ Other (please describe): _________________

Preferred pronouns: □ He/Him □ She/Her □ They/Them □ Ze/Zir □ No pronouns/Name only

Current Marital Status: □ Single □ Married □ Living with significant other

□ Divorced/Separated □ Widowed

What is your race? (Defined by the federal government; please check one):

□ Asian or Pacific Islander □ Hispanic □ Black/African American

□ American Indian or Alaskan Native □ White □ Other ________________________________

Thank you for taking the time to complete the intake form. This information will be used by your healthcare provider(s) to help you in reaching your healthcare goals. Please provide this packet to the front desk staff upon arriving to the clinic.

The information that I have provided is true and complete to the best of my knowledge.

Patient Signature: ____ Date: _____/______/______

NORTHWESTERN HEALTH SCIENCES UNIVERSITY
Clinics

Patient Medications & Supplements List

Patient Name ____

Allergies (if yes, please include medication, food and environmental; if no, please write "none"):

____

____

____

Medication Name (include prescribed drugs, OTC drugs, herbs & supplements)	**Prescribed By**	**Dosage & Frequency**	**Reason for Taking**