HEALTH QUESTIONNAIRE

DR. KIM'S ACUPUNCTURE PLLC

Andrew H. B. Kim, Dr. Ac.

Date:_____

Name:_____ Sex: M ( ) F ( )

If Minor, Parent's Name:_____

Address:_____ Home Phone:_____

Employment:_____ Work Phone:_____

In Case of Emergency Contact:_____

Physician's name:_____ Insurance:_____

Referred by:_____

Date of Birth:_____ S. S. #:_____

Please take your time, be patient and answer all the questions as accurately as possible. This questionnaire has been prepared in order to assist you with your health problem(s).

Please state specifically for what types of health problems you are seeking treatment.

_____

_____

How long have you been suffering from your health problem?_____

Please state the name of any other health practitioner with whom you have previously consulted for your health problems. _____

Have you ever previously had acupuncture treatment? Yes ( ) No ( )
If yes, please state the doctor's name, how long ago, and state what type of health problem.

_____

When was your last physical exam with your Medical Doctor? _____

Are you now under medical care? If so please explain. _____

_____

Have you ever had a serious illness or operation? _____

_____

Do you have a Pace-Maker? Yes ( ) No ( )

Are ALL or SOME of your medical problems result of an automobile accident? Yes ( ) No ( )

General Life Style

- How many meals do you eat a day?
  Do you have any snacks in between meals or late at night?
- What does your daily diet consist of?
- How much water do you drink a day?
- Do you consume any other liquids (coffee, tea, soda, juice, ...etc.)?
- Do you consume any alcohol or use tobacco daily?
- What kind of sports or hobbies do you participate in?
- Do you think you are over or under-weight?
  Please state your height and weight.

General Health Condition

- Do you think you are in good health?
  Please check Yes ( ) No ( ) or Fair ( )
- Has there been any change in your health within the past year?
  If so, please explain.
- Do you have any type of headache quite frequently?
  If so, please explain how often and which part of your head.
- Do you have any problem or injury to your neck?
  If you have had a neck injury, please state when it occurred.
- Do you have any problems with your nose, eyes or ears?
  If so, please explain.
- Have you ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)?

- Do your gums bleed when you brush your teeth?
- Do you grind or clench your teeth?
- Do you have frequent sores in your mouth?
- Do you have any problems or injuries to your back (spine or muscle)?
  If you have had any injuries, please explain when it occurred and which part of your back.
- Do you suffer from any other physical injuries?
- Do your ankles swell?
  If so, which one is it? Right ( ) Left ( ) or Both ( )
- Do you have any structural problem(s) with your legs?
  Flat feet ( ) High arch ( ) Knock knee ( ) Bow leg ( )
  Pigeon toes ( ) Others_____
- Do you have any of the following problems with your limbs?
  Cold limbs ( ) Varicose veins ( ) Arthritis ( ) Phlebitis ( )
  Thrombosis ( ) Gangrene ( ) Frequent cramps ( )
  Others: _____
- Do you bruise easily?
- Do you have artificial joints or body parts (organs)?
  If so, please explain.
- Do you have a pacemaker?
- Do you have (or have you ever had) any of the following symptoms or diseases?
  Fainting spells or seizures ( ) Epilepsy ( ) Kidney problem ( )
  Venereal diseases ( ) Syphilis ( ) AIDS, AIDS-related complex ( )
  Tested positive to HIV virus ( ) Cancer ( )

Skin Condition

- Do you have any of the following skin disorders?
  Dry skin ( ) Excessive perspiration ( ) Excessive wrinkles ( ) Acne ( )
  Eczema ( ) Itching ( ) Psoriasis ( ) Baldness ( )
  Others: _____
- How often do you take a bath or shower? Do you take any other special care for your skin?

Respiratory, Cardiovascular, & Blood Condition

- Do you have or have you ever had any of the following symptoms or diseases?

  Allergies ( ) Hay fever ( ) Asthma ( ) Emphysema ( )
  Tuberculosis ( ) Persistent cough or cough up blood ( )
  Rheumatic fever or Rheumatic heart disease ( ) Heart attack ( )
  Coronary insufficiency or occlusion ( ) High blood pressure ( )
  Arteriosclerosis (Hardening of arteries) ( ) Stroke ( ) Edema ( )
  Angina pectoris ( ) Raynaud's syndrome ( ) Low blood pressure ( )

  Others: _____

Psychiatric & Emotional Condition

- Do you have or have you ever had any of the following symptoms or disorders?

  Anxiety ( ) Depression ( ) Fatigue ( ) Insomnia ( ) Nervousness ( )
  Anorexia ( ) Obesity ( ) Alcoholism ( ) Smoking addiction ( )
  Drug dependance ( ) Speech disorders ( ) Schizophrenia ( )

  Others: _____

- Are you satisfied and content with your present lifestyle?
  If not, where do you feel your life needs improvement?

Female Only

- Are you pregnant? If so, please state how many months.
- Do you have any problems associated with your menstrual period?

  Amenorrhea (absence of menses) ( ) Dysmenorrhea (painful menses) ( )
  Oligomenorrhea (scanty or frequent menses) ( ) Premenstrual tension ( )
  Menometrorrhea (excessive menstruation) ( ) Menopause ( )

  If you are in menopause, are you experiencing any menopausal syndromes such as hot flashes or other symptoms? Please explain.

- Do you have or have you ever had any of the following health problems?

