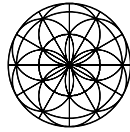


Dr. Jay Bulloch
Integrative Healthcare

Patient Confidential Information

Patient Name ______________________________ Date ____________

Address ______________________________

City ____________________ State __________ Zip Code __________

Home Phone ____________________ Business/Cell Phone ____________________

Email Address ______________________________

Date of Birth _____ / _____ / _____ Sex (circle) **MALE** **FEMALE**

Social Security # ____________________ Place of Birth ____________________

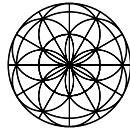
Emergency Contact ____________________ Relationship ____________________

Emergency Contact Phone ______________________________

Referred By ______________________________

Occupation/Profession ______________________________

Employer ______________________________



Dr. Jay Bulloch
Integrative Healthcare

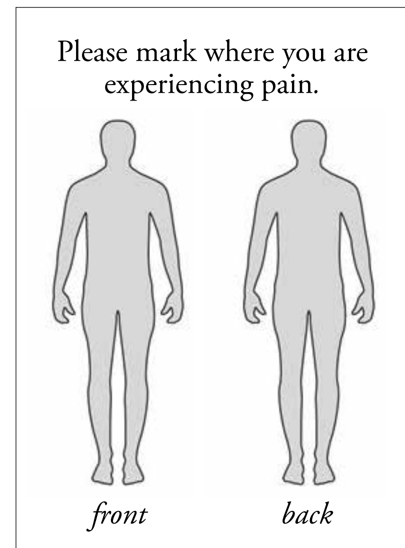
Patient Confidential Information

All information is kept strictly confidential in compliance with HIPPA

Please complete all of the following as accurately as possible, even if you think that it does not pertain to your chief complaint. Holistic medicine looks at the entire body, and things that you may not think are important could, in fact, be related to or the cause of your current condition. Thank you.

Patient Name ______________________________ Date ______________

Please mark where you are experiencing pain.



PRESENT ILLNESS:
What is your chief complain/reason for your visit?

When did this condition begin?

Have you received a diagnosis from an M.D. for this or any other current condition? *(list other conditions)*

What treatment have you received for this condition already?

PAST MEDICAL HISTORY:
List all surgeries that you have had and the approximate date.

List any serious injuries, illnesses, accidents, known problems with your birth, or traumatic events (including from your childhood) with the approximate date.

List all known allergies (food, medication, or other).

MEDICATIONS:

Prescription drugs you are currently taking and the conditions you are taking them for:

Over the counter medications or supplements you are taking and the reason you are taking them:

FAMILY HISTORY:

Is there a family history of any of the following? (Please note who next to any items)

_____ Allergies
_____ Arthritis
_____ Asthma or respiratory disease
_____ Autoimmune disease
_____ Bleeding disorders
_____ Cancer
_____ Diabetes
_____ Epilepsy or other seizure disorders
_____ Heart Disease
_____ High blood pressure
_____ Kidney disorders
_____ Mental illness
_____ Stroke

RECREATIONAL SUBSTANCE USE:

History of smoking? _____ How many years? _____ How many per day? _____
History of smokeless tobacco use? _____ Recreational drug use? Past _____ Present _____
Alcohol consumption? Past _____ Present _____ How many drinks per week? _____
How many cups of coffee per day? _____ How many sodas per day? _____

DIET & EXERCISE:

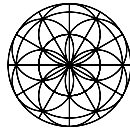
Describe a typical days' diet (approximate i.e. cereal, sandwich, vegetables, salad, animal protein):

Breakfast ***Lunch*** ***Dinner*** ***Snacks***

Describe you exercise regimen (or lack of):

GYNECOLOGY:

Please fill out the separate gynecology form that is provided.



Dr. Jay Bulloch
Integrative Healthcare

Review of Systems

Patient Name ______________________________ Date ______________

Put **C** next to any current or **P** next to any past conditions that are no longer present.
(put approximately how long ago next to any past items)

HEAD & NECK:
_____ Dizziness
_____ Fainting
_____ Neck Stiffness
_____ Headaches
_____ Enlarged lymph glands
_____ Other ______________________

EYES:
_____ Blurred vision
_____ Dry eyes
_____ Poor night vision
_____ Spots/Floaters
_____ Styes/Redness
_____ Itching or burning
_____ Other ______________________

