Notice of Privacy Practices Acknowledgement

A record of the health care services that we provide to you is used and disclosed by this office when providing you with treatment, collecting payments for treatment provided to you and in other health care operations.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, our obligations in protecting your health information and your rights regarding the information contained in your medical record.

We will not use or disclose the information contained in your record in any way that is inconsistent with the policies detailed in our current Notice of Privacy Practices.

If you have questions or would like additional information about this notice, please notify our office.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

__________________________________________  __________________________  __________________________
Signature of patient or legally authorized individual  Date  Time

__________________________________________  __________________________
Printed name if signed on behalf of patient  Relationship to patient (parent, legal guardian, etc.)

This form will be retained in your medical record.
Informed Consent for Treatment

Traditional Chinese Medicine includes various modalities such as acupuncture, herbology, tuina, massage cupping, guasha, moxibustion, acupressure, warming, and other types of hands-on healing, as well as electric stimulation to filaments and infrared cold laser. These ancient oriental techniques utilize a natural system of healing within the body.

I, the undersigned, hereby authorize the licensed staff of the Acupuncture & Healing Arts Medical Group to perform the above listed modalities, including acupuncture procedures induced by the insertion of sterile, single-use needles/filaments into the underlying tissues at certain indicated points on the surface of the body. The nature, consequences, and potential risks and benefits of these procedures have been explained to me.

POTENTIAL RISKS: Discomfort at the insertion site of the needle, bruising, weakness, fainting, nausea, and possible short term aggravation of symptoms existing prior to acupuncture treatment.

POTENTIAL BENEFITS: To allow for drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures. I understand these techniques are not a substitute for conventional medical care. I realize that no guarantees have been given to me regarding cure or improvement of my condition and that no treatment program is effective for everyone.

I understand that I am free to discontinue my treatment at any time. I also understand that my medical and/or clinical records will be kept confidential and only disclosed with my permission or summarized anonymously. (initial ________)

I hereby authorize the licensed staff of the Acupuncture and Healing Arts Medical Group to verify my history or condition with my physician, if required, and to release my medical records to my insurance company if they so require in order to honor my insurance claim.

Payment is due at the time services are rendered. First appointment fees are $140 for adult acupuncture (over the age of 15), $50 for pediatric (under the age of 15), and $50 for herbal consultation. Follow up appointment fees are $75 for adult acupuncture (over the age of 15), $40 for pediatric (under the age of 15), and either $50 or $25 for herbal consultation, depending on the length of the visit. Herbal preparations are additional.

We require 24 hour notice given to change or cancel your appointment. We understand emergency situations but otherwise you will be charged for the missed visit. Please do not wear colognes, perfumes, or scented lotions to the office.

Welcome as a new client. We greatly appreciate your cooperation and look forward to treating you.

Print Patient Name ____________________________ Date __________________

Patient/Guardian Signature __________________________________________
NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help you with your health care or with payment for you health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our offices to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations... or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive it electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA: The U.S Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201

toll free 877-696-6775
Name ________________________________________________________________

Allergies ______________________________________________________________

List all medicines, herbs, remedies, and supplements used in the last 2 months.

<table>
<thead>
<tr>
<th>Medicine/herb/supplement Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

List all Doctors and Therapists you have seen in the last 2 years.

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
4. ____________________________________________
5. ____________________________________________
6. ____________________________________________
7. ____________________________________________
Musculoskeletal
- Muscle pain
- Muscle spasms, cramps, tension
- Swollen joints
- Joint pain
- Muscle weakness
- Osteoporosis
- Fractures/broken bones
- Arthritis
- Leg cramps
- Bone pain
- Neck pain
- Gout
- Joints make noise
- Joint replacement
- Whiplash
- Pain down legs
- Bone problems
- Trembling, terrors
- Back pain
  - Upper
  - Mid
  - Lower
- Numbness, tingling
- Disc problems

No pain
Mildly
Annoying
Nagging,
uncomfortable
Distressing,
miserable
Intense,
horrible
Worst possible,
unbearable
Current level of pain 0 1 2 3 4 5 6 7 8 9 10

Are you physically active on a regular basis? yes / no  
Type of exercise: ___________________________ 
How long: ___________________  
How often: ___________________

Neuro/Emotional/Psychological
- Seizures
- Areas of numbness
- Concussion
- Worry a lot
- Depression
- Anxious/nervous
- Feel overwhelmed
- Poor memory
- Unusual fears
- Forgetful
- Agitation
- Decisions difficult
- Lose temper easily
- Easily stressed
- Feel unhappy
- Work/family problems
- Poor concentration
- Fatigue
- Considered suicide
- Attempted suicide
- Treated for emotional problems
- Repeated thoughts
- Disorientation
- Mood swings
- Drug addiction
- Inability to focus on tasks
- Hold a grudge
- Fearful
- Hyperactivity
- Dull thinking
- Stroke
- Paralysis
- Pessimistic
- Optimistic
- Perfectionist
- Motivation low
- Motivation normal
- Motivation high

