

David Toone, L. Ac.

770-783-1663

www.davidtoone.com

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Information

Home # _____ Work # _____ Cell # _____ E-Mail : _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Who referred you or how did you hear about Hill Country Health? _____

Who is your primary care physician? _____

Employer: _____ Position: _____

Employer Address: _____

Spouse/Parent Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Occupation _____ Employer: _____

Employer Address: _____

Work # _____ Cell : _____ E-Mail: _____

Any drug allergies? Yes _____ No _____ If yes, please identify _____

Patient Name: _____

Please place a check (√) in response to each question as it **currently** applies to you. If you are presently ill or in pain, respond as it applied to your health before this condition occurred.

Yes	No	Energy Level
		Are you fatigued or do you fatigue easily?
		Do you need to take naps?
		Do you generally feel cold?
		Do you have cold hands?
		Do you have cold feet?
		Do you have a low grade fever?
		Do your hands and cheeks warm up easily?
		Do you ever wake up sweating during the night?

Please place a check (√) in response to each question as it **currently** applies to you. If you are presently ill or in pain, respond as it applied to your health before this condition occurred.

Appetite and Taste		Yes	No
Has your appetite altered recently?			
Do you have a poor appetite?			
Do you have poor digestion?			
Do you experience acid reflux?			
Do you have epigastric (stomach) distention?			
Do you have abdominal (large intestine) distention?			
Are you experiencing belching?			
Do you tend to binge eat and/or purge?			
Do you exhibit symptoms of anorexia nervosa?			
Do you have flatulence?			
Do you have a preferred taste?	Please circle: Salty Sweet Sour Bitter Spicy		
Do you have cravings?	Please list:		
What is your favorite food(s)?	Please list:		

What percentage of your diet is of the following?

0-100%	Categories
	Animal protein (eggs, meat, poultry, fish, wild meats or birds, etc.)
	Dairy products (cheese, milk, cream, etc.)
	Vegetables
	Fruit
	Carbohydrates (whole grains – wheat, rice, barley, millet, etc.)
	Refined carbohydrates (processed grains, flours)
	Legumes (beans, lentils, peas)
	Sweets (cakes, cookies, candies, etc.)
	Snacks (potato chips, pretzels, nuts, etc.)
	Processed foods (Fast food, pre-packaged, etc)

Patient Name: _____

List any food sensitivities or allergies.

Food	Reaction

Please place a check (✓) in response to each question as it **currently** applies to you.

Yes	No	Thirst and Dryness
		Do you have dry eyes?
		Do you have dry nose?
		Do you have dry lips?
		Do you have dry skin?
		Do you have dry hair?
		Excessive thirst?
		Don't experience thirst?

Approximately how many glasses of water or fluids do you drink daily? _____

Stools and Urine		
Stools – Are your stools:	Yes	No
Normal (daily with same shape and size)?		
Unusually hard (small or large pellet like)?		
Unusually loose (with undigested food)?		
Erratic (sometimes hard, sometimes loose)?		
Do you have bowel movements less than 5 times per week?		
Do you experience chronic constipation?		
Do you experience chronic diarrhea?		
Do you experience urgency before a bowel movement?		
Is there blood or pus in your stool?		
Do you have hemorrhoids?		
Urine – Is your urine:	Yes	No
Unusually dark and scanty (deep coloration and small volume)?		
Unusually clear (very light coloration and large volume based on intake)?		
Do you wake more than once a night to urinate?		
Do you experience any dribbling of urine?		
Excessive urination?		
Scanty urination?		
Do you have urgency to urinate?		
Do you experience burning with urination?		
Is there blood or pus in your urine?		

Patient Name: _____

Yes	No	Sleep
		Upon waking do you feel refreshed?
		Do you experience difficulty falling asleep?
		Do you experience difficulty staying asleep?
		Is your sleep disrupted by vivid dreams?
		Do you experience night terrors?
		Would you describe your sleep as restless?
		Do you have restless legs?
		Do you eat within 2 hours of going to bed?
		Do you drink within 2 hours of going to bed?
		Do you read in bed?

What do you do to facilitate a good night's rest? _____

Emotions		
Do you experience excessive:	Yes	No
Anger?		
Sadness?		
Worry?		
Fear?		
Anxiety?		
Do you experience mood swings?		
Are your mood swings related to eating or not eating?		
Do you take medications or other chemicals to modulate your moods?		

Physical Structure	
Do you suffer from:	Describe
Chronic or occasional back or neck aches?	
Chronic or occasional joint pain?	
Muscle aches or cramping?	
Numbness of limbs, hands or feet?	
Do you have a pacemaker, hearing aid, breast implants or prosthesis?	

Patient Name: _____

Accidents			
Please list all major accidents, including fractures, deep cuts and wounds, serious sprains, etc.			
Injury	Date	Age	Description
Surgeries			
Please list all surgeries, elective or necessary, and any consequence from procedure.			
Surgery	Date	Age	Outcome

Exercise	
In what type of exercise do you engage?	
How many days a week do you exercise?	
How do you feel after you exercise?	
Do you feel compelled to exercise? Yes _____ No _____	

Drug History			
Please indicate with check (✓) current or previous use of the following.			
Now	Past		Years used
		Anti-depressants	
		Antibiotics	
		Estrogen	
		Birth control	
		Pain medication/Narcotics	
		Steroids	
		Antacids	
		Thyroid medication	
		Sedatives or mood modifiers	
		Alcohol	
		Cigarettes	
		Amphetamines	
		Cocaine	
		Heroin	
		Marijuana	

Patient Name: _____

Please indicate with check (√) if you now or have had any of the following symptoms or diseases.					
Now	Past		Now	Past	
		Allergies			Heart palpitations
		Anemia			Hepatitis – Type: _____
		Anxiety			Herpes
		Arthritis			Hypertension
		Asthma			Hypotension
		Bruising			Hyperthyroidism
		Cancer			Hypothyroidism
		Candida			Kidney stones
		Cholesterol, high			Low sex drive
		Chronic fatigue			Mental illness
		Constipation			Mononucleosis
		Depression			Nose bleeds
		Diabetes			Numbness
		Diarrhea			Prostate issues
		Digestive problems			Sciatic pain
		Dizziness, vertigo			Skin problems
		Edema			TMJ
		Epilepsy			Ulcers
		Food allergies			Venereal disease
		Frequent colds			Vision issues
		Frequent gas			- near sighted
		Gallstones			- far sighted
		Hay fever			- use reading glasses
		Head injury			
		Headache			
		Heart murmur			

Patient Name: _____

Family History		
	Maternal	Paternal
Do your parents have any unusual health problems? Please list		
If deceased, please list cause and date.		
Family history of mental illness? Please list		
Family history of substance abuse		
During your mother's pregnancy with you, did she:	Yes	No
• Drink alcohol		
• Smoke cigarettes		
• Take medication		
• Have a sudden and serious illness		
• Suffer emotionally or physically		

Concerns
List below your five (5) main physical complaints in order of importance:
1. _____
2. _____
3. _____
4. _____
5. _____

How would you rate your current level of health?
(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?
(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Patient Name: _____

Please answer the following questions if you are undergoing assisted reproductive technologies.

Assisted Reproduction	
Are you working with a Reproductive Endocrinologist? Yes:____ No:____	
If Yes – Name of Group: _____	
Name of physician: _____	

Number of IUI's _____	Dates: _____
Number of IVF's _____	Dates: _____
Upcoming procedure: _____	
Date: _____	
Hysteroscopy date: _____	
Laparoscopic surgery date: _____	
Reason: _____	
Previous abdominal surgeries:	
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____

Pertinent Lab Information:	
FSH: _____	

For Office Use

Notes _____

Diagnosis _____

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Men Only		
Please place a check (✓) in response to each question as it current applies to you.	Yes	No
Prostate issues?		
Difficulty urinating?		
Dribbling after urination?		
Frequent night-time urination?		
Diminished libido?		
Excess libido?		
Difficulty achieving an erection?		
Difficulty maintaining an erection?		
Morning erection?		
Premature ejaculation?		
Nocturnal emission?		
Spermatorrhea (involuntary discharge)?		
Pain on the inside of legs or heels?		
Feeling of incomplete bowel evacuation?		
Lack of energy?		
Migrating aches and pains?		
Tire too easily?		
Avoid activity?		
Leg nervousness at night?		
Please list any other urinary and/or genital issues:		

For Office Use

Notes _____

Diagnosis _____

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To protect the privacies of our patients please respond to the following questions.

Please indicate your answer with a check to the right of each question.	Yes	No
Do we have your permission to contact or leave a message on your home phone?		
Do we have your permission to contact or leave a message on your work phone?		
Do we have your permission to correspond with you through the USPS mail at home or work? (Examples include: sending appointment reminders, birthday wishes, or a thank you notes when you have made a referral to us)		
Do we have your permission to correspond with you via the e-mail address you have provided?		
Do we have permission to contact your doctor(s)?		
If photographed for the purpose to training or teaching, do we have your permission to use the photograph(s) to share, publish or use in a presentation?		

Signature of Patient or Legal Guardian

Date

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Hill Country Health** may use and disclose health information [treatment, payment or healthcare operations (TPO)] about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Hill Country Health's** Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Hill Country Health** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Hill Country Health at 411 Selborne Way, Palmetto, GA 30268.**

With my consent, **Hill Country Health** 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 the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Hill Country Health** may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, **Hill Country Health** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Hill Country Health** restricts how it uses or discloses my Protected Health Information (PHI) to carry out TPO.

By signing this form, I am consenting to **Hill Country Health** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Hill Country Health** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

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Office Policies

Fees

Acupuncture and Moxibustion Therapies

Initial Visit, consultation, diagnosis and treatment: \$150

Follow-up Visits: Adults: \$90; Children: \$45

Herbal Therapies

Adult: Most herbal therapies \$45 a week

Children: \$25 per week

Making Appointments: For healing to be most effective, a series of visits is usually necessary. We advise that you schedule in advance to ensure continuity of appointments.

Cancellation Policy: Missed appointments without prior notification is subject to a full visit fee. If possible, please provide a 48-hour advance cancellation notice so that we may staff the office properly and that other patients can be helped in that time slot.

Payment Policy: We charge for services provided. Payment is due at the time of service. We accept cash, checks, Visa, Master Card, American Express and Discover. Returned checks are charged a \$10 fee.

Insurance: We provide a Superbill, which contains the information you need to submit a claim for reimbursement to your insurance carrier. Please check with your insurance carrier to determine if acupuncture is covered under your plan. Payment is due at the time of services. Please note we do not know of any herbal therapies that are covered under insurance at this time.

Childcare Policy: We do not offer childcare in the clinic. However, we are a child-friendly practice. Please do not leave children unattended if they are very young or may become disruptive.

Change of Address: Please notify us when your address or phone number changes as soon as possible.

Mobile Phones: Please turn off your cell phones before entering treatment rooms.

Patient Name (Please Print)

Relationship to Patient

Patient Signature (or Guardian if Patient is a minor)

Date