heather hyun, DO

OSTEOPATHIC Patient Intake Form

As an integrative medicine physician, my goal is to help you achieve optimal health in all areas of your life utilizing osteopathic manipulative medicine, acupuncture, herbal remedies, lifestyle and nutritional counseling. Please take your time and answer as best as you can. The more you tell me about yourself, the better I will be able to treat you.

– heather hyun, DO

Name:_____ **Date:**_____

Date of Birth:_____ **Age:**_____ **Sex:**_____**Male**_____**Female**

Address_____

City_____ **State** _____ **Zip**_____ **SS#**_____

Phone_____**Cell** _____ **Email** _____

Occupation_____ **Work Phone**_____

Referred by:_____

Emergency Contact: _____**Relation:**_____**Contact #:**_____

Current Physician:_____**Specialty:**_____ **Phone:**_____

Significant Health History (hospitalizations, illnesses, surgeries)**:** □ None

_____

_____

Reason for your visit/Health Concerns: (in order of importance):

1._____

2._____

3._____

Please elaborate above concerns:

1. How long as this been bothering you?_____
   On a scale of 1-10 (0=no pain, 10=severe pain) at worst_____ Current level _____
2. How long as this been bothering you?_____
   On a scale of 1-10 (0=no pain, 10=severe pain) at worst_____ Current level _____
3. How long as this been bothering you?_____
   On a scale of 1-10 (0=no pain, 10=severe pain) at worst_____ Current level _____

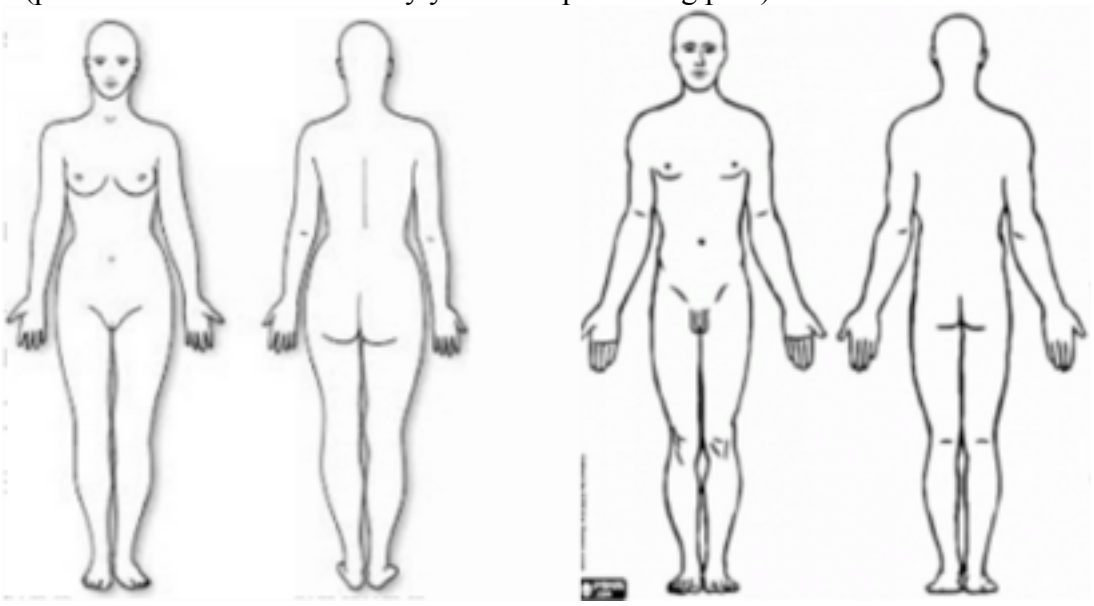
Prior Studies Completed (MRI/CT-scan/X-Ray): □ None

_____

Prior Therapies (were they helpful?): □ None

_____

Pain (please circle areas of the body you are experiencing pain)



Please describe your pain: (please check all that apply)

□ stiff	□ tingling	□ stabbing	□ pressure	□ constant
□ burning	□ tense	□ radiating	□ throbbing	□ other
□ shooting	□ sharp	□ dull	□ localized	
□ achy	□ numb	□ tightness	□ intermittent	

What makes it feel better? (please check all that apply)

□ cold	□ rest	□ massage	□ lying down	□ medication
□ warmth	□ activity	□ quiet	□ standing	□ nothing

What makes it feel worse? (please check all that apply)

□ cold	□ rest	□ massage	□ lying down	□ medication
□ warmth	□ activity	□ quiet	□ standing	□ nothing

What time of day do you feel the pain the most?

