

PATIENT CONFIDENTIAL INFORMATION

Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Work Phone _____ E-Mail Address _____

Age _____ Date of Birth ____/____/____ Gender Assigned at Birth: _____
MM DD YY

*Current Gender Identity: _____ *Preferred Pronouns: _____

Ethnicity: _____

Emergency contact: _____
Name Relationship Phone #

Street City State Zip Code

Primary language spoken at home: _____

*Place of Birth _____ * Marital Status S M D W

*Occupation or profession _____ *Employer _____

*Where did you hear about us? _____

**This information is helpful, but optional. All other information is mandatory.*

PATIENTS PLEASE FILL IN: Name: _____ Date: _____

INTERN CLINIC TERMS AND CONDITIONS OF SERVICE

TREATMENT OF MINORS

During the treatment of patients under 18 years of age, the patient's legal guardian must be present in the clinic during the entire session for each treatment. Please speak to the front desk for details.

INSURANCE AND WORKERS COMP

We will only prepare insurance billing information for patients paying our standard fee. Billing information is prepared after every fifth visit. Emperor's College does not treat worker's compensation injuries.

ECTOM 24-HOUR CANCELLATION POLICY

In order to maintain the integrity of our low-cost community treatment clinic, Emperor's College must request that all cancellations be made with a minimum of 24-hour notice. Appointments and cancellations must be made with the front desk only. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation at our standard fee. This means that low income patients and Emperor's College students and staff will also be charged the standard fee for late cancellations or not showing up to an appointment. Last minute cancellations and failures to show affect our ability to serve both our community and our interns. Also, there are NO refunds given or returns on any herbal products that are purchased.

OBSERVERS

Given that Emperor's College Clinic is a teaching clinic; all patients must assume that an observer will be present during the course of their appointment. Emperor's College charges a reduced fee because we are a teaching clinic. Patients who refuse to allow an observer can be denied service.

SEXUAL HARASSMENT

Be advised that interns and student observers attending Emperor's College Clinic do so in pursuit of an education only. All comments or questions from patients regarding an intern's or student observer's appearance, dating habits or personal life are not permitted. Any complaint regarding a violation of this policy will result in that patient being barred from this facility. We have high expectations of professionalism from our interns and student observers and expect the same of our patients. We will vigorously protect the intern's and student observer's right to pursue their education in an environment completely free from all harassment.

ADMISSION AND MEDICAL SERVICES AGREEMENT

The patient or the patient's representative consents to the admission of the patient to Emperor's College Teaching Clinic if this is deemed necessary for the care of the patient. All the terms and conditions hereof shall also apply to such admissions.

MEDICAL CONSENT

I have read and fully understand that Emperor's College Intern Clinic is a teaching clinic. I understand that interns and Oriental Medical students as observers and post-graduate fellows under the supervision of attending Practitioners of Oriental Medicine (Licensed Acupuncturists) are participating in my treatment procedures as part of the medical education program of the institution. Under this condition, the patient or the patient's representative consents to any Oriental Medical treatments or procedures that are given by the Interns under the general and special instructions of the attending practitioner or any other Practitioner of Emperor's College Teaching Clinic assisting in the care of the patient. The patient accepts the full responsibility to follow up the medical advice given at Emperor's College Teaching Clinic.

The patient or the patient's representative consents to the treatment procedures and its results and repercussions thereof and accepts arbitration if deemed necessary.

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, ECTOM Clinic, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ECTOM Clinic’s Notice of Privacy Practices for a more complete description of such uses and disclosures. (This allows your information to be used for clinic and teaching purposes only! We will not release this information unless we receive a subpoena or “authorization to release” signed by you.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ECTOM Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ECTOM Clinic Privacy Officer at 1807-B Wilshire Blvd., Santa Monica, Ca 90403.

ECTOM Clinic may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

ECTOM Clinic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

ECTOM Clinic may e-mail to my appointment reminder cards and patient statements. I have the right to request that ECTOM Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ECTOM Clinic’s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ECTOM Clinic may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient’s Name

Date

Print Name of Patient or Legal Guardian

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following as accurately as possible.

Patient Name: _____

Date: _____

Present Illness:

What is your chief complaint?

Mark below with an X where you feel pain or discomfort.

When did this condition begin?

What treatment have you received already?

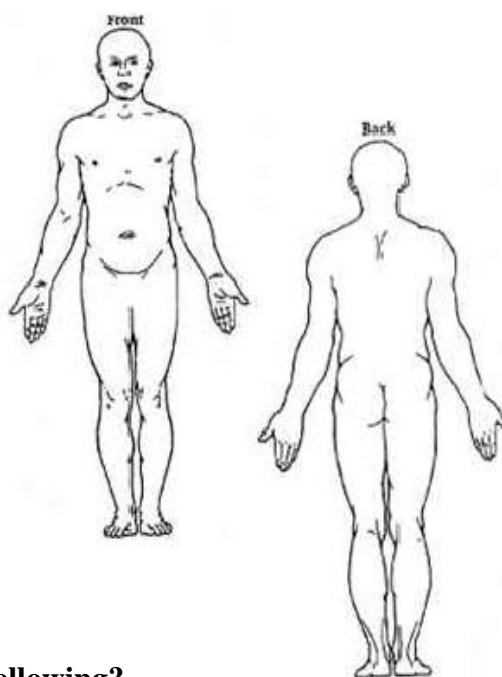
Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

What medications are you taking?



