CONFIDENTIAL PATIENT INTAKE

Natural Health Therapies, L.L.C. • 11495 Sunset Hills Road STE 240, Reston, VA 20190 • 703-742-7856 • www.cccreston.com

PERSONAL INFORMATION

First Name:_______________________**M.I.**_____**Last Name:**______________________ **Preferred Name:**_____________________

Address:____**City:**_______________________**State:**______**Zip:**_____________

Birthdate(MM/DD/YY):______/______/______ **Age:**______ **Gender at Birth:** ☐ **Male** ☐ **Female Height:**_______ **Weight:**_______

Primary Phone #:____________________ **Secondary Phone #:**____________________ **Email:**______________________________

By providing my email address & cell phone#, I authorize my doctor to contact me via email, phone and/or text regarding appointments and health information.

Status (check one): ☐ Single ☐ Married ☐ Other____

Occupation:____ **Employer:**____

Emergency Contact: (Name, Relationship, Phone #)____

How did you hear about our office? ____

INSURANCE OR PRIVATE PAY INFORMATION

Type of Insurance:

☐ Health Insurance Carrier:______________________ (***Please provide your insurance card at reception)*** ☐ Self Pay ☐ Auto Ins.

FINANCIAL POLICY/CANCELLATION AND RESCHEDULING FEE:

Your insurance contract is between you, your employer, and the insurance company. Please contact your insurance company for any coverage questions or issues. Not all services are covered by all contracts. We will file a claim for you with your primary insurance company only on your behalf. Any copays, coinsurance, deductible payments, remaining balances and fees are your responsibility. If you are not using insurance, you will be charged our cash rate. Payment is due at time of service, unless other arrangements, based on financial cause, have been made through our billing department. A $30 fee will be charged for returned checks. We require 24 hours' notice for all appointment cancellations and rescheduling. ***A $50 fee may be charged if notice is less than 24 hours.*** I authorize release of any information necessary to my insurance company to determine benefits for services rendered. I understand that I am responsible for any balance in my account regardless of my insurance status. I understand I am responsible for providing up to date insurance information. I understand the cancellation/rescheduling policy and that I am responsible for any fees that have been charged.

Please note all **credit and debit card** transactions will receive a **3.5% surcharge** for processing and security fees. Dr. Amanda Ngui-Yen does not receive any portion of this surcharge. If a refund is requested via credit or debit card the base amount of the transaction will be refunded 100%, but the surcharge fee will be retained by the third party processor. Payments by cash or check are free of any surcharge.

X____ **DATE:** __________________________________

Signature of Patient, Parent or Legal Guardian (if minor)

PRIVACY NOTICE

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. A signed consent form permits us to use your personal health information for the purposes of treatment, receiving payment, and health care operations. It is our policy to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients as outlined in HIPAA. This includes third party payers, insurance companies, etc. If protected health information must be released, the patient or outside entity must provide us with a medical records release form signed by the patient. Where required by law we will only release the minimum information necessary to law enforcement or public health agency. You, as the patient, have the right to see your medical record during normal office hours. You also have the right to revoke in writing this consent at any time. A copy of our privacy policy is available upon request.

