Maria Andino, MATCM, L.Ac.

PATIENT DATA (CONFIDENTIAL)

(PLEASE PRINT)

LAST NAME:_____FIRST NAME_____M/F

ADDRESS:_____

CITY:_____STATE:____ZIP:_____ HOME PHONE:_____

WORK or CELL PHONE:_____ E- MAIL_____

DATE OF BIRTH_____ REFERRED BY_____

EMERGENCY CONTACT:_____

CONTACT #:_____

DO YOU GRANT PERMISSION FOR YOUR EMAIL TO BE USED SEND YOU INFORMATIONAL AND/OR PROMOTIONAL INFORMATION? YES NO

PARTNER STATUS: SINGLE MARRIED DIVORCED WIDOWED IN RELATIONSHIP

OCCUPATION:_____ HEALTH INS. CARRIER:_____

GROUP #_____ MEMBER#_____

MEDICAL DOCTOR:_____

OTHER PROVIDERS:_____

MEDICAL HISTORY

What would like to address regarding your health? _____

_____

Have you seen another health professional to address your concerns? Y N
When?_____Any treatment provided? Y N

When did you first notice this problem: _____

_____

How did it originally occur?

_____

How has it progressed recently? ___Same ___ Improving ___Getting Worse

How frequent is the condition? ___Constant ___Frequently ___Intermittent ___Occasionally

Please place an "X" on the line below to indicate the level of your problem.

No Symptoms ←——————————————→ Extreme Symptoms

Does anything relieve the problem? No ___Yes. Please list._____

_____

Does anything make it worse? No ___Yes. Please list._____

_____

_____

Please list any currently prescribed medications? _____

For what conditions? _____

CURRENT MEDICAL HISTORY (con't.)

Please list any current vitamins/supplements? _____

Please list drugs used for non-medical purposes _____

Height _____ Current Weight _____lb. Maximum Weight _____lb. When? _____

Any food intolerances?_____

How many glasses/cups do you drink each day OR week of the following? (please indicate)

Water D___/W___ Soda D___/W___ Coffee/Tea/Energy Drinks D___/W___ Alcohol D___/W___

How much do you consume (servings per day OR week)? (please indicate)

Meats D___/W___ Sugar/Sweets D___/W___ Dairy/Milk/Cheese/Yogurt D___/W___

Vegetables D___/W___ Fruits D___/W___ Grains D___/W___ Fish D___/W___

Are you always thirsty? Y N When is your thirst strongest? AM __ MIDDAY ___ PM_____

What temperature drinks do you prefer? HOT___ COLD____ ROOM TEMP_____

Taste Preferences (Indicate 1-5; 1 = Favorite; 5 = Dislike)

Salty_____ Sour_____ Bitter_____ Sweet_____ Spicy_____

Do you or did you smoke? Y N How many packs a day OR week?_____ Number of years ____

How often do you exercise per week? _____ What type of exercise?_____

How many hours of sleep do you get per night? _____ Do you wake during the night? Y N

If so, are you able to go back to sleep? Y N Do you wake rested? Y N

What is your energy level during the day? High Low Moderate Varies

Please mark with a C for current issue or P for Past issue:

Headache on: Front Temple Side Back Top __Dizziness __Fainting __Fatigue/weakness __Anxiety __Easily Angered __Depressed __Blurred Vision __Eye Pain __Tinnitus HI LO __Hearing loss __Trouble swallowing __Dry Mouth/Throat __Thirst HI LO __Bleeding Gums __Bruises Easily __Diabetes __Stroke	__Cancer __Chest Pressure/Pain __Blood Pressure HI LO __Palpitations __Excessive Sweating __Hot Flashes __Trouble breathing __Cough __With blood __Phlegm clear/colored __Frequent colds __Nasal Congestion __Allergies __Hives/Rashes __New/change in mole __Cold hands/feet __Breast Pain __Breast Lump __Swollen Glands __Liver Disease	__Lung Disease __Kidney Disease __Heart Disease __Upper/lower Abdominal Pain __Gas/Bloating __Nausea/Vomiting __Heartburn/Reflux __Increase/ Decrease in Appetite __Diarrhea __Loose Stools __Constipation Stools per day ____ __Incontinence __Urinary Pain __Frequent urination __Waking at night to urinate __Blood in urine/stool	**FOR WOMEN ONLY** __Pregnant # of Pregnancies __ # of Births __ Age at onset of 1st period ____ Date of Last Period_____ Age at Menopause _____ Regular Cycle Y N # of days in cycle _____ Avg. Days of Flow _____ __PMS Flow Heavy Normal Light Color _____ __Bleeding not related to cycle __ Vaginal Discharge __ Genital sores __ Contraception __ Type_____ __ GYN diagnosis _____ _____ _____ _____

Please mark with a C for current issue or P for Past issue:

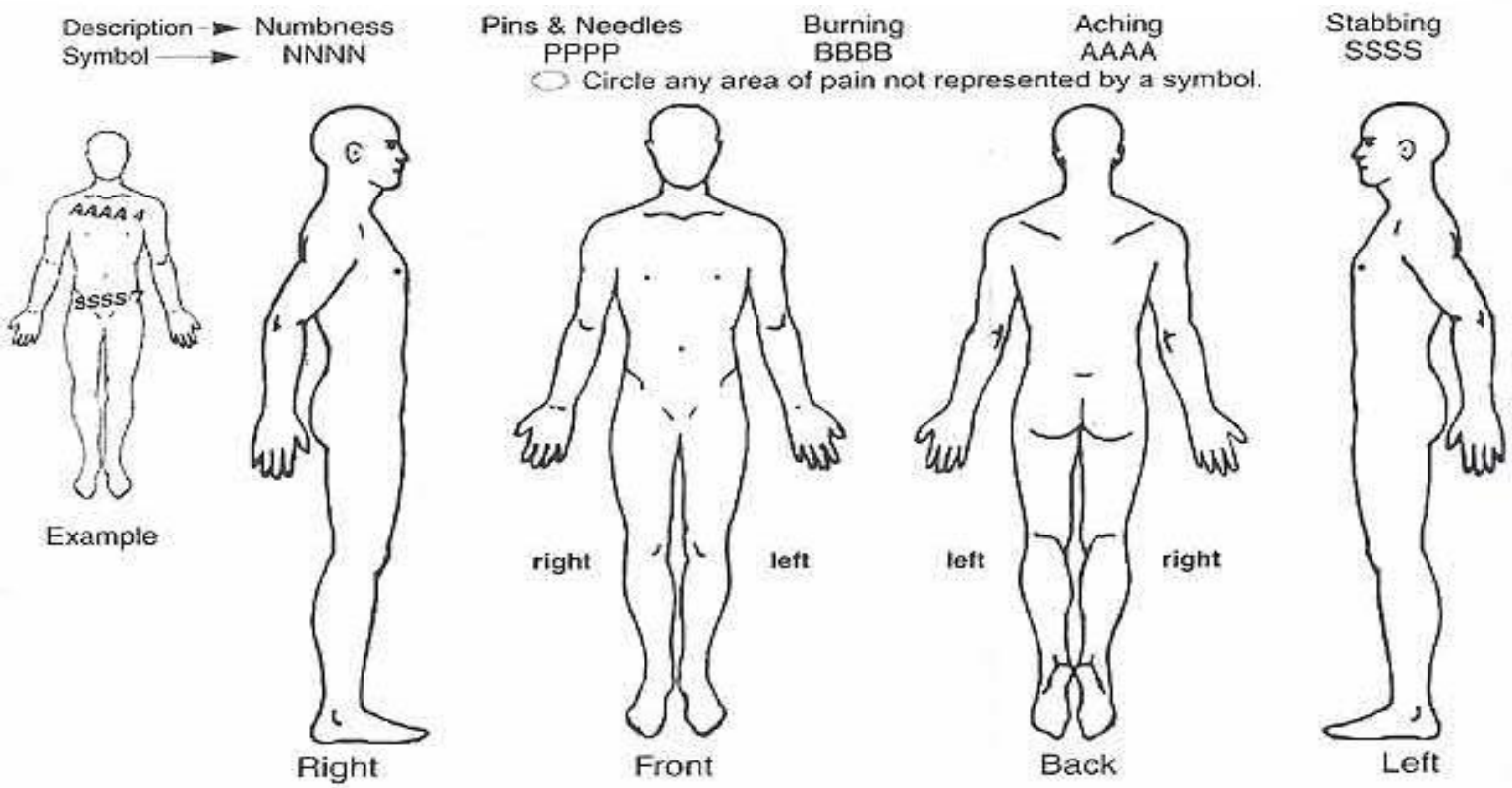
FOR MEN ONLY

___Testicular Pain ___Testicular Mass ___Penile Discharge ___ Erectile Dysfunction
____ Premature Ejaculation ___Prostate Enlargement ___Genital Sores ___Hernia

BODY ACHES/CONCERNS

___Arthritis ___ Joint Pain ____ Joint Swelling _____ Joint Stiffness ____Swollen Limbs
_____Numbness _____ Cramping _____Joint Weakness _____Hot/Cold Limbs

Using the letters noted below in the diagram, please indicate any areas where you are currently experiencing pain on the figures in the diagram.



Please list any surgeries, hospital stay or significant injuries below.	
DATE	Surgery or Reason for Hospital Stay or Significant Injury

FAMILY MEDICAL HISTORY Please indicate any conditions that run in your family and use the letter for the family member : **G**randparent, **F**ather, **M**other, **S**ister, **B**rother, **A**unt or **U**ncle:

_____Diabetes	_____Cancer	_____Mental Illness
_____Stroke	_____Asthma	_____Kidney Disease
_____ Obesity	_____Arthritis	_____Liver Disease
_____Heart Disease	_____Lung Disease	_____High Blood Pressure

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact us at (818) 275-2444

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to perform medical investigations or for other treatment purposes. For example, a doctor treating you may need to know if you are on any herbs that may interfere with a specific drug. We may provide that information to a physician treating you at another institution.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicaid agency, or a third party. For example, we may need to give your health insurance plan information about your office visit so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicaid agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

Research. There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medical treatment over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to an order issued by a court or administrative tribunal. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are the victim of a crime and we are unable to obtain your consent;
- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Such releases of information will be made only after efforts have been made to tell you about the request and you have time to obtain an order protecting the information requested.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have certain rights to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of your health information, we may charge a fee for the costs of locating, copying, mailing or other supplies and services associated with your request.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing.

We may deny your request for an amendment if it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing. Your request must state a time period that may not be longer than six years. The first list of disclosures you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a

list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you could ask that access to your health information be denied to a particular member of our workforce who is known to you personally.

While we will try to accommodate your request for restrictions, we are not required to do so if it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice at our website: www.mariaandinolac.com.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on our website and make a copy available in our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

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 document, Maria Andino, L.Ac. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name or Legal Guardian (PRINT) Date