Which, if any, of your blood relatives have had any of the following?

- Stroke Cancer Heart Disease Tuberculosis Bleeding disorders
 Diabetes High blood pressure

Please list your primary physician's name and contact information:

Name: _____ Phone: _____

Address: _____

Specialty, if any: _____

Menstrual History:

Age of your first period: _____
Vaginal discharge: _____
Length of cycle, day 1 to day 1 _____
Length of flow (days): _____
Date of your last period: _____
Do you believe you are pregnant? Yes ___ No ___
Number of pregnancies: _____
Number of live births: _____
Number of Miscarriages _____
Number of Terminated Pregnancies _____

Recreational Substance Usage:

History of smoking? ___ How many years? ___
--how many per day? ___
History of smokeless tobacco use? ___
History of drinking alcohol? ___
--how many drinks/week? ___
History of recreational drug use? ___
How many cups of coffee/day? ___
How many sodas/day? ___

MEDICAL HISTORY—SYMPTOM CHECKLIST

MARK WITH AN "X" ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(please write the word "Past" next to those conditions which you have ONLY had in the past and which are no longer present)

HEAD AND NECK:

- Dizziness***
- Fainting***
- Neck Stiffness
- Enlarged lymph glands
- Headaches
- _____ Other

EARS:

- Infection
- Ringing
- Decreased hearing
- _____ Other

EYES:

- Blurred vision
- Visual changes
- Poor night vision
- Spots/Floaters
- Eye inflammation/Styes
- _____ Other

NOSE, THROAT & MOUTH:

- Bleeding
- Sinus infection
- Hay fever or allergies
- Sore throat
- Hoarseness
- Changes in taste
- Difficulty swallowing
- Changes in smell
- Oral ulcers/Canker sores
- _____ Other

SKIN:

- Hives
- Rashes
- Eczema
- Psoriasis
- Seborrhea
- Night sweating
- Excess sweating
- Dryness
- Bruises easily
- Changes in moles or lumps
- _____ Other

NEUROLOGICAL:

- Numbness or tingling of limbs
- Seizures***
- Tremors
- Pain
- Paralysis
- Epilepsy or Convulsions***
- _____ Other

INFECTION HISTORY:

- HIV/AIDS, or HIV risks:** Self or partner*
- TB: Self or household
- Hepatitis, or Hepatitis risk:** Self/Partner*
- History of sexually transmitted diseases: Self or partner:
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes (oral) _____ Herpes (genital) _____
- MRSA, Staph, CRE, or other Drug-Resistant Infections***

RESPIRATORY:

- Chronic cough
- Coughing up blood
- Coughing up phlegm frequently
- Difficulty breathing
- Wheezing/Asthma
- Frequent Colds
- Emphysema
- Pneumonia repeatedly
- _____ Other

CARDIOVASCULAR:

- Palpitations
- Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Heart Disease
- Poor circulation
- Swelling of ankles
- Phlebitis
- Cold hands/feet
- Cardiac Pacemaker***
- High blood pressure***
- Stroke***
- _____ Other

GASTROINTESTINAL:

- Indigestion
- Nausea
- Stomach pain
- Irritable bowel disease
- Colitis
- Crohn's Disease
- Pancreatitis
- Celiac Disease
- Recent change in bowel habits
- Diarrhea (___ stools/day)
- Constipation (___ stools/week)
- Dry, hard stools
- Soft, difficult, sticky stools
- Irregularly or poorly-formed stools
- Poor appetite
- Excessive hunger
- Blood in stool or black stools
- Hemorrhoids
- with pain or blood
- Gall bladder disorder
- Vomiting blood
- Peptic Ulcer
- Recent change in weight
- Food cravings
- _____ Other

MUSCLES AND JOINTS:

- Joint disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Spinal curvature
- Backache
- Back pain
- Fibromyalgia
- _____ Other

MALE:

- Pain/itching of genitalia
- Genital lesions/discharge
- Impotence
- Premature ejaculation
- Prostate problems
- Infertility (e.g., abnormal sperm)
- _____ Other

FEMALE:

- Frequent vaginal infections
- Infertility
- Pain/itching of genitalia
- Genital lesions/discharge
- Pelvic inflammatory disease
- Abnormal Pap smear
- Irregular periods
- Emotional changes with menses
- Clots with menses
- Painful menstrual periods/cramps
- Premenstrual Syndrome
- Abnormal bleeding
- Menopausal symptoms (hot flashes, etc.)
- Breast lumps/cysts
- Breast swelling and/or pain
- _____ Other

URINARY:

- Frequent urinary tract/bladder infections
- Weak urinary stream
- Recent change in bladder habits
- Kidney Disease
- Frequent day urination (___ X)
- Frequent night urination (___ X)
- _____ Other

GENERAL:

- Fatigue
- Thirst
- Aversion to cold
- Insomnia
- Frequent dreams/nightmares
- Depression
- Agitation
- Irritability
- Anxiety
- History of psychiatric treatment
- Poor memory
- Difficulty concentrating
- Sores that don't heal***
- Congenital abnormalities
- Surgical implants***
- Unusual bleeding or discharge
- Jaundice
- Hernia
- Epstein Barr virus (EBV)
- Rheumatic Fever
- Diabetes mellitus***
- Thyroid Disorder
- Cancer
- Anemia or other blood disorder***
- Lupus erythematosus
- _____ Other

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