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Intentional Health Clinic
1785 NE Sandy Blvd., Suite 290,
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www. IntentionalHealthClinic.com

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Thank you for choosing Intentional Health Clinic to be part of your healthcare. We ask for your cooperation and patience as you complete this health history questionnaire. Integrative healthcare is enhanced dramatically when the provider has a complete picture of the patient physically, mentally, emotionally, and spiritually. If something in the form is hard to recall, we only ask you to do your best. The more information you provide, the better your practitioner will be able to serve your health needs. Please allow 15-20 minutes to complete the entire form before your first visit. You may e-mail filled out form to your provider or bring it with you to the appointment. We would prefer completion of the form and submission via e-mail at least 1 day before your appointment to have a more directed and efficient visit with you.

New Patient Intake

Name: _____ **Date**: _____

Age: _____ **DOB**: _____

Gender at birth: Male / Female **Identifying Gender**: Male/Female/Other

Preferred Pronoun: He/She/They

If patient is under 18 years of age, please list guardian and their relationship to patient:

_____

Telephone: (h) _____ (c) _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email: _____

Emergency Contact: _____ **Relationship**: _____

Telephone: (h) _____ (c) _____

Name of primary care physician: _____

HEALTH CONCERNS

Please list your most important physical, emotional, or mental health concerns. Indicate which is/are of the most immediate concern to you.

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH GOALS

Please list your long-term health goals, ranking the most important first.

1. _____
2. _____
3. _____

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What are your expectations for your first visit?

HEALTH HISTORY

- Do you have a PCP (primary care physician) _____ Name: _____
- When did you last receive medical care? _____
- Where (Clinic)? _____
- By whom (Practitioner)? _____

Please list the following:

Surgeries/Date	Hospitalizations/Date

HEALTH STUDIES/LABS

- When was your last blood test? _____
- Abnormal values? _____
- What is your blood type? _____
- Any other recent tests? _____

IMMUNIZATION HISTORY: Please indicate if you have received any of the following vaccines

Hep A	Y/ N	Tetanus (DtAP/TdAP)	Y/ N	Polio	Y/ N
Hep B	Y/ N	Flu (seasonal)	Y/ N	Shingles	Y/ N
HPV	Y/ N	MMR(Measles/Mumps/Rubella)	Y/ N	Rotovirus	Y/ N
Chicken pox	Y/ N	Pneumococcal	Y/ N	HiB	Y/ N
Smallpox	Y/ N	Meningococcal	Y/ N	TB	Y/ N

HISTORY- PERSONAL

Please list significant illness or diseases you have been diagnosed with in the past (ie. chicken pox, asthma, etc.) and the approximate date you were diagnosed.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS & ALLERGIES

PRESCRIBED & NATURAL MEDICINES Please list all prescribed drugs, vitamins, herbs, and others you are taking at present, with dosage.	**ALLERGIES/INTOLERANCES** Please list any food, medication, or environmental allergies and your reaction to them.

HISTORY- FAMILY

Please list ages and check any major health problems. If deceased, please list what they died from (ie. cancer, old age), and at what age

	Living/ Deceased	Age	Cancer	Diabetes	High Blood Pressure	Thyroid Disease	Auto-Immune Disease	Please Specify or Indicate Others
Immediate Family								
Mother	L/ D							
Father	L/ D							
Sisters	L/ D							
Brothers	L/ D							
Mother's Side								
Grandmother	L/ D							
Grandfather	L/ D							
Father's Side								
Grandmother	L/ D							
Grandfather	L/ D							

SOCIAL HISTORY

Occupation: _____

Are you: ____ Married ____ Separated ____ Divorced ____ Single ____ Widowed ____ Partnered

With whom do you live? ____ Spouse ____ Parents ____ Relatives ____ Friends ____ Alone ____Other

Do you have the support of family and friends to make positive changes in your life?

_____

Have you traveled outside the US?

- Where & when?

  _____

Do you have a religious or spiritual practice? _____

Please rate your current level of satisfaction for the following: (1=very dissatisfied; 5= very satisfied)

Work: 1—2—3—4—5	Family: 1—2—3—4—5
Social: 1—2—3—4—5	Financial: 1—2—3—4—5

ENVIRONMENTAL HISTORY

Check any of the following you routinely use at home or at work.

