DR. JULES BOGDANSKI, DAOM L.Ac.

230 Grand Avenue, Suite #301C, Oakland, CA 94610 · 510-387-0852

*The information provided on these forms is confidential.

Date _____

Name _____ Date of Birth ____/____/_____Age _____

Address _____ Gender _____

City/ State/ Zip _____

Home phone _____ Cell/other phone_____

Email_____

Emergency Contact _____ Phone _____

Occupation _____ Hours per week _____

Do you have a Primary Care Physician, if so whom?_____

☐ Yes ☐ No - May we contact you via email regarding office updates, promotions, or other news?

Please indicate your top 3 health concerns for which you are seeking treatment.

Please include date of onset, duration, and level of severity.

1. _____

2. _____

3. _____

What other treatments have you received for any of these conditions? _____

_____

List any drugs, supplements, or herbs you are taking – please state *how often*, *how long* and *for what conditions*:

_____

_____

_____

Are you taking blood thinners? ☐NO ☐YES Are you pregnant? ☐NO ☐YES, how far along? _____

I am allergic to: _____

_____

Circle conditions you have now or have had in the past:

Anemia	Stroke	Insomnia
Arthritis	Heart Disease	Seasonal Allergies
Cancer	High Blood Pressure	Migraines
Bleeding Disorder	High Cholesterol	Frequent Cold/Flu
Pacemaker	Diabetes I or II	Hepatitis B or C
Anxiety	Thyroid Disorder	Seizures
Depression	Autoimmune Disorder	HIV+/AIDS

Please list any surgeries or serious injuries, along with dates of occurrence:

_____

_____

_____

Have any immediate family members passed away from serious health conditions? If so, please state your relationship, the condition, and age of deceased:_____

_____

_____

Physical Activity:

How many days per week do you exercise?_____ What types of exercise do you do?_____

_____

Describe your energy level during the day _____

Sleep:

Average hours of sleep _____ Bedtime most nights?_____ Waking time most mornings? _____

Check any that apply:

□ Difficulty falling asleep □ Difficulty staying asleep □ Waking up at ____ AM/PM □ Dream-disturbed sleep

How do you generally feel when you wake up?_____

Digestion:

Appetite: □ Good □ Poor □ No interest in food at all □ Strong cravings for _____

Typical diet:_____

_____

_____

Special diet/Food allergies:_____

_____

Do you experience any of the following? □ gas □ bloating □ acid regurgitation □ ulcers □ nausea

Bowel movements: _____ x/day ____ x/week □ formed □ hard □ constipation □ loose □ diarrhea

Urination: _____ x/day _____ x/night □ strong odor present □ color _____

Please describe your use (if at all) of alcohol, caffeine, cigarettes, and recreational drugs: _____

_____

_____

Treatment Goals

What do you hope to achieve through working together?

_____

_____

_____

_____

Chinese Medicine Constitutional Intake **(required)**

Please mark the boxes of the symptoms you are currently experiencing - this detailed information will help me establish the types of excesses and/or deficiencies you are experiencing, and determine which meridian systems are in need of balancing. Feel free to add comments next to any relevant symptoms.

Liver/Gallbladder
☐ depression/stress
☐ irritability/anger
☐ PMS
☐ headaches
☐ red, dry or itchy eyes
☐ blurred vision
☐ dizziness
☐ 'lump in throat' feeling
☐ teeth clenching
☐ muscle cramping
☐ tendonitis
☐ neck/shoulder tightness
☐ pain below ribcage
☐ seizures/tremors
☐ poor circulation
☐ brittle nails
☐ gallstones
☐ bitter taste in mouth
☐ frequently indecisive

Heart/Small Intestine
☐ heart palpitations
☐ 'tight chest' feeling
☐ chest pain
☐ easily startled
☐ anxiety
☐ restlessness
☐ high blood pressure
☐ low blood pressure
☐ insomnia
☐ vivid dreams/nightmares
☐ dark urine
☐ flushed complexion
☐ mouth ulcers

Spleen/Stomach
☐ hard to get up AM
☐ foggy thinking
☐ pensive/worrisome
☐ body heaviness
☐ energy level? #_____
(1-10, low to high)
☐ sleepy after meals
☐ edema
☐ gain weight easily
☐ thirsty
☐ not thirsty
☐ bruise easily
☐ hemorrhoids
☐ excessive appetite
☐ low appetite
☐ lack of taste
☐ food allergies
☐ nausea/vomiting
☐ heartburn
☐ indigestion/gas/bloating
☐ abdominal pain
☐ chronic loose stools

Lung/Large Intestine
☐ grief/sadness
☐ dermatitis/rash
☐ eczema/psoriasis
☐ seasonal allergies
☐ asthma
☐ cold/flu often
☐ chronic sinus infections
☐ nasal congestion
☐ nasal discharge
☐yellow ☐white ☐clear
☐ bronchitis/pneumonia
☐ chest congestion
☐ cough with phlegm
☐yellow ☐white ☐clear
☐ chronic cough
☐ bloody cough
☐ dry cough
☐ dry throat/nose/eyes
☐ itchy or sore throat
☐ shortness of breath
☐ sweat easily/excessively
☐ diarrhea
☐ constipation
☐ bloody stools
☐ irritable bowel syndrome
☐ colitis

Kidney/Urinary Bladder
☐ urinary tract infections
☐ frequent urination
☐ night-time urination
☐ incontinence
☐ lower back pain
☐ sore/achy knees
☐ low libido
☐ excessive libido
☐ impotence
☐ premature ejaculation
☐ nightsweats
☐ hot flashes
☐ osteoporosis
☐ dental caries
☐ dark circles under eyes
☐ hypo-thyroid
☐ hyper-thyroid
☐ cold hands/feet
☐ poor memory
☐ grey hair/hair loss
☐ hearing issues/tinnitus

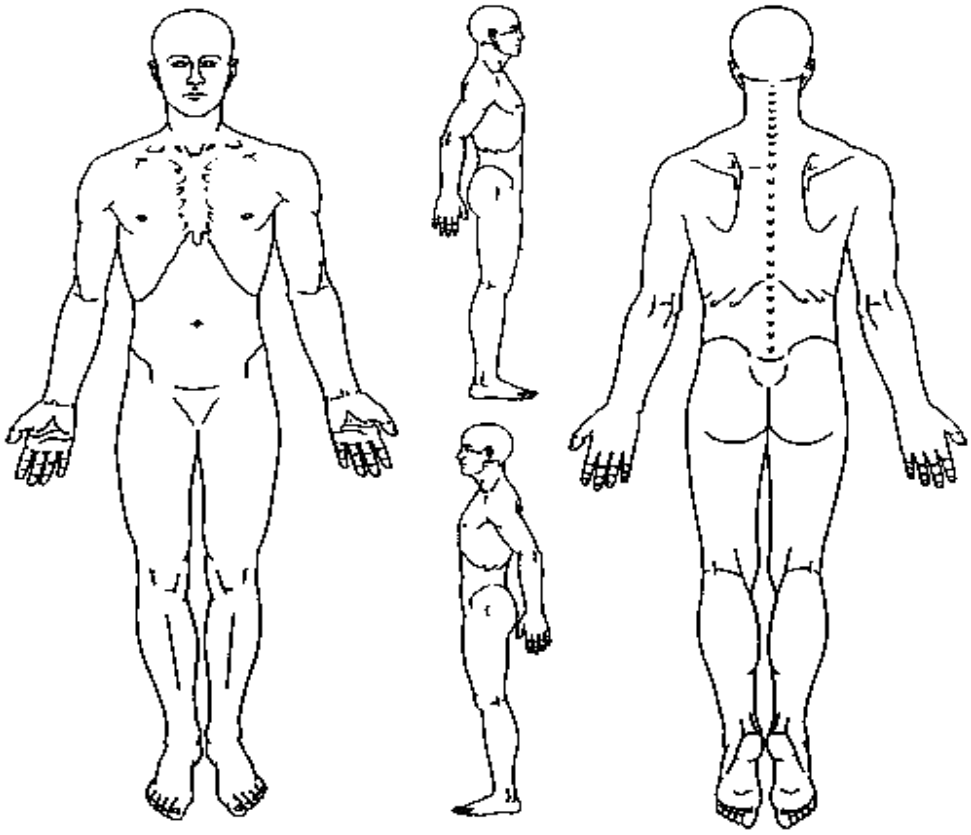
General Questions:
☐ I most often feel hot.
☐ I most often feel cold.
☐ I prefer hot food/drinks.
☐ I prefer warm food/drinks.
☐ I prefer cold food/drinks.
☐ I am prone to light-headedness/dizzy spells.
☐ I often see 'floaters'.
☐ I have been diagnosed with anemia.
☐ I have excessively dry skin.
☐ My fingers/toes sometimes feel numb.
☐ I frequently experience sharp pains or stabbing headaches.
☐ I feel tired most of the time.
☐ I am vegetarian.

