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.

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

Gender: ☐ Male ☐ Female ☐ Trans Man ☐ Trans Woman ☐ Nonbinary/Other
Pronouns _____
Gender at birth _____ Gender on insurance _____

Age _____ Date of Birth _____
Employer _____ Occupation_____

Relationship Status:
☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Name of Spouse/Partner _____

Emergency Contact:
Name _____ Relationship _____
Mobile Phone _____

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

Barrington Acupuncture Clinic **Health History**

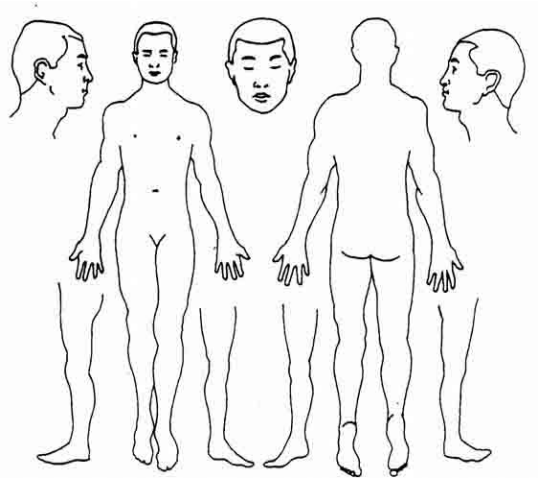
Patient Name Date

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