

McKay  
Chinese Herbal Medicine & Acupuncture

NORTH CAROLINA NOTICE FORM  
Notice of Privacy Practices  
to Protect the Privacy  
of Your Health Information

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

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.

- "PHI" refers to information in your health record that can identify you.
- "treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician.
- "payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "health care operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "use" applies only to activities within my (office, clinic, practice, etc.) such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "disclosure" applies to activities outside of my (office, clinic, practice, etc.) such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

(as described in section III of this notice). On your request, I will discuss with you the details of the accounting process.

- **Right to a Paper Copy---** You have a right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

#### My Duty to you

- I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by U.S. mail.

#### Complaints:

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may send a written complaint to the Secretary of the Department of Health and Human Services.

#### Effective Date, Restrictions and Changes to Privacy Policy:

This notice will go into effect as of April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice.

**McKay**  
**Chinese Herbal Medicine & Acupuncture**

Notice Receipt Acknowledgement

\*\*\*\*\*

Purpose: This form is used to confirm that an individual has received a copy of the notice of primary practices.

\*\*\*\*\*

I, \_\_\_\_\_, acknowledge that I received a paper copy of McKay's Notice of Privacy Practices.

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

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**INFORMED CONSENT TO ACUPUNCTURE**  
**TREATMENT AND CARE**

I hereby request and consent to the performance of acupuncture and other procedures within the scope of the practice of acupuncture on me (or the person listed below, for whom I am legally responsible) by one of the licensed acupuncturists at McKay Healing Arts.

I have had the opportunity to discuss with one of the acupuncturists the nature and purpose of acupuncture.

I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some potential risks to treatment, an example being nausea. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications prior to administering acupuncture. I wish to rely on him or her professional judgment during the course of the procedure, and based upon the facts then known, to proceed with treatment in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

\_\_\_\_\_

\_\_\_\_\_  
Print Patient's name

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name \_\_\_\_\_

Relationship to patient \_\_\_\_\_



# Welcome to Chinese Herbal Medicine & Acupuncture

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

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

Phone: (Hm) \_\_\_\_\_ (Other) \_\_\_\_\_ E-mail \_\_\_\_\_

Birthdate \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Social Security # \_\_\_\_\_

Weight \_\_\_ Height \_\_\_ Pulse Rate \_\_\_ Normal Blood Pressure \_\_\_\_\_

Are you pregnant or think you might be? \_\_\_\_\_

Current Medications, Herbs, Drugs \_\_\_\_\_

Major Operations, Surgeries, Illnesses (with dates) \_\_\_\_\_

Chief complaint; Describe your problem \_\_\_\_\_

Date it began \_\_\_\_\_ Was cause an accident? \_\_\_\_\_ Rate pain 1-10 \_\_\_\_\_

Does anything make it worse? \_\_\_\_\_ Make it better? \_\_\_\_\_

Do you have a medical diagnosis for your problem? \_\_\_\_\_

Were X-rays, MRI, or lab tests taken? \_\_\_\_\_

Do you have any other major health problems such as pacemaker, heart condition, or diabetes? \_\_\_\_\_

Primary Physician \_\_\_\_\_

How did you hear about us? (Please circle)

Search Engine: Google

Yahoo

Other \_\_\_\_\_

Publication: Encore

Natural Awakenings

Phone Book

Radio

Drive By

Referral: (name?) \_\_\_\_\_

Physician (name?) \_\_\_\_\_

Other \_\_\_\_\_

Emergency Contact name \_\_\_\_\_

Emergency Contact phone \_\_\_\_\_

# PATIENT SYMPTOM SURVEY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE CHECK YOUR PAST & PRESENT SYMPTOMS SO WE CAN BETTER EVALUATE YOUR PROBLEM

## GENERAL

PAST NOW

- fatigue
- sleep problems
- swollen glands
- hot or cold intolerance
- frequent headaches
- weight loss
- weight gain
- fever or chills
- allergies

## NERVOUS SYSTEM

- dizziness
- blurred vision
- fainting
- paralysis
- tremors
- numbness/tingling
- convulsions
- imbalance
- memory loss
- muscle weakness

## URINARY

- painful urination
- frequent urination
- hard to urinate
- incontinence
- bed wetting
- discolored urine
- frequent infections
- prostate problems
- unusual discharge

