FIQUET HANNA DUCKWORTH D.O.M.
505 982 9626 FAX 505 983 2320
1510 S. St. Francis Drive
Santa Fe, NM 87505

PATIENT INTAKE FORM

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Email _____

Age _____ Date of Birth _____ ❒ Male ❒ Female

Occupation _____ Employer _____

Responsible Party (if dependent) _____ Phone _____

Marital Status ❒ Single/Never Married ❒ Married ❒ Divorced ❒ Separated

Insurance Co. _____ Policy No. _____

In Emergency Notify _____ Phone _____

Referred By _____ Treated with Acupuncture Before? ❒ Yes ❒ No

MAIN COMPLAINT(s) _____

_____

_____

Date problem began _____ Have you had this problem in the past? ❒ Yes ❒ No If yes, when? _____

Is your condition ❒ Getting Worse ❒ Constant ❒ Comes and Goes Pain is: ❒ Slight ❒ Moderate ❒ Severe

What makes it better? _____

What makes it worse? _____

How does it interfere with your activities (work, sleep, sex, etc.)? _____

_____

Have you been given a diagnosis for this problem? ❒ Yes ❒ No If so, what? _____

_____

What kinds of treatment have you tried? _____

_____

Any other complaints? _____

Medications/drugs/herbs/supplements you are currently taking _____

_____

Are you currently under the care of any other health care provider? ❒ Yes ❒ No If so, by whom and for what conditions? _____

_____

_____

Date of your last physical exam _____ By whom? _____

Is your condition related to a motor vehicle accident? ❒ Yes ❒ No If so, please explain _____

_____

_____

MVA where when insurance accident claim# Police report

Do you have or have you ever had any of the following:

❒ Arthritis ❒ Cancer ❒ Diabetes ❒ Seizures
❒ Asthma ❒ Stroke ❒ Gallstones ❒ Ulcers
❒ Anemia ❒ Hepatitis ❒ Thyroid Disease ❒ Venereal Disease
❒ Heart Disease ❒ Chronic Fatigue ❒ Immune Deficiency ❒ High Blood Pressure
❒ Sudden Weight Gain ❒ Sudden Weight Loss ❒ Other _____

_____

Is there a history in your family of any of the above conditions? ❒ Yes ❒ No Who and what did they have? _____

_____

List all surgeries/operations you have had and dates: _____

_____

_____

List any traumas you have had and dates (accidents, injuries, etc.) _____

_____

_____

List any allergies you may have (foods, medications, pollens): _____

_____

_____

Is your energy level: ❒ Good ❒ Insufficient ❒ Erratic ❒ Low (time of day) _____ ❒ High (time of day)_____

Sleep: ❒ Trouble falling asleep ❒ Trouble staying asleep ❒ Restful ❒ Other _____

Stress: ❒ None ❒ Moderate ❒ Severe What causes it? _____

_____

Blood Pressure: ❒ High ❒ Low ❒ Normal ❒ Don't know Meds: _____

How much alcohol do you consume per week? _____

Do you smoke? ❒ Yes ❒ No If yes, how much per day? _____ How long?_____

How much coffee/tea/cola do you consume? _____

Do you have a regular exercise program? ❒ Yes ❒ No If yes, please describe: _____

_____

Please check all that apply:

DIGESTION:

❒ Nausea ❒ Abdominal Pain ❒ Heartburn ❒ Belching
❒ Vomiting ❒ Bad Breath ❒ Abdominal Bloating ❒ Gas
❒ Constipation ❒ Diarrhea ❒ Bloody Stools ❒ Hemorrhoids
❒ Stomach Aches ❒ Excessive Appetite ❒ Poor Appetite ❒ Appetite Keeps Changing
❒ Feel tired or weak if a meal is missed ❒ Excessive Thirst ❒ Other _____