  Vaginal infections ( ) Herpes ( ) Tumor or growth in uterus ( )
  Lumps or tumor in the breast ( ) Cancer ( )

Digestion

- Do you have or have you ever had any of the following symptoms or diseases?

  Heartburn ( ) Indigestion ( ) Belching (burping) ( )

  Distention after meal (bloating) ( ) Difficulty in swallowing ( )

  Frequent nausea ( ) Hiatus hernia ( ) Stomach ulcer ( )

  Duodenal ulcer ( ) Gallstone ( ) Diabetes ( )

  Others: _____

- Do you have or have you ever suffered any of the following liver problems?

  Hepatitis ( ) Jaundice ( ) Enlarged liver ( ) Liver cirrhosis ( )

  Others: _____

Elimination

- How often do you have a bowel movement?

  Once a day ( ) 2-3 times a day ( ) Once in 2-3 days ( )

  Once in 5 days or more ( )

  Others: _____

- Do you have a normal, well-formed bowel movement?

  Formed but pencil thin ( ) Not formed ( ) Diarrhea ( ) Excessive mucus ( )

  Pass gas frequently ( )

  Others: _____

- When you have a bowel movement, have you ever seen blood?

  Blood outside of the stool ( ) Blood mixed with the stool ( )

  Bright red blood ( ) Dark red blood ( )

- Do you have or have you ever had any of the following health problems?

  Hemorrhoids ( ) Diverticulitis ( ) Colitis ( ) Ileus ( )

  Chron's disease ( ) Colostomy ( )

  Others: _____

- Do you have any problem with urination?

  More frequent ( ) Less frequent ( ) Free flow but not forceful ( )

  Dribbling ( ) No control of urine ( )

  Yellow in color ( ) Cloudy ( ) Dark color ( )

  Pass blood in urine ( ) Burning sensation during urination ( )

  Once in a while sharp pain during urination ( )

  Others: _____

Medication

- Are you taking any of the following medications?

  Antibiotics or sulfa drugs ( ) Anticoagulants (blood thinner) ( )

  Medication for high blood pressure ( ) Cortisone or steroids ( )

  Tranquilizers ( ) Aspirin or other pain killer ( )

  Dilantin or other anticonvulsives ( ) Nitroglycerin ( )

  Digitalis or drugs for heart trouble ( )

  Insulin, tolbutamide, orinase or similar drugs ( ) Birth control pills ( )

  Others: _____

- Are you allergic to or have you ever reacted adversely to any of the following?

  Local anesthetics ( ) Penicillin or other antibiotics ( ) Sulfa drugs ( )

  Barbiturates, sedatives, or sleeping pills ( ) Aspirin ( )

  Others: _____

- Do you have any disease, condition, or problem not listed above?

  If so, please explain. _____

The undersigned agrees that the information which he/she has given on this questionnaire is accurate.

_____ _____

Signature Date

Notice of Privacy Practices For Protected Health Information

"This notice describes how medical information about you may be used and disclosed and how you may get access to this information". Please review it carefully!

We Safeguard Information about Your Health and Person:

We collect information from you and stored in a medical record as well as on a computer. Charger stored in a secure area and available only the designated staff only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for services computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosures such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, are those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- **When required by law**
- **Public health activities (yes, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/visibility control/prevention)**
- **Health oversight activities (audits, investigations, inspections)**
- **Judicial or administrative proceedings (court order)**
- **Appropriate law enforcement request (to identify or locate a suspect, fugitive, material witness, or missing person)**
- **Deceased person information to coroners, medical examiners, funeral directors**
- **Organ and tissue donation**
- **Research, provided authorization is IRB-approved or privacy-board approved**
- **Emergencies or to avert serious threat to health or safety**
- **Specialized government functions (military, inmates)**
- **Worker's compensation**
- **Disaster relief and fund-raising**

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request of our office and pay the copy fee and receive a copy of your record. We must respond within 30 days of the records readily available in within 60 days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions of the amount of medical information we disclosed. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We May Contact You for Appointment Reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the privacy notice and an opportunity to review and understand it.

Our responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.
We reserve the right to make changes to this notice. We will post a notice that the notice has been changed in the effective date of the change, copies will be made available.

You can complain about our privacy policy or its execution either verbally or in writing to our ***PRIVACY OFFICER at:***

Phone: **352-688-8088**

If you get no resolution to your complaint, you can send a written statement of this office or the Sec. of Health and Human Services.

Effective date: April 14, 2003

Amended dates:

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by **Dr. Andrew Kim** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of my past/current medical for treatment.

Signature X_____ Date X_____

AUTHORIZATION AND ASSESSMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by **Dr. Andrew Kim** I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize **Dr. Andrew Kim** to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payment directly to **Dr. Andrew Kim** for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.
I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature X_____ Date X_____

DESIGNATED RELATIVE

I Authorize Discussion of My General Medical Condition and Diagnosis (including treatment, payment and health care operations) with: ( ) Spouse ( ) Children ( ) OtherX_____

Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency:
Name:X_____ Phone Number:X_____
Name:X_____ Phone Number:X_____

Signature X_____ Date X_____

PRIVACY NOTICE

I have received a copy of **Dr. Andrew Kim's** office privacy notice as required by HIPAA.

Signature X_____ Date X_____

Patient Name (Print): X_____ SS#: _____

Witness: _____ Relationship: _____