EARS, NOSE, THROAT:
_____ Ear infection
_____ Ear ringing
_____ Decreased hearing
_____ Nose bleeding
_____ Sinus Infection
_____ Allergies
_____ Post-nasal drip
_____ Nasal congestion
_____ Sore throat
_____ Hoarse voice
_____ Difficulty swallowing
_____ Other ______________________

ORAL:
_____ Bleeding gums
_____ Bad breath
_____ Toothache
_____ Changes in taste
_____ Mouth ulcers
_____ Canker sores
_____ Dry mouth
_____ TMJ
_____ Other ______________________

RESPIRATORY:
_____ Chronic cough
_____ Cough with blood
_____ Cough with phlegm
_____ Difficulty breathing
_____ Wheezing/Asthma
_____ Frequent colds
_____ Repeated pneumonia/infection
_____ Shortness of breath
_____ Other ______________________

CARDIOVASCULAR:
_____ Palpitation
_____ Chest pain or tightness
_____ Rapid heart beat
_____ Irregular heart beat
_____ Heart disease
_____ Cold hands and/or feet
_____ Swelling ankles

Bulloch Integrative Healthcare Jay Bulloch, DAOM, L.Ac Ph: 310 428 4841 jaybulloch@me.com

CARDIOVASCULAR *(continued)*:

_____ Pacemaker
_____ High blood pressure
_____ Stroke
_____ Inflammation
_____ Other ______________________________

GASTROINTESTINAL:

_____ Indigestion
_____ Nausea
_____ Bloating
_____ Vomiting
_____ Poor appetite
_____ Excessive appetite
_____ Stomach pain
_____ Irritable bowel disease
_____ Colitis
_____ Crohn's disease
_____ Pancreatitis
_____ Celiac disease
_____ Recent changes in bowels
_____ Diarrhea (_____ stools/day)
_____ Constipation (_____ stools/week)
_____ Dry, hard stools
_____ Loose stools
_____ Blood in stool, or black
_____ Hemorrhoids
_____ --with pain or blood
_____ Soft, sticky stools
_____ Irregular/unformed stools
_____ Peptic or gastric ulcers
_____ Recent changes in weight
_____ Other ______________________________

URINARY:

_____ Frequent UTI/Bladder infection
_____ Frequent urination (__times/day)
_____ Night-time urination (__times)
_____ Recent change
_____ Kidney disease
_____ Other ______________________________

SKIN:

_____ Hives
_____ Rashes
_____ Eczema
_____ Psoriasis
_____ Dryness
_____ Bruise easily
_____ Changes in moles or lumps
_____ Other ______________________________

NEUROLOGIAL:

_____ Numbness or tingling of limbs
_____ Seizures
_____ Tremors
_____ Pain
_____ Paralysis
_____ Epilepsy or Convulsions
_____ Other ______________________________

MUSCLES & JOINTS:

_____ Joint pain
_____ Sore or aching muscles
_____ Muscle weakness
_____ Muscle atrophy
_____ Spinal curvature
_____ Back ache or pain
_____ Fibromyalgia
_____ Other ______________________________

SLEEP:

_____ Insomnia
_____ can't fall asleep
_____ can't stay asleep
_____ wake frequently
_____ Fatigue upon waking
_____ Vivid dreams
_____ Nightmares
_____ Repetitive dream themes
_____ Somnolence
_____ Night sweats
_____ Sweating and hot
_____ Sweating and cold or cool
_____ Other ______________________________

MENTAL/EMOTIONAL:

_____ Poor memory
_____ Difficulty concentrating
_____ Mental fatigue
_____ Foggy or heavy head
_____ Emotional sensitivity
_____ Frequent/excessive emotion
_____ anger
_____ mania
_____ worry
_____ sadness/grief
_____ worry
_____ fear
_____ Anxiety
_____ Panic attacks
_____ Depression
_____ Moodiness
_____ Irritability
_____ Agitation
_____ Psychiatric treatment
_____ Other ______________________________

HORMONES:

_____ Low thyroid
_____ Overactive thyroid
_____ Diabetes
_____ Low libido
_____ Other ______________________________

GENERAL:

_____ General fatigue
_____ Frequent thirst
_____ Tend to feel cold
_____ Tend to feel warm/hot
_____ Easy to bruise
_____ Sores slow to heal
_____ Hernia
_____ Anemia
_____ Spontaneous sweat
_____ Easy to sweat
_____ Excessive sweat
_____ Other ______________________________

MALE:

_____ Genital pain or itch
_____ Genital lesions or discharge
_____ Impotence or other ED
_____ Prostate problems
_____ Other ______________________________

FEMALE:

_____ Frequent vaginal infections
_____ Genital pain or itching
_____ Genital lesions or discharge
_____ Pelvic inflammatory disease
_____ Abnormal Pap smear
_____ Menopausal symptoms
_____ Breast lumps or cysts
_____ Other ______________________________

INFECTIONS & VIRUSES:

_____ Tuberculosis
_____ Hepatitis Type _____
_____ Shingles
_____ Epstein Barr Virus (EBV)
_____ Sexually Transmitted Disease
_____ HIV/AIDS
_____ HIV Risk
_____ Gonorrhea
_____ Chlamydia
_____ Syphilis
_____ Genital Warts
_____ Herpes (oral)
_____ Herpes (genital)
_____ Other ______________________________

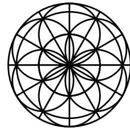
OTHER:

Please list any other health related information that you feel is important or you would like help with.

____

____

____



Dr. Jay Bulloch
Integrative Healthcare

Gynecology

Age of first menses ________ Date of last Menstrual period ________ Duration of flow ________

Blood clots (circle) **YES** **NO** When ________ Length of cycle ________

Color of mestrual blood (circle) **PALE** **BRIGHT** **RED** **DARK** **BROWN** **OTHER** ________

Texture of mestrual blood (circle) **THICK** **THIN** **WATERY** **NORMAL**

Pain (circle) **YES** **NO** When ________

Irregular periods (please describe) ________

PMS (please describe) ________

Current method of contraception ________ Past method of contraception ________

Are you currently pregnant? (circle) **YES** **NO** Number of pregnancies ________ Number of live births ________

Number of miscarriages ________ Number of abortions ________ Number of premature births ________

Breast (lumps, cysts, tenderness, etc.) ________

Urinary tract infections ________ How frequent ________

Vaginal infections/discharges (describe color) ________

Pain/itching of genitalia ________

Pap smear (circle) **NORMAL** **ABNORMAL** Date of last Pap smear ________

Uterine fibroids ________ Endometriosis ________ Other ________

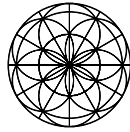
Menopause (date of onset) ________ Symptoms ________

Any bleeding since? (circle) **YES** **NO**

Are you currently on Hormone Replacement Therapy (HRT)? (circle) **YES** **NO** Dose ________

How long have you been on HRT? ________ Any side effects? ________

Other: ________



Dr. Jay Bulloch
Integrative Healthcare

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Bulloch Integrative Healthcare/Jay Bulloch L.Ac. (hereafter noted as Jay Bulloch) 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 by Jay Bulloch 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. Jay Bulloch is not required to agree to the restrictions that I may request. However, if Jay Bulloch agrees to a restriction that I request, the restriction is binding upon Jay Bulloch.

With my consent, Jay Bulloch may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist him in carrying out Treatment, Payment, and Healthcare Operations (TPO), such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. Jay Bulloch may mail to my home or other designated location any items that assist him in carrying out TPO as long as they are marked personal and confidential.

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.

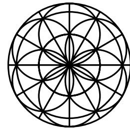
I understand I have the right to review Jay Bulloch's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bulloch Integrative Healthcare. The Notice of Privacy Practices will be provided upon my request. This Notice of Privacy Practices also describes my rights and the duties of my practitioner and Bulloch Integrative Healthcare with respect to my identifiable health information.

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

Bulloch Integrative Healthcare/Jay Bulloch 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 accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative ______________________ *Date* __________

Printed Name and Relationship/Patient Name ______________________



Dr. Jay Bulloch
Integrative Healthcare

Acupuncture Informed Consent to Treat

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) by Jay Bulloch, L.Ac.

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 understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing, and that the herbs may have an unpleasant smell and/or taste. I will immediately notify Jay Bulloch, L.Ac. of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but 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. Bruising is a common side effect of cupping. Burns, blisters, and/or scaring are a possible risk of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Jay Bulloch, L.Ac. uses sterile, single use, disposable needles only and maintains a clean and safe environment. 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 Oriental Medicine, although some herbs may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify Jay Bulloch, L.Ac if I am or become pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

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

I understand that 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 acupuncture and other procedures, and have had the 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 Name ______________________ *Legal Guardian Name* ______________________

Signature ______________________ *Signature* ______________________

Date ______________________ *Date* ______________________