

Longmont Institute of Integrative Medicine
1304 North Vivian Street Longmont, Colorado 80501

New Patient Documents

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Natural Medicine and Acupuncture



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www.liim.org
www.nycacupuncture.com

Longmont Institute of Integrative Medicine

1304 North Vivian Street Longmont, Colorado 80501

Patient Profile

Please Print

Name (Last, First):

Street Address:

City, State, Zip:

Email Address:

This information will permit your acupuncturist to communicate with you by email.
You will also receive our informative quarterly newsletter.

Home Phone :

Work Phone:

Cell Phone:

Current age: _____

Birth date:

Place of Birth (City, State, Country):

Time (include AM or PM):

Social Security Number:

Emergency Contact (Name and Phone Number):

Please tell us how you heard about Acupuncture here so we can acknowledge them:

_____ Google

_____ Other Internet Resource (specify)

_____ Referred by an Organization (specify)

_____ Referred by a Person

Referrer's Name and (if known), Address: _____

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This questionnaire is an essential component for successful diagnosis and treatment. Please answer all questions carefully.

Name _____ Date _____ Age _____ Gender _____

List your five main complaints below, in order of importance:

Number of Years

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

Check if you have taken frequent:

- ___ Antibiotics
- ___ Antihistamines
- ___ Sedatives
- ___ Hormones
- ___ Birth Control Pills
- ___ Bronchial Inhalers
- ___ Cortisone
- ___ Nose Drops or Sprays
- ___ Skin Ointments
- ___ Vitamins
- ___ Antidepressants

List any drugs, vitamins, herbs or homeopathics you are currently taking: (use back of sheet if necessary)

Check if your mother, father, brothers or sisters have had any of the following:

	Diabetes	Cardio-Vascular Disease	Allergies	Asthma	Cancer	Rheumatic Disease
Father	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____	_____	_____

Have you ever been hospitalized for a:

- Medical problem no _____ yes _____
- Surgical procedure no _____ yes _____
- Psychiatric reason no _____ yes _____

If yes, list reasons for hospitalization, treatment & date of stay: (use back of sheet if necessary)

Name _____

Body Systems Review (please check all that apply):

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4	low appetite	0 1 2 3 4	ravenous appetite
0 1 2 3 4	loose stools	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	mouth sores	0 1 2 3 4	fatigue after eating
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	bruise easily
0 1 2 3 4	gums (bleeding/swollen)	0 1 2 3 4	thirst
0 1 2 3 4	organ prolapsed (diagnosed)	0 1 2 3 4	belching or vomiting

0 1 2 3 4	spontaneous sweat	0 1 2 3 4	fatigue
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	shortness of breath
0 1 2 3 4	general weakness	0 1 2 3 4	cough
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	nasal discharge
0 1 2 3 4	feel worse after exercise	0 1 2 3 4	sinus congestion

0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feel cold
0 1 2 3 4	low back pain	0 1 2 3 4	edema
0 1 2 3 4	frequent urination	0 1 2 3 4	urinary incontinence
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	ear problems

yes	no	impaired memory		yes	no	hair loss
yes	no	infertility	high	normal	low	libido

0 1 2 3 4	muscle spasms/twitches	0 1 2 3 4	irritable
0 1 2 3 4	feel better after exercise	0 1 2 3 4	numb extremities
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	red eyes

0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	headaches
0 1 2 3 4	anxiety	0 1 2 3 4	restlessness
0 1 2 3 4	chest pain traveling to shoulder		

high	normal	low	overall body temperature
high	normal	low	overall energy level

0 1 2 3 4	see floaters in eyes	0 1 2 3 4	foggy thinking
0 1 2 3 4	heat in palms or soles	0 1 2 3 4	dizzy upon standing
0 1 2 3 4	feeling of heaviness	0 1 2 3 4	nausea
0 1 2 3 4	afternoon fever	0 1 2 3 4	night sweats
0 1 2 3 4	enlarged lymph nodes	0 1 2 3 4	cloudy urine
0 1 2 3 4	face flushes		

Name _____

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty
Profuse Dribbling Greater than 1x a night

Bowel Movements: Frequency: _____ When? _____ Feels complete? Yes No

Please circle any of the following symptoms you are currently experiencing:

Stools: Undigested food Blood Mucus
Consistency: Well-formed Hard Loose Alternates

Men Only:

Have you been diagnosed with prostate problems? Yes No
Do you experience premature ejaculation? Yes No
Do you have problems with Impotence? Yes No
Have you been diagnosed with Infertility? Yes No

Diseases/ Disorders:

Women Only:

Fertility History

Are you pregnant now? Yes No
Have you been pregnant in the past? Yes No
Number of live births _____ Miscarriage _____ Abortion _____
Infertility work-up (if pertinent)

Doctor or clinic _____ When? _____

What tests (HSG? Blood work, etc.) and findings _____

Current medications (Clomid, Lupron etc.) _____

Name _____

Menstrual History

At what age did you get your first period: _____ Date of last menstrual cycle? _____

Are you currently on the Pill? Yes No

Number of days from the start of one period to the start of the next: _____

Are your menstrual cycles spaced regularly? Yes No

Average number of days of flow: _____

Maximum Flow Day: Use of tampon or pad is _____ Light = use one for longer than 4 hours

Normal = change every 3 hours Heavy = change every hour or less Heavy with clots

Maximum Flow Day: Color is _____ Pink _____ Red _____ Dark _____ Bright Red Brown

Does your period cause you pain or cramping? No Yes: Before During After Period

Do you get nausea or vomiting with your period? No Yes: Before During After Period

Do you experience any of the following before your period each month?

Water retention Breast tenderness or swelling Mental depression Irritability

Food cravings Migraines Other _____

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you have any vaginal discharge between periods? Yes No

Gynecological Problems

Date of last pap smear? _____ Have you ever had an abnormal pap smear? Yes No

Any gynecological surgery? No Yes: _____

Have you ever had a venereal disease or PID? No Yes: _____

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with ovarian cyst or PCOS? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed pelvic adhesions abnormalities? Yes No

Menopause

Have you experienced menopause? Yes No When? _____

Are you on HRT or herbal aids now? Yes No What? _____

If you are experiencing menopausal symptoms, please describe: _____

Name _____

Lifestyle/habits

List what you typically eat for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you skip meals? Breakfast _____ Lunch _____ Dinner _____

Do you drink caffeinated beverages?

No _____

Yes _____ Coffee _____ (cups/day) Tea _____ Soda _____

Do you drink alcohol? No _____

Yes _____ What? _____ How often? _____

Do you eat fish _____ chicken _____ meat _____ eggs _____ dairy products _____

Do you eat fruit? _____

Which? _____

How often? _____

Do you eat vegetables? _____

Which? _____

How often? _____

How much water do you drink? _____

Do you eat sweets (cake candy, ice cream, cookies, etc.)? No _____

Yes _____ What? _____ How often? _____

Do you have or have you had an eating disorder? No _____

Yes _____ Anorexia _____ Bulimia _____

Do you exercise? No _____ Yes _____

How often? _____ What type of exercise? _____

How many hours do you typically sleep? _____

What time do you typically go to bed? _____ Arise? _____

Do you have trouble falling asleep? _____

staying asleep? _____

Do you have nightmares? _____

Do you use sleep medication? No _____

Yes _____ What kind _____

How often _____

Name _____

Do you _____ smoke marijuana?
_____ use cocaine?
_____ heroin?
_____ other drugs? What kind?

Do you smoke cigarettes? No _____
Yes _____ How much? _____ For how long? _____
Have you ever tried to quit before? _____
What means? _____
Longest time cigarette free _____

What kind of work do you do?

Is the work stressful for you? _____
Is there stress in other areas of your life (home, family, relationships)?

Medical/Psych Care

Who is your personal physician?

Name:

Address:

Phone:

Do you regularly see any specialists? (Gyn, GI, ENT, GU, etc.)

Name:

Name:

Address:

Address:

Phone:

Phone:

Do you get chiropractic, osteopathic, physical therapy or massage treatment? If so, which one(s)?