Office Use:
Tongue Diagnosis:

Pulse Diagnosis:

Physical Pain Assessment **(optional - please fill out if it is relevant to your chief concerns)**

Pain Diagram: Please mark all areas of pain or discomfort on the diagram below and number the intensity of your pain on a scale of 1-10 (low to high) – please feel free to add further comments.



Check any that apply:
I would describe my physical pain/discomfort as:
□ General 'aches and pains' that come with age or a less active lifestyle
□ Overuse/repetitive stress injuries
□ Arthritis or other inflammatory pain
□ Associated with an autoimmune condition (such as rheumatoid arthritis, fibromyalgia, or lupus)
□ Chronic pain (has lasted more than three months)
□ Acute pain from a recent injury (*please answer last question)

Quality of pain/discomfort:
□ Deep □ Dull □ Aching □ Sharp □ Burning □ Numb/Tingling □ Shooting □ Muscle cramping

Pain is worse in the □ AM □ PM
With HEAT, pain is □ BETTER □ WORSE
With COLD, pain is □ BETTER □ WORSE
With MOVEMENT, pain is □ BETTER □ WORSE
With PRESSURE, pain is □ BETTER □ WORSE

*Is your current pain the result of a past or recent injury? Please describe it in detail:

_____

_____

_____

Women's Health

*The information provided on these forms is confidential.

Please check any that apply:

□ Breast cancer □ Cervical cancer □ Hysterectomy □ Uterine fibroids □ Frequent yeast infections
□ Endometriosis □PCOS □ Excessively low libido
□ Use of hormonal birth control *(what type?, and for how long?)*:_____

Are you pregnant? ☐NO ☐YES If so, how far along are you? _____

Additional comments:_____

_____

Are you past menopause? ☐NO ☐YES If so, since what age?_____

Are you currently experiencing any troubling menopausal symptoms? _____

_____

Menstrual History:

At what age did you begin menstruating? _____

Date of your last period _____Days of bleeding _____ Days between menses _____
□ Irregular periods
□ No periods, how long?_____

Quality of menses: □ dark □ bright □ red □ pink □ watery □ brown □ clots □ excessive flow □ scanty flow
□ other: _____

Do you experience any the following during your period?

□ cramping, *please circle* all that apply: *before, during, after* period
□ acne □ breast tenderness □ low back pain □ irritability □ anxiety □ sadness □ constipation □ diarrhea
□ other PMS symptoms, please describe: _____

Reproductive History:

□ Infertility – how long have you been actively trying to conceive? _____

Additional comments: _____

_____

□ Spontaneous Miscarriage – please list year and how far along you were:

_____

□ Pregnancy Termination (medical or surgical) – please list year of each procedure:

_____

□ Births - please list year of each birth: _____

_____

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INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for) by Jules Bogdanski, who is a Licensed Acupuncturist in the state of California, and or other licensed acupuncturists who now or in the future treat me while employed by, working for, associated with, or serving as back-up for Jules Bogdanski, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 clinic uses sterile disposable needles and maintains a clean and safe environment. I have had the opportunity to discuss with Jules Bogdanski, L.Ac. the nature and purpose of acupuncture treatments and other procedures.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) recommended in the practice of Chinese medicine are traditionally considered safe. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform Jules Bogdanski, L.Ac.

Jules Bogdanski, L.Ac. does not provide Western medical care, and asks that you see your medical doctor for routine check-ups. If you are pregnant, have a pacemaker, high blood pressure, have a bleeding disorder, local infection, or if you have been prescribed anticoagulant medications such as Coumadin, she can still treat you but needs to be informed of your condition. I have informed Jules Bogdanski, L.Ac. of such conditions above and voluntarily consent to the above procedures.

I do not expect Jules Bogdanski, L.Ac. to be able to anticipate and explain all risks and complications. I wish to rely on her to exercise judgment during the course of the procedure, which she feels at the time, based upon the facts then known, is in my best interests.