Please use the diagram to indicate where you feel pain or symptoms
<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Gastrointestinal</th>
<th>Genitourinary</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Hiatal hernia</td>
<td>Burning/pain with urination</td>
<td>Ovarian cysts</td>
<td>Testicular pain</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>IBS</td>
<td>Unable to hold urine</td>
<td>Vaginal infections</td>
<td>Penile pain</td>
</tr>
<tr>
<td>Coughing blood</td>
<td>Acid reflux</td>
<td>Wake up to urinate</td>
<td>Last menstrual period</td>
<td>Genital itch</td>
</tr>
<tr>
<td>Asthma</td>
<td>Indigestion</td>
<td>Frequent urination</td>
<td>Number of births</td>
<td>Sexually active</td>
</tr>
<tr>
<td>TB</td>
<td>Bad breath</td>
<td>Weakened urine stream</td>
<td>Premature births</td>
<td>Prostate enlargement</td>
</tr>
<tr>
<td>Tight chest</td>
<td>Constipation</td>
<td>Cloudy urine</td>
<td>Miscarriages</td>
<td>Nocturnal emissions</td>
</tr>
<tr>
<td>Wheezing or gasping</td>
<td>Diarrhea/loose stool</td>
<td>Kidney urine</td>
<td>Age of first menses</td>
<td>Hernia</td>
</tr>
<tr>
<td>Dry cough</td>
<td>Stomachache</td>
<td>Kidney stones</td>
<td>Duration of periods</td>
<td>Loss of erection, impotence</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Pain/cramps</td>
<td>Dribble urine with aneese</td>
<td>Last mammogram</td>
<td>Nocturnal emissions</td>
</tr>
<tr>
<td>Seasonal allergies</td>
<td>Rectal pain/itch</td>
<td>Difficulty or slow starting stream</td>
<td>Fibroids</td>
<td>Prostate enlargement</td>
</tr>
<tr>
<td>Frequent colds</td>
<td>Bloody stools</td>
<td>Kidney infections</td>
<td>Water retention</td>
<td>Nocturnal emissions</td>
</tr>
<tr>
<td>Emphysema</td>
<td>Black stools</td>
<td>Bladder infections</td>
<td>Abortions</td>
<td>Hernia</td>
</tr>
<tr>
<td>Excessive phlegm</td>
<td>Gall bladder problems</td>
<td>Difficulty breathing when lying down</td>
<td>Sexually active</td>
<td>Loss of semen during the day</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Colon problems</td>
<td>How many pillows used?</td>
<td>Other surgeries</td>
<td>Premature ejaculation</td>
</tr>
<tr>
<td>Difficulty breathing when lying down</td>
<td>ST problems</td>
<td></td>
<td>Sexual drive increased</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemorrhoids</td>
<td>Recent weight loss/gain</td>
<td>Sexual drive depressed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of daily BMs</td>
<td>Laxative use</td>
<td>Children (names/ages)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe your usual flow

| | | | | |
| | | | | |

Women:
- Vaginal burning/itching
- Vaginal discharge
- Yeast
- Vaginal soreness
- Itch
- Vaginal bleeding before periods
- Number of pregnancies
- Endometriosis
- Change in flow
- Ovarian cysts
- Vaginal infections
- Last menstrual period
- Number of births
- Premature births
- Miscarriages
- Age of first menses
- Duration of periods
- Last Pap
- Last mammogram
- Fibroids
- Water retention
- Abortions
- Sexually active
- Irregular menses
- Clots
- Painful menses
- Birth control
- Now pregnant
- Breast lumps
- Breast tenderness/pain
- Breast discharge
- Hysterectomy
- Menopausal
- Other surgeries
- Sexual drive increased
- Sexual drive depressed
- PMS
- Change in body/psych prior to menstruation
- Hot flashes
- HRT
- PID
- Herpes
- Gonorrhea
- Syphilis
- Children (names/ages)

Men:
- Testicular pain
- Penile pain
- Genital itch
- Sexually active
- Prostate enlargement
- Hernia
- Loss of erection, impotence
- Nocturnal emissions
- Herpes
- Gonorrhea
- Prostatitis
- Loss of semen during the day
- Premature ejaculation
- Syphilis
- Sexual drive increased
- Sexual drive depressed
- Children (names/ages)
## Physical Symptoms
Please check all symptoms you have experienced during the past 6 months. Circle those that have been the most troublesome.