Are you now or have you been in

_____ psychotherapy?

_____ group therapy?

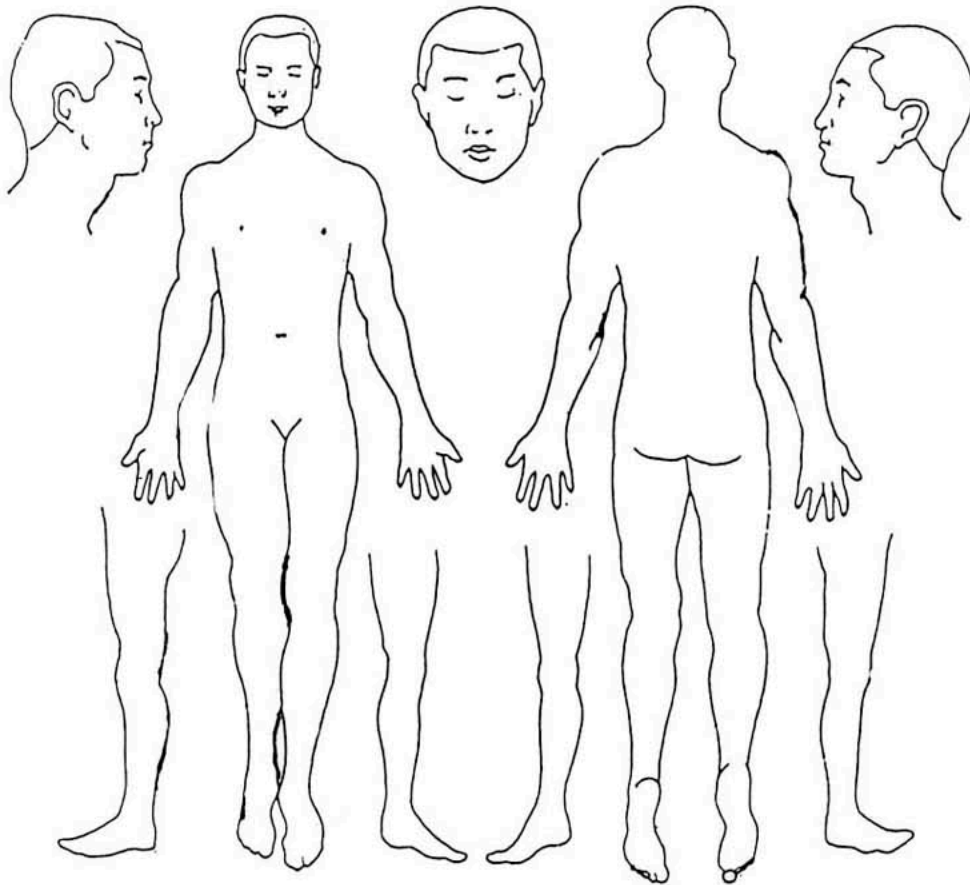
_____ 12 step program?

Do you regularly meditate or participate in spiritual practice?

Have you ever had acupuncture before? No _____
Yes _____ When and with whom?

Do you have experience with western or Chinese herbal treatment?

Please shade area of pain



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Insurance Billing Information

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address			Home Phone No. ()
Is this person a patient here?	Yes	No			
Employer	Employer Address			Employer Phone No. ()	
Is this patient covered by insurance?	Yes	No			
Please indicate Primary insurance					
Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	
Relationship to Subscriber	Self	Spouse	Child	other	
Name of Secondary Insurance (if applicable)	Subscriber's Name		Group #	Policy #	
Patient's Relationship to Subscriber	Self	Spouse	Child	other	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not living at same address)	Relationship to Patient	Home Phone No.	Work Phone
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance or charges denied by the insurance company. I also authorize Craig Bereznoff, D.O. or insurance company to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE

Date

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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. If you have any questions about this notice, please contact:

Craig M Bereznoff D.O. at 303-776-3202.

This notice describes the privacy practices at our office.

We are required by law to:

- * Maintain the privacy of protected health information
- * Give you this notice of our legal duties and privacy practices regarding your health information
- * Follow the terms of the notice currently in effect.

How we may use and disclose your health information:

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Craig M. Bereznoff D.O.

Treatment:

We may use and disclose your health information for your treatment and to provide you with treatment- related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:

We may use and disclose your health information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations:

We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health- Related Benefits and Services:

We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care:

When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research:

We may use and disclose your health information for research. For example, a research

project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates: We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans: If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation:

We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks:

We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes:

If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement:

We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a

crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors:

We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities:

We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody:

If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to Craig M Bereznoff D.O.

Right to Amend. You have the right to request an amendment to your records by written request to Craig M Bereznoff D.O.

Right to an Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Craig M Bereznoff D.O.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Craig M Bereznoff D.O.
We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Craig M Bereznoff D.O. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Craig M Bereznoff D.O.

Craig M. Bereznoff D.O.
1304 North Vivian Street
Longmont, CO, 80501
303-776-3202

I have read and understand the Notice of Privacy.

Name: _____

Date: _____