I understand 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.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content.

By signing below, 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. I agree to the policies and informed consent as set forth in the entirety of this document.

Patient's Name (PLEASE PRINT) _____

Signature: _____ Date: _____

Name of Legal Guardian (PLEASE PRINT) _____

Signature: _____ Date: _____

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HIPAA Notice of Privacy Policies

We are required by law to:
- Maintain the privacy of protected health information.
- Give you the notice of legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information:
- We will use and disclose health information only with your written permission
- You may revoke such permissions at any time by writing to our practice's privacy officer.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and medical treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Patient's Name (PLEASE PRINT) _____

Signature: _____ Date: _____

Name of Legal Guardian (PLEASE PRINT) _____

Signature: _____ Date: _____

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Office Policies and Financial Agreement

The office has a **24-hour cancellation policy** – if you do not cancel your appointment with a minimum of 24-hours notice, **you will be responsible for the full fee of your scheduled service**. Please be on time for your appointments – a specific amount of time has been set aside for your treatment. **Arriving late means that your treatment will be adjusted to fit into the scheduled time allotted.**

Payment in full of time-of-service fees (discounted rates for non-insured), deductibles, co-pays, and co-insurance is always due at each appointment. I accept cash, checks, and credit cards (Visa or Mastercard). There is a $25 fee for any returned checks. Information about insurance billing is detailed below.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture but please be informed that insurance policies do vary greatly in terms of deductibles, co-pays, and percentage of coverage. This office makes no representation that your policy does provide for acupuncture treatments.

I can assist you in the verification of your insurance coverage, but this service is offered as a COURTESY. Obtaining accurate information regarding your particular insurance plan's coverage is ultimately your responsibility. I am also happy to assist you in understanding your insurance benefits based upon the information provided by your insurance company, but I take no responsibility for the accuracy of the information provided.

Upon verification of your insurance benefits, we can discuss your billing options. I am an in-network provider with Blue Shield of California, Cigna PPO, and Cigna HMO plans; and an out-of-network service provider with all other insurance companies.

In most situations, it will be possible for my office to bill your insurance directly – you will responsible for paying any co-pay/co-insurance amounts at the time of service. If you have not met your deductible, you will be responsible for paying out-of-pocket until you meet your deductible, and my office can submit claims towards your deductible.

For in-network claims, payment in full for any modalities or diagnoses that your insurance does not cover is your responsibility as determined by your insurance carrier.

For out-of-network claims, payment in full for insurance denials for any reason is your responsibility. If I have not received reimbursement from your insurance within 90-days of the treatment date, you will be responsible for any unpaid balances within 14 days of my notice to you.

In some situations, it will not be possible for my office to bill your insurance directly. In such cases, payment in full will be due at each office visit; however, I can provide you with a Superbill that you may submit to your insurance company for reimbursement. Any reimbursements that you may be entitled to are determined by the rules of your particular insurance plan, and are a contract between you and your insurance provider. Your insurance company will reimburse you directly for your Superbill submission. A Superbill is not a guarantee for reimbursement, and I reserve the right to not be involved in any claim disputes.

Assignment of Benefits
I hereby authorize insurance benefits to be assigned to the above listed health care provider, for health care services provided to me.

_____ Please initial here.

If I am billing your insurance directly, and if for any reason your insurance company sends payments directly to you for services performed in this office, you agree to inform the office of any payments received and pay forward these amounts to the office immediately upon receipt. If the office has been informed that you received payment for services performed in this office, and you have not notified the office or paid forward the amounts paid by your insurance to the office within 30 days of the payment's issue date, lack of communication on your part will result in the claims being turned over to collections.

Release of Information
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

HIPAA Compliant Email Communication
Your privacy is important to us – email communication between our office and you may include your protected health information – please be aware that our office does not use a specialized HIPAA compliant email service. Your signature below acknowledges this fact, and consents to our office communicating with you via email using a standard email service (e.g., Gmail, Yahoo, Webmail). You may revoke this consent at any time, in writing.

I have read, or have had read to me, the cancellation policy and financial agreement of Jules Bogdanski, L.Ac. By signing below, I agree to all policies as set forth in the entirety of this document.

Patient's Name (PLEASE PRINT) _____

Signature: _____ Date: _____

Name of Legal Guardian (PLEASE PRINT) _____

Signature: _____ Date: _____