**Wolf Crow Medicine**  Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

J. Whiskey Northrop, L.Ac

OR Lic# AC173827

**Client Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Preferred pronoun: \_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to leave messages about appointment scheduling? Phone/Text/Email

Do you have any medical conditions that have been diagnosed by a physician? If yes please list.

Do you have a primary care Physician? Y / N; if yes, whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain your current or most relevant heath concerns?

1)

2)

3)

Do you have any significant family health history that may impact your health? (cancer, stroke, etc)

Have you had a major illness surgery, or accident within the last 3 years, if yes please explain.

Do you have any allergies or food sensitivities? Y / N; if yes please list them.

Are you currently taking any medications, vitamins, or supplements? if yes what for?

Do you have any ailments that are restricting you from performing daily tasks? if yes what do you have trouble accomplishing?

**Please mark any areas of pain or discomfort on the following chart**:

**Please circle any current problems and underline problems in the past:**

\_\_Diabetes \_\_Cancer \_\_Hepatitis \_\_Blood disorder \_\_heart palpitations \_\_Mouth/tongue sores \_\_Vivid/lots of dreams \_\_Anxious feelings \_\_Mental confusion \_\_Restlessness \_\_Chest pain \_\_Ribcage pain \_\_low/high BP \_\_Asthma \_\_Fibromyalgia \_\_ headache/migraine \_\_Low/high appetite \_\_Fatigue after eating \_\_Bloating/gas \_\_Acid regurgitation \_\_Ulcer \_\_Stomach pain \_\_Strong appetite \_\_Painful bleeding gums \_\_Belching \_\_Nausea/vomiting \_\_Heartburn \_\_Bad breath \_\_Burning after eating \_\_Skin rashes \_\_Urinary frequency \_\_Utis \_\_TMJ \_\_Thyroid issues \_\_Sweating \_\_Low/high thirst \_\_Nasal discharge \_\_chronic cough \_\_Nose bleeds \_\_Sinus congestion \_\_Dry mouth/eyes \_\_Dry skin \_\_Sore throat \_\_Chills/fever \_\_Allergies \_\_Low immunity \_\_Low/high libido \_\_ (joint/bone) \_\_Sciatica \_\_Plantar fasciitis \_\_Arthritis \_\_Neurological disease \_\_Diarrhea \_\_Constipation \_\_Headaches \_\_Irritability \_\_Muscle cramping \_\_Neck/shoulder tension \_\_Fainting/vertigo \_\_Fatigue \_\_Gall/Kidney stones \_\_Floaters/blurry vision \_\_Dizziness \_\_Ringing in ears \_\_Cold extremities \_\_Heavy sensation in body \_\_Sleep disorders \_\_Numbness/tingling \_\_Light/heavy menses \_\_PMS \_\_Food cravings \_\_ (weakness) \_\_Sore/weak knees \_\_Low back pain \_\_Early gray/hair loss \_\_Easy bruising \_\_Poor memory \_\_Fertility issues \_\_Dental issues \_\_PTSD \_\_Easily startled \_\_Fearful \_\_Worry \_\_Sadness/depression \_\_Anger issues \_\_Grief \_\_Overthinking \_\_Stress

**Lifestyle questions:**

Describe your typical diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where in your body do you hold your stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do to relax? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Y N Activity/how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly drink water? Y N how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume caffeine? Y N how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do/did you use tobacco? Y N when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol or rec. drugs? Y N frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, moxibustion, cupping, gua sha, electrical stimulation, massage, herbal therapy and nutritional counseling. Though we take every precaution to ensure your safety there are some risks associated with these procedures: bruising, swelling, bleeding at the needle site, sore muscles and temporary exacerbation of symptoms that may last a few days. Rare risks may include: dizziness, fainting, infection, nerve damage, and pneumothorax. I understand large doses of herbs taken without my practitioner’s recommendation may be toxic and some inappropriate during pregnancy/nursing. This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment. I take full responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health.

Payment Agreement

Full Payment is expected at the time of treatment. You are responsible for $20 fee for no call/no shows. In the case that you are using health or auto insurance, arrangements may be made to omit payment and await reimbursement. Claims can take 6 weeks to 3 months to be processed. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my insurance company and I authorize my provider, J. Whiskey Northrop, to release my medical records relating to claim for benefits submitted.

ARBITRATION

By signing an arbitration agreement, you the patient and me the practitioner agree to use a

private, confidential, and expedited arbitration, rather than a public, lengthy and costly

courtroom trial, to settle any malpractice claims.

HIPPA: Notice of Privacy Policies

Wolf Crow Medicine, LLC is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in maintaining our professional relationship. Wolf Crow Medicine, LLC may use or disclose your Protected health Information when required by law. You have the right to request restrictions on certain uses and disclosures of your health information.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment. Wolf Crow Medicine, LLC will not use your health information for marketing communications without your written consent. We may send newsletters and appointment reminders, by calls, texts, or emails, unless otherwise advised by you.

You have the right upon written request:

to access, receive, or review copies of your healthcare records

to receive a list of items this office disclosed of your protected healthcare information

to request that this office place additional restrictions on disclosure of your health

to request that we amend your health information

Wolf Crow Medicine, LLC is required by law to comply with this Notice. Complaints about your privacy rights, or how we have handled your health information should be directed to J. Whiskey Northrop by calling this office at (503) 701-6077. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights 200 Independence Ave., S.W. Room 509F HHH Building Washington, DC 20201

I understand and I have the right to discuss the Notice of privacy and procedures form of this practice before I sign this consent form.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_