## HEAD

- headache
  - entire head
  - back of head
  - forehead
  - temples
  - migraine
- head feels heavy
- loss of memory
- light-headedness
- fainting
- light bothers eyes
- loss of smell
- loss of taste
- loss of balance
- dizziness
- loss of hearing
- pain in ears
- ringing in ears
- buzzing in ears

## NECK

- pain in neck
- neck pain with movement
- pinched nerve in neck
- neck feels out of place
- stiff neck
- muscle spasms in neck
- grinding sounds in neck
- grating sounds in neck
- popping sounds in neck
- arthritis in neck

## EMOTIONAL

PAST NOW

- anxiety or worry
- frequent crying
- anger
- tension
- mood swings
- fear
- restlessness
- confusion
- depression
- suicidal

## REPRODUCTIVE SYSTEM

- painful intercourse
- prostate problems
- sexual problems
- loss of sex drive
- genital infections
- Birth Control Method \_\_\_\_\_

## WOMEN ONLY

- cramps
- PMS
- irregular periods
- Are you Pregnant?  Yes  No
- date last period \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- # of miscarriages \_\_\_\_\_
- # of abortions \_\_\_\_\_
- date last PAP \_\_\_\_\_
- difficult labor
- breast problems

## LOW BACK

- low back pain
- Low Back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
- pinched nerve in low back
- slipped disk
- low back feels out of place
- muscle spasms
- arthritis

## MID BACK

- mid back pain
- pain between shoulder blades
- sharp stabbing pain/midback
- muscle spasms

## CHEST

- chest pain
- shortness of breath
- pain around ribs

## EENT

PAST NOW

- earache
- ear discharge
- ringing in ears
- hearing loss
- nosebleeds
- hoarseness
- problems swallowing
- sore throat
- jaw tight or sore
- dental problems
- glasses/contacts

## MUSCULOSKELETAL

- joint swelling
- muscle cramps
- neck pain
- shoulder pain
- tennis elbow
- arm pain
- hand sensations
- loss of grip
- midback pain
- rib pain
- low back problems
- hip pain
- foot problems
- leg cramps
- knee pain
- ankle weakness
- tingling foot

## SHOULDERS

- pain in shoulder joint
- pain across shoulders
- bursitis (R-L)
- arthritis (R-L)
- Can't raise arm:
  - above shoulder level
  - over head
- tension in shoulders
- pinched nerve in shoulder
- muscle spasms in shoulders

## ARMS & HANDS

- pain in upper arm
- pain in forearm
- pain in hands
- pain in fingers
- pinched nerve in arm
- pinched nerve in fingers
- pins & needles in arms
- pins & needles in fingers
- fingers go to sleep
- hands cold
- swollen joints in fingers
- arthritis in fingers
- loss of grip strength

## HEART/LUNG

PAST NOW

- chest pain
- high blood pressure
- low blood pressure
- persistent cough
- hard to breathe
- coughing blood
- coughing phlegm
- irregular heartbeat
- varicose veins
- ankle swelling

## GASTROINTESTINAL

- change in appetite
- thirst
- nausea
- vomiting
- diarrhea
- constipation
- gas
- hemorrhoids
- gall bladder
- belching
- heartburn
- abdominal pain
- bloody/black stools
- indigestion
- liver trouble

## SKIN

- easy bruising
- dry skin
- itching
- boils
- rashes
- excessive sweat
- hair changes

## HIPS, LEGS & FEET

- pain in buttocks (R-L)
- pain in hip joint (R-L)
- pain down leg (R-L)
- pain down both legs
- leg cramps
- pins & needles in legs
- numbness of leg (R-L)
- numbness of feet (R-L)
- numbness of toes
- feet feel cold
- cramps in feet (R-L)
- swollen ankles (R-L)
- swollen feet (R-L)
- painful joints in toes
- pain in foot (R-L)
- pain in knee (R-L)