_____

_____

What are some of your favorite foods? _____

Any food allergies or strong dislikes? _____

Do you: ❒ Eat frequently between meals ❒ Eat when you're not hungry
❒ Eat until you feel full ❒ Occasionally go on crash diets
❒ Binge ❒ Eat sweets every day
❒ Follow any restricted diet? Describe: _____

_____

_____

_____

MUSCULOSKELETAL:

Pain in:

❒ Muscles ❒ Joints ❒ Neck ❒ Shoulders
❒ Arms/Hands ❒ Feet/Legs ❒ Hip ❒ Knees
❒ Upper Back ❒ Mid Back ❒ Lower Back ❒ Bones
❒ Muscle Cramps/Spasms ❒ Muscle Weakness ❒ Stiff all over ❒ Swelling
❒ Other _____

_____

CARDIOVASCULAR/RESPIRATORY:

❒ Palpitations ❒ Difficulty breathing ❒ Wheezing ❒ Shortness of breath
❒ Pain/Pressure in chest ❒ Persistent cough ❒ Coughing phlegm ❒ Coughing blood
❒ Cold hands or feet ❒ Dizzy/Lightheaded ❒ Fainting ❒ Irregular Heartbeat
❒ Other _____

_____

HEAD:

❒ Headaches (what areas and how often?) _____

_____

❒ Dizziness ❒ Neck pain ❒ Grinding teeth ❒ Jaw Clicks
❒ Tooth problem ❒ Migraines ❒ Facial pain
❒ Other _____

_____

EYES:

❒ Glasses/Contact Lenses ❒ Dryness ❒ Pain/Burning ❒ Itching
❒ Redness ❒ Blurred Vision ❒ Other _____

_____

EARS:

❒ Poor hearing ❒ Earaches ❒ Ear Infections ❒ Poor balance
❒ Ringing or buzzing in ears ❒ Other _____

_____

NOSE:

❒ Excessive mucus ❒ Blocked sinuses ❒ Sinus pressure/pain ❒ Hayfever/Allergies
❒ Nose bleeds ❒ Other _____

_____

THROAT/MOUTH:

❒ Recurrent Sore Throat ❒ Hoarseness ❒ Difficulty swallowing ❒ Bleeding gums
❒ Sores on lips or tongue ❒ Other _____

_____

URINE:

Color _____ Frequency _____

❒ Up at night to urinate ❒ Unable to hold urine ❒ Hard to urinate ❒ Pain or burning when urinating
❒ Blood in urine ❒ Urinary infections ❒ Water retention ❒ Kidney stones
❒ Other _____

_____

SKIN:

❒ Dry ❒ Itching ❒ Burning ❒ Rashes
❒ Hives ❒ Eczema ❒ Boils ❒ Acne
❒ Changing moles ❒ Lumps/cysts ❒ Swelling ❒ Bruise easily
❒ Dry scalp ❒ Hair loss ❒ Other _____

_____

FEMALE:

Are you pregnant? ❒ Yes ❒ No ❒ Don't know Date of last period _____

No. of days between periods_____ Age started _____ Age stopped _____

Form of birth control _____

No. of Pregnancies_____ No. of Deliveries _____ No. of Miscarriages _____

No. of abortions_____ No. of Cesareans _____

Operations:_____ ❒ Cervix ❒ Uterus ❒ Ovaries

❒ Other _____

_____

❒ Menstrual pain/cramps ❒ Low back pain ❒ Leg cramping ❒ Painful breasts
❒ Clotting ❒ Heavy bleeding ❒ Light scanty bleeding ❒ Dark color
❒ Water retention ❒ Irregular periods ❒ Miss periods ❒ Little or no sex drive
❒ Mood swings ❒ Hot flashes ❒ Food cravings ❒ Vaginal sores
❒ Infections ❒ Discharges - Color _____ ❒ Other _____

_____

_____

MALE:

❒ Low sex drive ❒ Impotence ❒ Painful ejaculation ❒ Discharges
❒ Sores ❒ Painful urination ❒ Premature ejaculation ❒ Prostate problems
❒ Nocturnal emissions ❒ Other _____

_____

_____

NEUROPSYCHOLOGICAL:

❒ Nervousness ❒ Depressed ❒ Easily angered/irritated ❒ Frequent crying
❒ Worry/anxiety ❒ Mood swings ❒ Memory confusion ❒ Poor concentration
❒ Suicidal ❒ Dizzy ❒ Seizures ❒ Neuralgia
❒ Numbness/tingling - Where? _____

❒ Other _____

_____

_____

FIQUET HANNA DUCKWORTH, D.O.M.
ACUPUNCTURE AND PHYSICAL MEDICINE

INFORMED CONSENT TO HEALTH CARE BY A DOCTOR OF ORIENTAL MEDICINE

I hereby request and consent to the performance of the following on me (or patient named below, for whom I am legally responsible) by Fiquet Hanna Duckworth, D.O.M. and/or other licensed doctors of oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Fiquet Hanna Duckworth, including those working at this office or any other associated office: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, manual palpation on a variety of areas of my body, observation, range of motion evaluation, muscle, orthopedic and nuerologic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary recommendations; advise regarding exercise regimes; and lifestyle counseling.

I have had an opportunity to discuss with Dr. Fiquet Hanna Duckworth and/or with other officer personnel the nature and purpose of acupuncture and oriental medical procedures. I understand that although acupuncture and other oriental medical procedures have helped millions of people no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine there are some risk to treatment. I understand that while unlikely, possible risks include but are not limited to: bleeding, bruising, pneumothorax (puncture of the lung), puncture of other organs, pain or other strong sensations at the location where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the doctor's judgement based on the facts known at the time.

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 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.

The following is to be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated.

_____	_____
Print Name of Patient	Print Name of Patient's Representative
_____	_____
Signature of Patient	Signature of Patient's Representative
_____	_____
Date Signed	Relationship of Patient's Representative

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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FIQUET HANNA DUCKWORTH, DOM, PC

FINANCIAL POLICY

1. Payment policy for ALL services rendered: Patients are 100% responsible for payment of all services rendered, regardless of your insurance coverage.

2. INSURANCE: Insurance coverage is a contract between you and your insurance company. Fiquet Hanna Duckworth, DOM, PC, is not a party to this contract. Our office will help you to utilize your insurance benefits to the best of our ability. We bill most insurance companies as a *courtesy* to our patients. Regardless of your insurance company's delaying tactics, they have 45 days to pay your claims. If your insurance company has not paid within this time frame, we will extend an additional 15 days to you, in order for you to pay your balance in full.

3. INSURANCE TERMINOLOGY:

    a. Yearly Deductible: An amount agreed upon by you and your insurance company, which is to be paid by you (out of pocket), PRIOR to your insurance company paying any contracted or benefit amount. Once your preset, yearly deductible has been met, you will then have one or more of the following:

    b. Co-Payment: An amount set forth by your insurance company to be paid at the time of your visit (once your yearly deductible has been met).

    c. Co-Insurance: An amount set forth by your insurance company as an ADDITION to your Co-Payment amount. This amount will also be due at the time of your visit (once your yearly deductible has been met).

4. IF YOU HAVE ANY QUESTIONS REGARDING YOUR DEDUCTIBLE, CO-PAYMENT AND/OR CO-INSURANCE, PLEASE CONTACT YOUR INSURANCE COMPANY.

5. ALL ACCOUNTS MUST BE PAID IN FULL WITHIN 60 DAYS: There will be NO EXCEPTIONS. If a payment plan is required, we will be happy to discuss your account with you and make arrangements as needed.

6. Default on Payment: In the event of default on payment, the patient or patient's guardian will be responsible for all collection costs and/or attorney fees.

By signing this, you acknowledge reading and understanding the financial policy and insurance nomenclature.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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