Consultation Form

First Name (Print) _____ Last Name (Print) _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip Code _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

E-mail address _____ Date _____

Referral _____ Nationality _____ Occupation _____

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them *directly opposite* on the right side. Be sure to mention any drugs, vitamin supple ments, or other medicinal substances you are taking.

Complaints:	How long have you had it?	Treatment:

Brief Health History: (list major diseases, surgeries, etc.)

How many times per year do you get a cold or the flu?_____

Family Medical History:

What other medication and/or supplements are you taking? How long have you taken them?

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Emotions: ____**Normal** ____**Problem**

____Depression ____Sadness ____Panic attack ____Sensitive

____Worries ____Overly excited ____Angry ____Anxiety

Describe:_____

Energy: ____**Normal** ____**Problem** ____Low ____Up and down

____Exhausted ____Hyperactive ____Nervous energy ____Abundant

Describe:_____

Sleep Pattern: ____**Normal** ____**Insomnia**

Falling Asleep: ____Sometimes difficult ____Always difficult ____Sometimes very difficult

____Always very difficult ____Sleepy in daytime ____Take naps

Waking up: ____Times per night ____Wake up too early

____Wake up at night and cannot go back to sleep again

Sleep Quality: ____Deep ____Light ____Poor ____Many dreams

____Bad dreams ____Grinding teeth ____Talking in sleep ____Other

Describe:_____

Diet: Any special diet?

____**Food cravings**: ____Sugar ____Salt ____**Food allergies**

Describe:_____

Temperature: ____**Normal** ____**Abnormal**

____Feel cold easily ____Cold hands ____Cold feet ____Feel hot easily

____Alternating hot & cold ____Hot flash ____Sensitive to weather changes

Describe:_____

Sweating: ____**Normal** ____**Abnormal** ____Too easily ____Too much

____Difficult ____Too little ____Night sweats ____Other

Describe:_____

Sensitivity and Allergy: ____**No** ____**Yes**

Temperature: ____Cold ____Hot ____Dampness ____Light

____Noise ____Airborne particles ____Drugs ____Other

Describe:_____

Appetite and Digestion: ____**Normal** ____**Abnormal**

____Rapid hungering ____Poor appetite ____Nausea ____Anorexia

____Hungry, but no desire to eat ____Bloating ____Gas ____Other

Describe:_____

Bowel Movement: ____**Normal** ____**Abnormal** ____**Time of day**

____Constipation ____Diarrhea ____Loose ____Watery ____Incomplete

____Hard and dry ____Strong smell ____With mucus ____With blood ____Other

Describe:_____

Body Weight: ____**Normal** ____**Overweight** ____**Underweight**

If overweight: ____How many pounds would you like to lose?

____How many years ago did you first start to gain weight?

____Are you following a weight control program at this time?

Describe:_____

Drinking: ____**Normal** ____**Abnormal**

____Thirsty ____Dry mouth ____Drink a lot

____Dry mouth but no desire to drink

____Not thirsty, but drink a lot of water anyway

Describe:_____

Urination: ____**Normal** ____**Abnormal**

____Frequent ____Urgent ____Burning ____Painful ____Cloudy

____Dark color ____Foul smell ____Bloody ____Difficult ____Retention

____Number of time per day ____Number of times you get up to urinate at night ____Other

Describe:_____

Eye, Ear, and Nose: ____**Normal** ____**Abnormal**

Describe:_____

Sex Function: ____**Normal** ____**Abnormal**

Describe:_____

Menstrual Cycle: Age of onset: _____years old Date of last period: ____/____/

____**Regular** ____**Irregular** ____How many days between cycles?

____How many days did it last?

Color: ____Pale red ____Dark red ____Bright red ____Purplish

Were there clots? ____Yes ____No

Menstrual Pain: ____Yes ____No

____Before flow ____During flow ____After flow

____Abdomen ____Back ____Breast

Emotion around period: ____Normal ____Abnormal

____Before flow ____During flow ____After flow ____Depression

____Irritability ____Anger ____Sadness ____Crying ____Other

Describe:_____

Addictions: ____Tobacco ____Alcohol ____Others

Describe:_____

Any other disorders or abnormalities:

Describe:_____

Patient's First Name:_____

Last Name:_____

Notice of Privacy Practices

I. Understanding Your Health Record/Information

Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, a record of your visit is made. Typicality, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment This information, often referred to as your health or medical record, serves as a:

a) basis for planning your care and treatment
b) means of communication among the many health professionals who contribute to your care
c) Legal document describing the care you received
d) means by which you or a third-party payer can verify that service billed were actually provided
e) a tool for educating health professionals
f) a source of data for medical research
g) a source of information for public health officials charged with Improving the health of the nation
h) a source of data for facility planning and marketing
i) a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information ls used helps you to:
    1) ensure its accuracy
    2) better understand who, what, when, where, and why others may access your health information
    3) make more Informed decisions when authorizing disclosure to others

II. Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

a) request a restriction on certain uses and disclosures of your information
b) obtain a paper copy of this Notice of Privacy Practices upon request
c) inspect and obtain a copy of your health record
d) amend your health record under certain circumstances
e) obtain an accounting of disclosures your health Information
f) request communications of your health Information by alternative means or at alternative locations
g) revoke your authorization to use or disclose health information except to the extent that action has already been taken

III. Our Responsibilities

This organization is required to:

a) maintain the privacy of your health Information
b) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
c) abide by the terms of this notice
d) notify you If we are unable to agree to a requested restriction

e) accommodate reasonable request you may have to communicate health Information by alternative means or at alternative locations.

We reserve the right change our practices and to make the new provisions affective for all protected health Information we maintain. Should our information practices change, we will mail a revised notice to the address you supply to us.

We will not use or disclose your health information without your authorization, except as describe in this notice.

IV. For More Information or to Report a Problem

If have questions and would Iike to have additional information, ask your provider for clarification. If you believe your privacy rights have been violated, you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. You can find the Office for Civil Rights for your state at: http://www.hhs.gov/ocr/ragmall.html. There will be no retaliation for filing a complaint.

V. Examples of Disclosures for Treatment, Payment and Health Operations

Needless-to-say, we will disclose your protected health information in communications with you. For example, we may use and disclose health Information to contact you as a reminder that you have an appointment for treatment here, or to tell you about or recommend possible treatment options or alternatives that might be of interest to you. We may use and disclose health information about you to tell you about health-related benefit or services that might be of interest to you. Other reasons to disclose your health information include the following.

1) We will use your health information for treatment.

For example: Information obtained by your practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his or her expectations of any other members of your healthcare team. Those tam members will then record the actions they take and their observations. In that way, the practitioner will know how you are responding to treatment.

2) We will use your health Information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Patient's First Name:_____

Last Name:_____

Acknowledgement of Receipt of Notice of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:
- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object
- **a)** To you
- **b)** As required by federal, state, or local law
- **c)** If child abuse or neglect is suspected
- **d)** Public health risks (for public health activities to prevent and control spread of disease)
- **e)** Lawsuits and disputes (in response to a court or administrative order)
- **f)** Law enforcement (to help law enforcement officials respond to criminal activities
- **g)** Coroners, medical examiners and funeral directors
- **h)** Organ or tissue donation facilities if you are an organ donor
- **i)** To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
- **a)** Right to inspect your health record and to receive a copy of your health record upon request
- **b)** Right to amend information in your health record you believe is inaccurate or incomplete
- **c)** Right to know to whom we have disclosed your health information
- **d)** Right to ask for limits on the health information data we give out about you
- **e)** Right to receive communication from us about your health information in alternate ways
- **f)** Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Patient/Guardian Signature:_____ Date:_____

Patient's First Name:_____

Last Name:_____

Consent to Treatment

I understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, QI Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or If I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which l have acknowledged receipt.

l understand that I can discuss risks and benefits further with my practitioner before signing lf I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient/Guardian

Signature: _____ Date: _____