

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so. If you have a preferred method of our contacting you please circle the e-mail address or phone number of your preferred choice; we will always try that method first.

Name _____
Address _____
City _____ State _____ Zip _____
e-mail address _____
Phones: Home _____ Mobile _____

Gender (circle one) Male/Female/Transgender/Non-Binary

If transgender or non-binary:

preferred pronoun _____ gender at birth _____ gender on insurance _____

Age _____ Date of Birth _____
Employer _____ Occupation _____

Relationship Status (circle one)

Single, Married, Divorced, Separated, Widowed, Domestic Partner

Name of Spouse/Partner _____

Emergency Contact

Name _____ Relationship _____

Home or Mobile Phone (circle one) _____

How did you find out about us?

- Referred by (circle one) Friend/Relative/Professional
Name _____
- Other _____

Signature of Patient (or Responsible Party if Patient is a Minor)

Date

Printed Name of Signer

Relationship to Patient

215 S Northwest Hwy Suite 102B
Barrington IL 60010
Phone 847-382-1884

We are located on the east side of Northwest Highway (Route 14)
south of Main St (Lake Cook Rd)

Patient Name _____

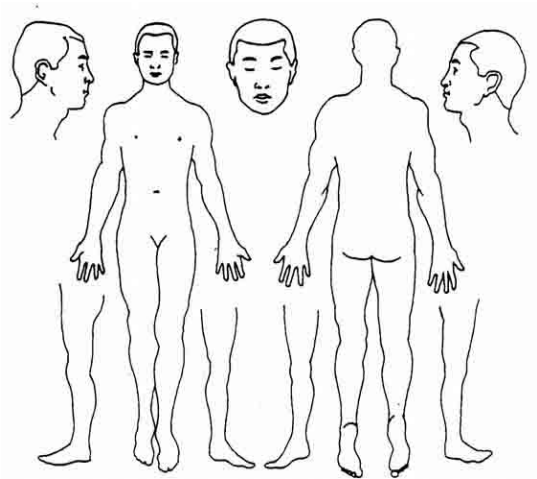
Date _____

Reason for visit _____

Are you experiencing pain/discomfort in any area of your body (circle one)? Yes/No

If yes, using the models below to indicate the location of discomfort by using the symbol that best describes the feeling:

- XXX Sharp/stabbing
- PPP Pins & Needles
- DDD Dull/Aching
- NNN Numbness



Surgical History:

_____	Date
_____	Date
_____	Date
_____	Date
_____	Date

For Women: Are you pregnant now? Yes/No (circle one)

Medications/Supplements

Please include prescription medications, supplements, herbal supplements and over the counter (OTC) medicines you take on a regular basis

Allergies (medications, chemicals, foods, animals, insects, plants or environmental):

Please comment on anything else that you think is relevant.

Barrington Acupuncture Clinic

Health History

Patient Name _____

Date _____

Please check all that apply:

General

- Appetite - Poor/Excessive
- Change in appetite
- Excessive thirst
- Insomnia
- Fatigue
- Fever/Chills
- Catch cold easily
- Excessive sweating
- Night Sweats
- Localized weakness
- Poor coordination
- Bleed or bruise easily
- Thyroid - low/high
- Other _____

Musculoskeletal

- Stiff neck/shoulders
- Low back pain
- Muscle spasm/twitching/cramps
- Sore/cold/weak knees
- Joint pain
- Replacement joint/prosthesis

Skin & Hair

- Rashes/Hives
- Itching
- Eczema/Psoriasis
- Pimples/Acne
- Dryness
- Lumps/tumors

Head & Neck

- Dizziness/Fainting
- Headaches
- Concussions
- Stiff neck

Eyes

- Blurred vision
- Visual changes
- Poor night vision
- Floaters
- Cataracts
- Eye inflammation
- Glasses/Contacts
- Near/far sighted
- Other _____

Ears

- Hearing loss
- Ringing
- Infection
- Hearing aid
- Other _____

Nose, Throat, Mouth

- Nose bleeds
- Sinus infections
- Hay fever/allergies
- Recurring sore throats
- Grinding teeth
- Difficulty swallowing
- Other _____