X____ **DATE:** __________________________________

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? ____

What caused this condition(s)? ____

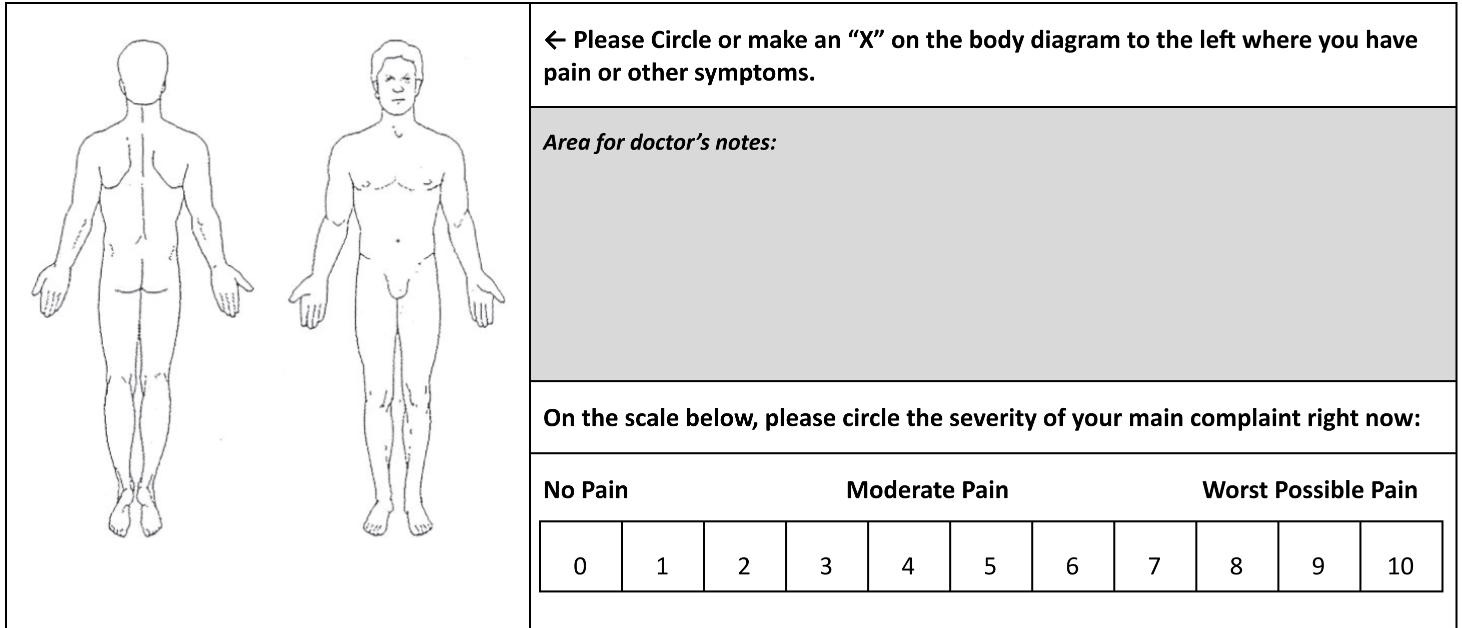
____

When did this condition begin(MM/DD/YY)?______/______ /______ **Symptoms are:** ☐ Improving ☐ Worsening ☐ Not changing

Have you had this or similar condition in the past? ☐ Yes ☐ No If "Yes", when?____________________________

What does your condition(s) feel like? Circle all that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*____________________________

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?: ____________________________



← Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain **Moderate Pain** **Worst Possible Pain**

0	1	2	3	4	5	6	7	8	9	10

What aggravates this complaint? Circle all that apply: *Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Personal care / Travel / Recreation / Daily Routine / Social Activities / Everything / Unknown / Other:*____________________________

What relieves this complaint? Circle all that apply: *Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Acupuncture / Nothing / Other:*____________________________

How often do you experience your symptoms? ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

What time of day are your symptoms the worst? ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping ☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other:____________________________

Is your complaint interfering with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Have you seen other practitioners for this complaint? ☐ Yes ☐ No If "Yes", please provide the following information:

Practitioner name:____________________________ **Date consulted:**________________ **Diagnosis:**____________________________

Have you experienced any of the following symptoms recently or as a result of your condition? Circle all that apply: *Unexplained Weight Loss/ Unexplained Weight Gain / Nausea / Vomiting / Dizziness / Vertigo / Night Sweats / Bowel Changes / Bladder Changes / Loss of Consciousness / Memory Loss*

HEALTH HISTORY

Please check ALL of the health conditions that apply to you currently or in the past:

☐ Acid Reflux	☐ Disc Degeneration	☐ Hypoglycemia	☐ Poor Digestion
☐ Alcoholism	☐ Disc Herniation	☐ Irritable Bowel Syndrome	☐ Restless Leg Syndrome
☐ Anemia	☐ Fatigue	☐ Kidney Disorder	☐ Scoliosis
☐ Arthritis	☐ Frequently Sick	☐ Lupus	☐ Sleep Apnea
☐ Anxiety/Depression	☐ Gall Bladder Dysfunction	☐ Lyme Disease	☐ STD's/HIV
☐ Asthma	☐ Heart Disease	☐ Measles/Mumps	☐ Stroke
☐ Bruise Easily	☐ Hepatitis/Liver Condition	☐ Mental Illness	☐ Thyroid Dysfunction
☐ Cancer	☐ High Blood Pressure	☐ Migraines	☐ TMJ Issues
☐ Concussion	☐ High Cholesterol/LDL	☐ Multiple Sclerosis	☐ Ulcer
☐ Diabetes	☐ Hot Flashes	☐ Osteoporosis/Osteopenia	☐

WOMEN ONLY: Currently Pregnant? ☐ Yes ☐ No **Painful/Abnormal Menstrual Cycle?** ☐ Yes ☐ No **Menopause?** ☐ Yes ☐ No
Date of last menstrual period (MM/DD/YY): ______________________________

FAMILY HISTORY (Please note any family members with the following conditions):

Diabetes		Osteoporosis	
Heart Disease/Stroke		Arthritis	
Cancer		Thyroid Disease	
Autoimmune Disease		Other	

SURGERIES and/or HOSPITALIZATIONS (List and Date):
____
____

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date):
____
____

Have you had an X-ray or CT scan or MRI in the past 2 years? ☐ Yes ☐ No

If "Yes", what was the result: ____
____

List current medications and/or supplements. If there are NO current medications and/or supplements, check here ☐

Name of medication/supplement	*Used for?/Start date*	*Name of medication/supplement*	*Used for?/Start date*
1.		4.	
2.		5.	
3.		6.	

List any known allergies: ____ **If NO allergies are known, check here** ☐

SOCIAL HISTORY

Do you exercise? ☐ Yes ☐ No **Times per week?** _________ **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous **Type?** ____________
____
Do you currently smoke tobacco of any kind? ☐ Yes, how often? _________________ ☐ Former smoker ☐ Never been a smoker
Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** _________________ **For how many years?** _________________
Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?_____What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks
What do your daily duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other: __________________________
What is your current stress level? ☐ Mild ☐ Moderate ☐ High
Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

INFORMED CONSENT

I give permission and authority to Natural Health Therapies LLC to provide care in accordance with appropriate tests, radiographs, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. The doctor will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures what he/she may be suffering from; latent pathological defects, illnesses or deformities that would otherwise not come to the attention of the physician. I have read and understand the foregoing CONSENT TO CARE and acknowledge that I have stated all conditions of which I am aware and this information is true and accurate. I will inform the healthcare provider of any changes in my status. My case may not be accepted for treatment at this clinic. If the doctor believes that I may respond to their care, additional services may be recommended, and I will be advised of applicable cost. If the patient is a minor, I, as the parent or legal guardian, give permission for my child to receive chiropractic care.

X____ DATE: ___________________________________

Name of Patient, Parent or Legal Guardian (if minor)

X____

Signature of Patient, Parent or Legal Guardian (if minor)

DRY NEEDLING CONSENT (IF APPLICABLE)

Myofascial trigger points and tender points which appear in soft tissue, and are painful sites, reflect abnormal nervous system activity associated with many neuro-musculo-skeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating and monitoring changes in myofascial trigger/tender points. During this procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles may be used, and the procedure may be performed during more than one office visit. The number of needles, and the frequency of the procedure will depend entirely on your condition at each office visit. There is little to no pain with this procedure. There is little to no bleeding with this procedure. While an infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is the risk of infection. Other unlikely but possible events include fainting, soreness, or pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example, Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example, Tylenol, Advil, Aleve, or Bufferin), please inform us by placing a check mark as indicated below:

- ☐ I have a fear of needles.
- ☐ I have a genetic bleeding disorder. Please specify:
- ☐ I have a history of a blood disorder that can be transmitted to another person. Please specify:
- ☐ I am regularly taking blood thinning (anti-coagulation) medication. Please specify:_______________________________________
- ☐ I am regularly taking pain relievers. Please specify:

I have read this Patient Information and Consent carefully, *I understand this procedure is not acupuncture* and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me.

FINANCIAL RESPONSIBILITY: A $10 supply and disposal fee per visit will be assessed depending on specific insurance coverage.

X____ DATE: ___________________________________

Name of Patient, Parent or Legal Guardian (if minor)

X____

Signature of Patient, Parent or Legal Guardian (if minor)