____ Gas heat ____ Oil heat ____ Electric heat ____ Wood stove ____ Air conditioning ____ Electric blanket

Water: ____ Distilled ____ Filtered ____ Spring ____ Well ____ Tap/City

Are you exposed to environmental or chemical hazards at home or work? If yes, please specify.

DIET

Number of meals eaten per day: 1 2 3 More than 3

How is your appetite? ____ Excellent/Love food! ____ Good

____ Eat food for sustenance ____ Go hours without eating

Do you follow any specific diet (vegan, vegetarian, etc.,)? If yes, please specify:

List the primary foods in your diet:

List the foods excluded from your diet:

List any of the following (and relative amounts) eaten regularly by you:

Coffee, caffeinated teas, processed foods, preservatives, refined foods, alcohol

---

List any of the foods you crave, regardless of their nutritional value (including sweets, salty,

sour, bread, rich/fatty foods, etc.) _____

Are you satisfied with your diet as it is now? __Y / N_____ If not, why not? _____

EXERCISE

Hours spent in physical activity per week _____ Type of exercise _____

HOBBIES_____

SYSTEMS REVIEW (Please check symptoms that you have now or have had in the past)

GENERAL/CONSTITUTIONAL

Height _____
Weight _____
Maximum weight _____
When? _____
Last physical? _____
Hours of sleep per night_____

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Night sweats

SKIN

- ☐ Rashes
- ☐ Itching
- ☐ Color change
- ☐ Lumps
- ☐ Varicose veins
- ☐ Dry skin

HEAD

- ☐ Headaches
- ☐ Head injury
- ☐ Dizziness/vertigo
- ☐ Hair loss
- ☐ Jaw pain

EARS

- ☐ Difficulty hearing
- ☐ Ringing
- ☐ Earache

EYES

- ☐ Impaired vision
- ☐ Eye pain
- ☐ Tearing/dryness
- ☐ Itchy eyes
- ☐ Double vision
- ☐ Cataracts
- ☐ Bulging eyes
- ☐ Blurriness

NOSE/SINUS

- ☐ Frequent colds
- ☐ Nose bleeds
- ☐ Stuffiness
- ☐ Sinus problems
- ☐ Loss of smell

MOUTH & THROAT

- ☐ Frequent sore throat
- ☐ Gum problems
- ☐ Hoarseness
- ☐ Difficulty swallowing

NECK

- ☐ Lumps
- ☐ Swollen glands
- ☐ Goiter
- ☐ Stiff or painful neck

CARDIOVASCULAR

- ☐ Heart disease
- ☐ Murmurs
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling in ankles, feet, or hands
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Shortness of breath

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Congestion
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Painful Breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis

BLOOD

- ☐ Easy bruising
- ☐ Clotting disorders
- ☐ Slow wound healing
- ☐ Anemia

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Arthritis
- ☐ Muscle pain or cramps
- ☐ Weakness
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty walking

NEUROLOGICAL

- ☐ Fainting
- ☐ Seizures
- ☐ Numbness/Tingling
- ☐ Tremors

- ☐ Paralysis

PSYCHOCOLOGICAL

- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Insomnia
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Memory loss
- ☐ Confusion

ENDOCRINE

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Cold/Heat intolerance
- ☐ Low blood sugar
- ☐ Diabetes
- ☐ Excessive hunger/thirst

URINARY

- ☐ Painful urination
- ☐ Increased frequency
- ☐ Frequency at night
- ☐ Urgency
- ☐ Frequent infections
- ☐ Kidney stones

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/Belching
- ☐ Heart burn
- ☐ Indigestion
- ☐ Blood in stool
- ☐ Blood in vomit
- ☐ Abnormal cramping
- ☐ Hemorrhoids
- ☐ Hernias
- ☐ Gallbladder problems
- ☐ Liver problems
- ☐ Change in bowel movements
- ☐ Loss of appetite

MALE REPRODUCTIVE

Currently sexually active?
☐Yes ☐No
Have you been in the past?
☐Yes ☐No
Type of contraception used
_____
Have you had a prostate exam?
☐Yes ☐No
If Yes, when? _____
Sexual desire, please rate:
1—2—3—4—5—6—7—8—9—10
(1: very unsatisfied → 10: very satisfied)

- ☐ Erectile dysfunction
- ☐ STDs
- ☐ Penile infections
- ☐ Split urine stream
- ☐ Abnormal discharge
- ☐ Redness
- ☐ Prostatitis
- ☐ Blood in semen
- ☐ Painful ejaculation
- ☐ Lump in testicle
- ☐ Painful testicles

FEMALE REPRODUCTIVE

Currently sexually active?
☐Yes ☐No
Have you been in the past?
☐Yes ☐No
Type of contraception used
_____
Sexual desire, please rate:
1—2—3—4—5—6—7—8—9—10
(1: very unsatisfied → 10: very satisfied)

Do you have a period?
☐Yes ☐No
Age of first period _____
Period is/was every _____
days, lasting _____ days
Is/was period regular?
☐Yes ☐No
Bleeding between cycles
☐Yes ☐No
Quality of blood (dark, clots)
_____
Flow on first day (#pads/or tampons per day) _____
(heavy, light) _____

- ☐ PMS

Date of last period
_____
Date when menopause began
_____
Date of last PAP _____
Abnormal PAP?
☐Yes ☐No
Number of:

- Pregnancies _____
- Births _____
- Miscarriages _____
  Abortions_____

- ☐ Difficulty conceiving
- ☐ Abnormal discharge
- ☐ Redness
- ☐ Itching
- ☐ Sense of pelvic fullness
- ☐ Breast pain/tenderness
- ☐ Lumps
- ☐ Infection
- ☐ Nipple discharge

Date of last mammogram:
_____

Are you currently pregnant?
☐Yes ☐No

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HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT

I hereby give my consent for **Dr. Mark Parzynski** to use and disclose **protected health information (PHI**) about me to carry out **treatment, payment, and health care operations (TPO),** or as otherwise required by law. The Notice of Privacy Practices provided by Dr. Parzynski describes such uses and disclosures more completely and is part of new patient documents.

- Notice of Privacy Practices details information about the usage and disclosure of my PHI. I have the right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed or electronic copy of the Notice.

- I have the right to request restrictions to the usage and disclosure of my PHI to carry out TPO. I understand that while Dr Parzynski may honor these requests, he is not required by law to do so. If Dr. Parzynski agrees, he is bound by this agreement.

- I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent. Revocations will be honored as of the date they are received by Dr. Parzynski at the following address: 1785 NE Sandy Blvd., Suite 290, Portland, OR 97232.

- Dr. Parzynski reserves the right to revise clinic's Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 1785 NE Sandy Blvd., Suite 290, Portland, OR 97232.

- With this consent, Dr. Parzynski may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

- With this consent, Dr. Parzynski may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked "Personal and Confidential."

- **Communication policy**: e-mail and phone message/text are not secure ways of communication and may be read by a third party. Therefore, the confidentiality of these messages, both sent and returned, cannot be guaranteed. Our preferred secure method of communication is through Charm Patient Portal which will be provided to you. If you still choose to use private e-mail and text, please **initial _____,** in addition to signing this form. Your e-mail address and phone number are used for patient care only and will never be shared with a third party without your consent.

By signing this form, I am consenting to allow Dr. Mark Parzynski to use and disclose my PHI to carry out TPO. If I do not sign this consent, or later revoke it, Dr. Parzynski may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Patient's Name

_____ _____

Print Name of Legal Guardian Date

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Consent to Treatment

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that youare under the care of a primary care physician or medical specialist,that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with,or serving as back-up for the acupuncturist named below, 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 understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, aswith all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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 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 that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am,or become, pregnantor if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until Ihave consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are:nausea;gas;stomachache;vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 that,as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform,this office of any medical history, family history,

medications,and/or supplements being taken currently (prescription and over-the-counter).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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 an opportunity to ask questions. I agree with the current or future recommendations for care. 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 do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient at Intentional Health Clinic. I understand that patient care is directed by licensed healthcare providers and I consent to services rendered and provided to me by these professionals.

I have fully read and understand the above agreements and authorizations.
To attest to my consent, I hereby affix my signature to this authorization for treatment.

_____ _____
Patient's Name (print) **Date**

_____ _____
Patient's Signature **Date of Birth**

Consent to Treatment of a Minor Child

I, _____, being the parent/legal

guardian/personal representative of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive treatment at Intentional Health Clinic.

_____ _____
Guardian/Representative Signature **Date**