Kamela Helsing, LAc, MAc

Classical Chinese Medicine

Website: rockwaterwellness.com ∞ Office Phone: 360.718.8240

Patient Intake

Name _____
Last *First* *M.I.*

Date of Birth _____ Age _____ Gender (circle one): F M

Home number _____ Cell number _____ Please circle the preferred phone number to contact you.

Address _____City, State,Zip _____

Email _____

Occupation _____ Hrs per week _____

Are you currently receiving healthcare? yes no

Consent Regarding Use of Information

_____ At times Kamela Helsing LAc, MAc uses email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this section, you consent to allow Kamela Helsing LAc, MAc to correspond with you via email in spite of these potential risks.

Context of Care

What are your most important health concerns, in order of importance?

1. _____ 3. _____

2. _____ 4. _____

Do you have any known contagious diseases at this time? yes no

If yes, what? _____

What *three* specific expectations do you have from this visit?

1.

2.

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3.

What long-term expectations do you have in working with me?

What expectations do you have of me personally as your healthcare provider?

Describe your current state of health.

What is your level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? *Rate from 0 – 10, where 10 is 100% committed.*

0 1 2 3 4 5 6 7 8 9 10

Current Medications
Do you use any of the following?

☐ Antacids	☐ Tylenol or Advil	☐ Oral contraceptives
☐ Antibiotics	☐ Anti-inflammatory medications	☐ Laxatives
☐ Antidepressants	☐ Other psychiatric medications	☐ Glucose or Insulin
☐ Aspirin	☐ Cholesterol lowering medications	☐ Daily vitamins
☐ Anti-fungals	☐ Radiation or Chemotherapy	☐ Thyroid medications
☐ Sleeping Pills	☐ Blood pressure medications	☐ Recreational or Illegal Drugs

Please list all prescription medications, over-the-counter medications, vitamins, herbs and nutritional supplements you use and how frequently. Include dosages if you can.

Substance	Dose + Frequency	Date began	Reason
1.			
2.			
3.			
4.			
5.			

Relevant medical history _____

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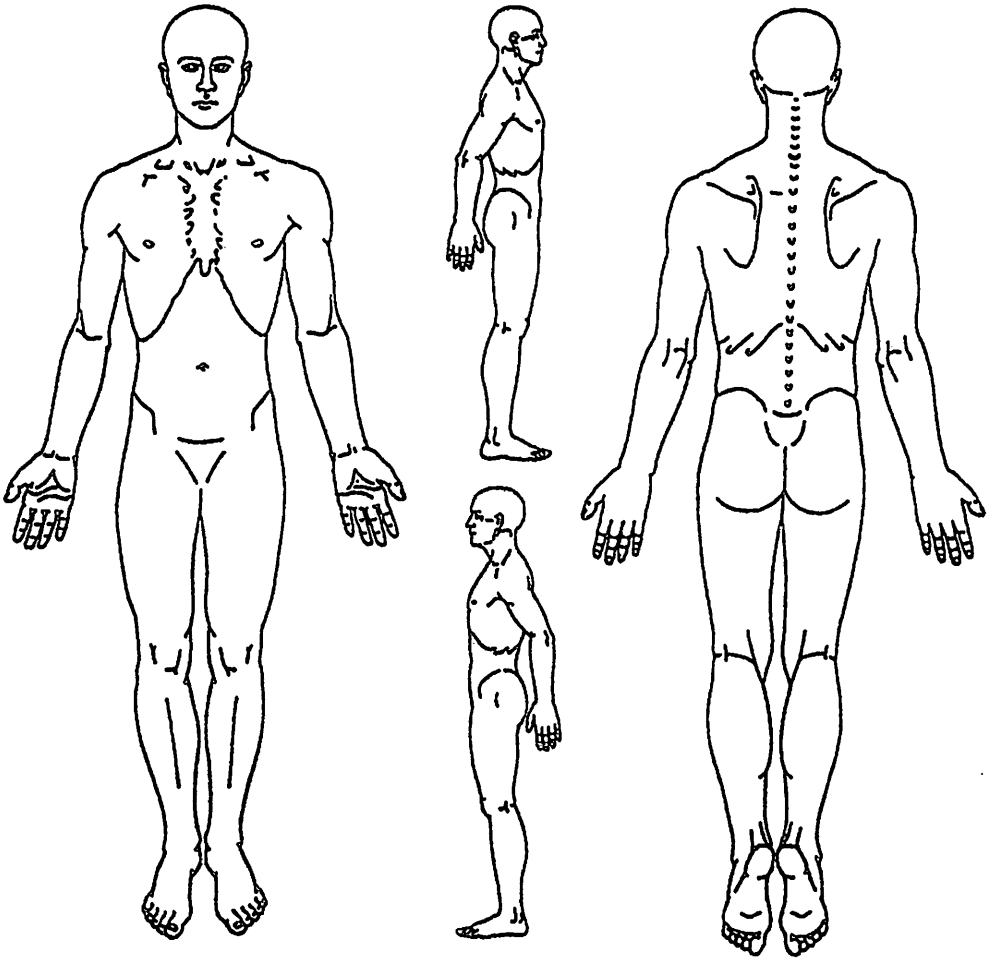
Pain and Scars

If you are currently experiencing pain or if you have scars anywhere on your body, please mark the figures below with the letters that best describe the sensation or pain you are feeling and draw in the areas of scarring. Please mark areas where pain radiates or spreads with an arrow to indicate the direction of radiating pain. (Include all affected areas)

A – Aching	B – Burning	R – Radiating	D – Dull
F – Fixed	C – Cramping	S – Sharp/Stabbing	N – Numbness
P – Pins & Needles	**Draw in scars		



Please indicate how you would rate your overall state pain: (Low) 0 1 2 3 4 5 6 7 8 9 10 (High)

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What makes the pain better?

- ☐ Soft Pressure
- ☐ Hard Pressure
- ☐ Warmth/Heat
- ☐ Cold
- ☐ Exercise
- ☐ Rest
- ☐ Other

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- ☐ Cold
- ☐ Exercise
- ☐ Rest
- ☐ Other

Are there any other health concerns that you have which have not been covered in this questionnaire?

Signature Date

Thank you for taking the time to fill out this questionnaire.

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

Patient Notification of Qualifications and Scope of Practice

East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. My qualifications include the following education and license information:

(a)Nationally certified licensed acupuncturist by NCCAOM ID: 151636
(b)Washington state department of health license# AC60337489
(c)Master of Acupuncture from nationally accredited National College of Natural Medicine
Clean needle technique from: Council of Colleges of Acupuncture and Oriental Medicine (CCAOM)

2. The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following:

(a)Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
(b)Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
(c)Moxibustion;
(d)Acupressure;
(e)Cupping;
(f)Dermal friction technique;
(g)Infra-red;
(h)Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
(i)Breathing, relaxation, and East Asian exercise techniques;
(j)Qi gong;
(k)East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
(l)Superficial heat and cold therapies.

3.Side effects may include, but are not limited to:
(a)Pain following treatment;
(b)Minor bruising;
(c)Infection;
(d)Needle sickness; and
(e)Broken needle.

4. The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.