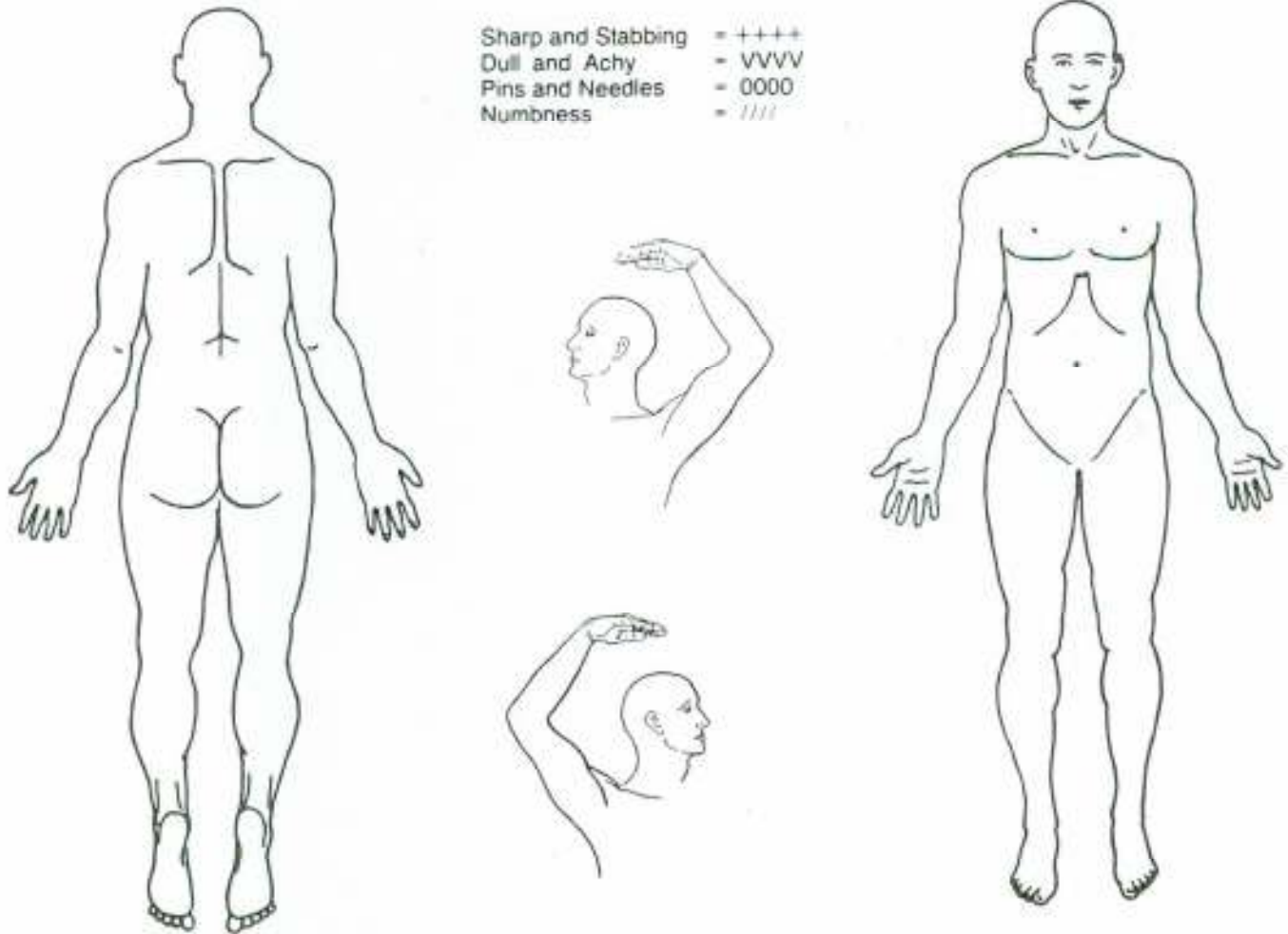
## GENERAL

- nervousness
- irritable
- depressed
- fatigue
- generally feel rundown
- loss of sleep
- loss of weight

# ANALOGUE PAIN SCALE

Name \_\_\_\_\_ Date \_\_\_\_\_

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.



Sharp and Stabbing = ++++  
 Dull and Achy = VVVV  
 Pins and Needles = 0000  
 Numbness = IIII

Please check the appropriate # to describe your present pain level:  
 With 0 being Normal (or no pain); and 10 being very severe pain.

C = CONSTANT  
 I = INTERMITTENT

Area of pain	Normal	Mildly in pain	Moderate pain	Severe pain		
Neck	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Middle back	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Lower back	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Hip(s) Lt Rt	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Shoulder(s) Lt Rt	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Arm(s) Lt Rt	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Legs Lt Rt	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Headaches	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Other:	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Other:	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I
Other:	<input type="checkbox"/> 1	2 3 4	5 6 7	8 9 10	C	I