□ morning	□ daytime	□ evening	□ night	□ all the time

Significant Trauma History (Fall, Strains, Fractures, MVA, etc.)**:** □ None

_____

_____

Allergies (medication, food, environmental)**:** □ No Known Drug Allergy

_____

Current Medications/Supplements (name, dosage, frequency—use back if necessary)**:** □ None

_____

_____

CHECKLIST:
Review of Systems

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping/ Insomnia

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

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Please Check	Self	Relative	Relation	Please Check	Self	Relative	Relation
Alcoholism	□	□	_____	Hepatitis	□	□	_____
Anemia	□	□	_____	High Cholesterol	□	□	_____
Arthritis	□	□	_____	Hypertension	□	□	_____
Asthma	□	□	_____	Immune Disorder	□	□	_____
Autoimmune d/o	□	□	_____	Learning disorder	□	□	_____
Birth Defect	□	□	_____	Lung disorder	□	□	_____
Bleeding Problem	□	□	_____	Mental disorder	□	□	_____
Colitis	□	□	_____	Scoliosis	□	□	_____
Dementia	□	□	_____	Stroke	□	□	_____
Food Allergy	□	□	_____	Substance abuse	□	□	_____
Genetic disorder	□	□	_____	Thyroid disorder	□	□	_____
Hay Fever	□	□	_____	Early death (>50)	□	□	_____
Hearing problems	□	□	_____	Other	□	□	_____
Hemorrhoids	□	□	_____	Other	□	□	_____

Typical Diet: □ No known dietary allergies

Breakfast_____

Lunch_____

Dinner_____

Snack_____

Social History

Single | Married | Domestic Partner | Divorced | Widowed

Who do you live with? _____

Is your home carpeted/hardwood floors_____

Pets_____

Occupation_____

Last STD check_____

Check if you do any of the following in the past or now:

□ Alcohol Age started____#oz/day____Age quit____

□ Caffeine Age started____#oz/day____Age quit____

□ CigarettesAge started____packs/day____Age quit__

□ MarijuanaAge started____amt/day____Age quit___

□ Illicit drugsAge started____amt/day____Age quit__

□ Exercise Type_____mins/day___days/week__

Gynecologic History (Women Only)

Age of first menses_____ Cycle length_____

Pregnancies #_____Births #_____ Miscarriages#____

Date of last pap _____ Result of last pap _____

Last mammogram/Result_____

□ Changes in Sex Drive

□ Vaginal Dryness

□ Urinary incontinence

□ Birth Control_____

□ Hormone Therapy_____

Urologic History (Men Only)

Last prostate exam/Result_____

Last PSA Level____

□ Erectile Dysfunction

□ Changes in urinary flow

□ Impotency

□ Changes in Sex Drive`

Patient Signature:_____**Date:**_____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of osteopathic manipulation and/or acupuncture treatments and other procedures within the scope of practice of Family Medicine on me (or on the patient named below, for whom I am legally responsible for) by Heather Hyun, who is a Family Medicine physician in the state of California, and or other licensed physicians who now or in the future treat me while employed by, working or associated with or serving as back-up for Heather Hyun, 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, osteopathic manipulation, 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 osteopathic manipulative medicine is a relatively safe method of treatment. A variety of techniques, including soft-tissue, musculoskeletal, and cranial techniques are used in order to stimulate the body's inherent healing capacity. The most common side effects include but are not limited to: fatigue, shifting body aches, aggravation of pre-existing symptoms, evocation of other symptoms, pain and bruising from performed techniques. With regards to high velocity low amplitude and direct therapies, some patients have reported worse pain after treatment, numbness or weakness, fractures (broken bones), spread of pre-existing conditions such as undetected cancer, breaking loose of blood clots, stroke and tears in blood vessels. The above side effects are extremely rare and I have any conditions that would make these therapies contraindicated, I will inform the physician prior to treatment.

I have also been informed that acupuncture is generally a safe method of treatment, but that there may be 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 been informed the side effects of acupuncture facial rejuvenation include bruising on the face, redness on the face, and/or bleeding on the face. I understand the contradictions of facial acupuncture include high blood pressure, dizziness, diabetes, pregnancy, facial sunburn, asthma, those who have had recent botox or restalyn injection, microdermabrasion, chemical peel, acute herpes outbreak on the face, have a cold/flu, pituitary tumors or Cushing's disease, hemophiliacs, those on blood thinners, taking aspirin, vitamin E, and/or fish oil, those prone to migraines, epilepsy or seizers, lymphoderma in the face, cancer, AIDS, or coronary diseases. If I have any of these above conditions I will inform the physician before starting treatment.

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, animal, and mineral 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 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 notify a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient 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, the above consent to treatment, have been told about the risks and benefits of osteopathic manipulation, 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 conditions and for any future conditions for which I seek treatment.

Patient Signature _____ Date _____

FINANCIAL AGREEMENT, INSURANCE POLICY, & CANCELLATION POLICY

Financial Agreement

Payment is due at the time of service. For your convenience we accept cash, check, and all major credit cards.

Insurance Policy

When using insurance you are responsible for the full payment of service at the time of service. The physician will provide you with a receipt of payment (super bill) that you can submit to your insurance for reimbursement. This is not a guarantee that they will reimburse you. Please check with you insurance provider before your first appointment to see if you have coverage.

Cancellation Policy

We have a 24 hour cancellation policy. We ask that if you would like to cancel that you give us at least 24 hours notification before the scheduled appointment. If a 24 hour notice is not given, you may be charged for the missed appointment.

I have read and understand the the financial agreement, insurance, and cancellation policy. I understand that all services that I have are my financial responsibility and due at the time of service.

Patient Signature _____ Date _____

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 of 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 surgical 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 Signature _____ Date _____