### General
- Poor Endurance
- Sleep (Avg ___ hrs)
- Insomnia
- Wakens easily
- Unable to fall asleep
- Heavy Sleep
- Unable to stay asleep
- Dream disturbed sleep
- Nightmares
- Localized weakness
- Awaken fatigued
- Poor appetite
- Heavy appetite
- Gnawing hunger
- Food cravings
- Peculiar tastes/smells
- Change in appetite
- Obesity
- Recent weight loss/gain
- Tire easily
- Fevers
- Chills
- Cold back
- Cold abdomen
- Sweat easily
- Excessive sweating
- Lack of perspiration
- Night sweats
- Sudden energy drop @___ time
- Fatigue
- Vertigo
- Chills easily
- Low fever, late afternoon or evening
- Blood transfusion
- Cold hands/feet
- Poor coordination
- Jaundice
- Anemia
- Tremors
- Aversion to talking
- Strong thirst cold/hot drinks
- Bleed or bruise easily (where? Mitral valve)
- Cuts bleed excessively
- Takes afternoon rests/naps
- Most energized in the am
- Most energized in the pm
- Prolonged recovery following illness

Overall energy level: □ very high □ high □ medium □ low □ very low

### Skin & Hair
- Rushes
- Eczema
- Ulcerations
- Psoriasis
- Fingernail problems
- Hair/skin changes
- Pimples/boils
- Purpura
- Warts/growths
- Hives
- Boils
- Danduff
- Itching
- Fungal infections
- Loss of hair
- Cracks
- Shingles
- Dry hair/skin
- Brittle hair
- Limp hair
- Painful scars
- Lumps or bumps
- Pasty/pale complexion
- Other hair/skin problems

### Head
- Dizziness
- Concussions
- Migraines
  - When? ___
  - Where? ___
- Headaches
- Paralysis
- Eye strain
- Color blindness
- Eye pain/itch
- Cataracts
- Spots in eyes/floaters
- Eyes watering
- Double vision
- Blurry vision
- Dry eyes
- Poor vision
- Night blindness
- Glaucoma (pressure in eyes)
- Ringing in ears
- Poor hearing
- Frequent head colds
- Earaches
- Loss of balance
- Mucus
- Ear drainage
- Hoarse voice
- Loss of taste
- Loss of smell
- Facial pain
- Mouth/flip sores
- Jaw clicks
- Sinus infections
- Sneezing spells
- Teeth problems
- Loss of teeth
- Teeth hurt
- Sore/bleeding gums
- Bad taste in mouth
- Dry throat
- Dry mouth
- Loose teeth
- Bad breath
- Difficulty swallowing
- Nasal congestion
- Glasses
- Recurrent sore throat
- Grinds teeth
- Sore tongue
- Facial pain/itch
- Excess saliva
- Stuffy/runny nose
- Nose bleeds
- Sinus pressure
- Sinus congestion
- Post nasal drip

### Cardiovascular
- High blood pressure
- Low blood pressure
- Chest pain/pressure
- Rapid heart beat
- Blood clots
- Palpitations
- Irregular heart beat
- Heart attack
- Heart murmur
- Pacemaker
- Fainting
- High cholesterol
- Vascular spiders
- Leg cramps
- Swelling in hands/feet
- Varicose veins
- Blood disorder
- Raynaud's disease
- Skipped heartbeats
- Phlebitis (inflamed veins)
- Mitral valve prolapse
### Patient Intake Form

**Date:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Male/Female</th>
<th>Date of Birth</th>
<th>Marital Status</th>
<th>Are you pregnant?</th>
</tr>
</thead>
</table>

**Street Address**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>E-mail</th>
</tr>
</thead>
</table>

**Occupation**

<table>
<thead>
<tr>
<th>Employer</th>
<th>Have you had acupuncture? Y N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Physician</th>
<th>Last date MD consulted</th>
<th>Emergency contact name</th>
<th>Emergency contact phone number</th>
</tr>
</thead>
</table>

**What is your present complaint/concern?**

________________________________________________________________________________________

** Significant Past Illnesses**

- Cancer
- Thyroid Disease
- Rheumatic Fever
- High Blood Pressure
- Diabetes
- Seizures
- Chicken Pox
- Meniere's
- HIV+
- CFS/EBS
- Stroke
- Mumps
- Heart Disease
- Epilepsy
- Measles
- Mono
- Fibromyalgia
- Hepatitis
- Hypoglycemia
- Polio

**Other Illnesses:**

________________________________________________________________________________________

**Surgeries (include procedure and date)**

________________________________________________________________________________________

**Significant Traumas (include auto accidents, falls, broken bones, etc.)**

________________________________________________________________________________________

**Family Medical History**

Please indicate Mother, Father, Sister, or Brother

<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis M F S B</td>
<td>Obesity M F S B</td>
<td>High Blood Pressure M F S B</td>
<td>Other M F S B</td>
<td>Allergies M F S B</td>
<td>Thyroid Problems M F S B</td>
<td></td>
</tr>
</tbody>
</table>

**Habits**

- Cigarettes
- Coffee
- Tea
- Cola
- Drugs
- Sugar
- Alcohol
- Salt
- Other

**Do you have any infectious diseases?** Y N If yes, please identify ____________________________

**Height:** ___________ **Weight:** Currently ___________ **Past Maximum:** ___________ When? ___________

**Blood Pressure:** What is your most recent blood pressure reading? ___________/ ___________

When was this reading taken? ___________