Respiration

- Asthma
- Bronchitis
- Frequent Colds
- COPD
- Pneumonia
- Chronic cough
- Coughing blood
- Phlegm production
- Other _____

Cardiovascular

- Low/high blood pressure
- Palpitations
- Blood clots
- Chest pain
- Irregular heart beat
- Cold hands/feet.
- Fainting
- Difficulty breathing
- Swelling of hands/feet
- Other _____

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Belching
- Bad breath
- Pain/cramps
- Indigestion
- Gas
- Hemorrhoids
- Gall bladder disorder
- Blood in stool/black stool
- Other _____

Urinary

- Frequent urination
- Urgency to urinate
- Painful urination
- Unable to hold urine
- Blood in urine
- Kidney stones
- Other _____

Infectious

- HIV
- TB
- Hepatitis
- Genital warts
- Herpes - oral
- Herpes - genital
- Other _____

Neurological

- Numbness/tingling
- Pain
- Seizures
- Tremors
- Concussion
- Paralysis
- Other _____

Psychological

- Anxiety/stress
- Depression
- Irritability
- Other _____

Female

- Frequent urinary tract infections
- Frequent vaginal infections
- Pain/itching of genitals
- Abnormal pap smear
- Irregular menstrual periods
- Painful menstrual periods
- PMS
- Abnormal bleeding
- Menopausal
- Hot Flashes
- Breast tenderness/lumps
- Other _____

Male

- Pain/itching of genitals
- Weak urinary system
- Lumps in testicles
- Other _____

Barrington Acupuncture Clinic

215 S Northwest Hwy Suite 102B
Barrington IL 60010
Phone: 847-624-4228

Barrie Hinman
Licensed Acupuncturist
Fax: 847-382-8422

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Barrington Acupuncture Clinic for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Barrington Acupuncture Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Barrington Acupuncture Clinic is not required to agree to the restrictions that I may request. However, if Barrington Acupuncture Clinic agrees to a restriction that I request, the restriction is binding upon Barrington Acupuncture Clinic.

I have the right to revoke this consent, in writing, at any time except to the extent that Barrington Acupuncture Clinic has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Barrington Acupuncture Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Barrington Acupuncture Clinic. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Barrington Acupuncture Clinic with respect to my identifiable health information.

Barrington Acupuncture Clinic reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

Barrington Acupuncture Clinic
Acupuncturist: L. Barrie Hinman

I hereby request and consent to the performance of acupuncture treatments and other procedures delivered in person or by telephone, email, text or video within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named above, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist above uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____ Are you pregnant? _____

Patient's Signature _____ Date _____

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____

Print Name of Patient Representative _____

Signature of Patient Representative _____ Date _____

Relationship or Authority of Patient _____

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Insurance Authorization & Assignment of Benefits

Release of Medical Information Authorization. I authorize Barrington Acupuncture Clinic to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization or payment for services.

Assignment of Benefits. I request that payment of authorized insurance benefits be made on my behalf to Barrington Acupuncture Clinic for any services provided to me by Barrington Acupuncture Clinic.

I understand and agree that a copy of this authorization and assignment of benefits, when signed by me, my authorized representative or a legal guardian may be sent to my insurance company or health care provider if requested.

I understand and agree to the following:

- I am financially responsible to Barrington Acupuncture Clinic for any charges not covered by my health care benefits and for any portion of any charges denied by my health care benefits, in accordance with applicable law.
- I am responsible to notify Barrington Acupuncture Clinic of any changes to my address or health care coverage. Failure to do so may result in delays in processing or inability to process claims for me.
- I understand that Barrington Acupuncture Clinic will endeavor to obtain authorization and payment from my insurance provider for services rendered. However there is no guarantee that Barrington Acupuncture Clinic will receive authorization or payment from my insurance provider.
- Since I am assigning to Barrington Acupuncture Clinic my right to receive payment directly from my insurance company, if I receive payment directly I agree to reimburse Barrington Acupuncture Clinic upon request for the cost of services rendered and I understand that Barrington Acupuncture Clinic has the right to recover its cost of collection from me if I fail to reimburse Barrington Acupuncture Clinic properly and timely in this circumstance.

By signing below, I certify that I understand and agree to the terms of this authorization and assignment of benefits.

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship