Star Acupuncture Clinic

Sara Pamela Star, L.Ac.
1906 D St, Iowa City, IA 52245
111 First Avenue NW, Mt. Vernon, IA 52314
(319) 895-6488

Welcome to Star Acupuncture Clinic. In order to provide you with the best possible care, please complete this entire form regarding your health so that we may form a successful and long-term working relationship. Your information provided here will remain confidential. Thank you and I look forward to working with you.

Sara Pamela Star, Licensed Acupuncturist

BASIC INFORMATION

Date: _____

Name: _____ Date of Birth (mm/dd/yy): ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): (____)_____ Work/Cell: (____)_____

Email address: _____

Please indicate preferred way of contact (circle): email | home | work/cell | best time: _____

Education: _____ Occupation: _____ Employer: _____

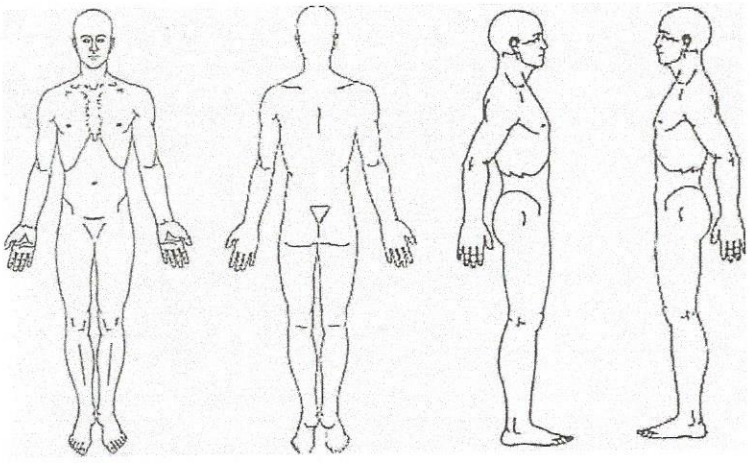
Status (circle): Single | Married | Partnership | Divorced | Separated | Widowed

Live with (circle): Alone | Spouse | Partner | Children | Parents | Friends

Emergency Contact: _____ Relationship to you: _____

Phone: (____) _____ Address: _____

First time to acupuncture? (circle): Y | N How did you hear about my clinic: _____



Reason for visit today. What are your most important health problems? List and draw your concerns in order of importance.

1.

2.

3.

Medical History

Please List any current medical diagnosis: _____

_____

Allergies (medication, foods, environmental): _____

Do you have a pacemaker or metal implants? (circle) Y | N
Do you have any known contagious disease? (circle) Y | N If yes, describe: _____

Please list any previous major illness, trauma, surgery, or hospitalization:

Illness, Trauma, Surgery, Hospitalization List	Year

Please list any prescription medications, vitamins, and supplements: (including birth control and over the counter medications)

Name + Dosage	For what condition	Starting date

Family history (circle and indicate your relationship to this first degree relative):

Heart disease _____
Diabetes _____
Kidney disease _____
Asthma _____
Eczema _____
High cholesterol _____
Stroke _____
Arthritis _____
Glaucoma _____
Epilepsy _____
High blood pressure _____
Cancer _____
Anemia _____
Mental illness _____
Hay fever/Hives _____
Other relevant family history: _____

Brief Symptom Rating Scale (BSRS-5)

Your emotions affect your health in many ways. Please take a moment to reflect the following items during the past week, including today. Please circle the number that best describes you.

	none	minor	moderate	often	extremely
Feeling of tension and unease	0	1	2	3	4
Easily distressed or angered	0	1	2	3	4
Feeling blue and sad	0	1	2	3	4
Feeling inferior to others	0	1	2	3	4
Difficulty with sleep	0	1	2	3	4

Total score: /20

Review of Systems

Please put a "C" if condition is current, "P" if you had it in the past:

General
___ Trouble sleeping
___ Significant weight gain
___ Significant weight loss
___ Fatigue
___ Fever
___ Chills

Mind
___ Poor sleep
___ Dreams / nightmare
___ Insomnia
___ Irritability
___ Depression
___ Anxiety
___ Mood swings
___ Poor memory

Head & Neck
___ Headache / Migraine
___ Stiff neck / Neck pain
___ Head injury
___ Fainting spells
___ Swollen glands

Ears
___ Ringing in the ear
___ Hearing loss / hearing aid
___ Ear infection
___ Ear ache

Eyes
___ Vision loss / change
___ Glasses / contact lenses
___ Blurred or double vision
___ Floaters
___ Poor night vision
___ Glaucoma
___ Cataract

Nose / Throat/ Mouth
___ Sinus infection
___ Allergies / Hay Fever
___ Sore throat
___ Dry mouth
___ TMJ (jaw pain)
___ Gum disease
___ Dentures
___ Mouth or Tongue sores

Skin
___ Rashes
___ Lumps
___ Eczema / psoriasis
___ Dry skin
___ Color changes
___ Hair and nail changes

Respiratory
___ Shortness of breath
___ Asthma / Wheezing
___ Cough
___ Cough Sputum
___ Cough Blood
___ Painful breathing
___ Smoking 1st hand/ 2nd hand

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Chest pain or tightness
___ History of heart attack
___ Palpitation / irregular beat

Gastrointestinal
___ Poor appetite
___ Nausea / Vomiting
___ Acid reflux
___ Gas and bloating
___ Loose stool
___ Constipation
___ Hemorrhids / rectal bleeding
___ Gall bladder disorder
___ Yellow eye or skin

Genito-Urinary
___ Urgent or Frequent urination
___ Change in urinary strength
___ Pain or burning on urination
___ Incontinence
___ Blood in urine
___ Kidney stone
___ Decreased libido
___ Impotence

Hematologic
___ Anemia
___ Easy brusing
___ Easy bleeding

Musculoskeletal
___ Joint pain / disorder
___ Weak muscles
___ Stiffness
___ Limited range of motion
___ Redness of joints
___ Swelling of joints
___ Trauma
___ Other: _____

Neurological
___ Seizures
___ Tremors
___ Numbness or tingling
___ Paralysis
___ Poor coordination
___ Decreased sensation

Infection
___ HIV risks: self or partner
___ TB: self or household
___ Hepatitis risk: self or partner
___ Sexually transmitted disease: self or partner

Endocrine
___ Heat or cold intolerance
___ Cold hands and feet
___ Night sweat
___ Hyperthyroid
___ Hypothyroid
___ Diabetes I
___ Diabetes II

Female Reproduction
Age of first menses: _____
Age of last menses: _____
Length of cycle: _____
Birthcontrol & duration:
_____
___ Heavy bleeding
___ Scanty bleeding
___ Clots
___ Painful menses
___ PMS
___ Fibroid / Endometrosis
___ Bleeding between cycles
___ Bleeding postmenopausal
Other: _____

Context of Care Overview

1. Why did you choose to come to see me as a Chinese medicine practitioner? _____

2. What expectations do you have from this visit today? _____

   What expectations do you have for me as a practitioner? _____

3. What is your present level of commitment to address any underlying causes of your signs and symptoms and that relate to your lifestyle? (circle and rate from 0 to 10 | 10 = 100 % committed)

   (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

4. What behaviors or lifestyles habits do you currently engage in regularly that you believe is
   supportive to your health? _____
   destructive to your health? _____

5. What potential obstacles do you foresee that may interfere in your ability to adhere to the therapeutic protocols that Sara Pamela will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____

7. What is it that you LOVE to do? _____

Star Acupuncture Clinic
Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Patient Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. Please review this information carefully.

Understanding your health record: A record is made each time you visit the Star Acupuncture Clinic. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information maybe used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, why others may be allowed access to your health information.

- We gather Patient History Information in several ways:
  - We receive information from you at intake and in the course of office visits.
  - We receive information from other healthcare providers.
  - We receive information from third party payers such as insurance companies.
- Your PHI is used for the purpose of treatment, payment, healthcare operations of this office and for coordination of care.
- You may specifically authorize this office to use your PHI for any purpose or to disclose your PHI to any party of your choosing by submitting the authorization in writing.

Understanding your health information rights: Your health record is the physical property of the Star Acupuncture Clinic, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restriction on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our responsibilities: The Star Acupuncture Clinic is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. The Clinic reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, the Star Acupuncture Clinic agrees not to use or disclose your health information without your authorization.

- This office may send appointment reminders by postcards, letters, telephone, or by answering machine unless you specify that we may not.
- A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
- The patient has the right to receive all notices from this office in written form.
- If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the Licensed Acupuncturist has the right to refuse to give care.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact the Star Acupuncture Clinic. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

Patient Name: _____

Patient Signature: _____ Date: _____

Star Acupuncture Clinic

111 First Avenue Northwest 1906 (S) D Street
Mt. Vernon, IA 52314 Iowa City, IA 52245

Sara Pamela Star is a practitioner of Traditional Chinese Medicine specializing in Five Elements Acupuncture, Chinese Herbology and a Feng Shui Consultant.

Sara Pameia Star obtained a Bachelor of Fine Arts degree in Art from the University of Nebraska and completed the Pre-Veterinary Medicine curriculum at Iowa State University. Sara Pamela has been involved in research during her undergraduate and graduate studies. Sara Pamela Star received a Masters of Science degree in Acupuncture and Chinese Herbal Medicine Certificate from Bastyr University in Seattle, Washington after 4 years of graduate study.

The program is comprised of 1350 hours of didactic and clinical work in Acupuncture and 1800 hours of didactic and clinical work in Chinese Herbology. Sara Pamela is a diplomate of the National Certification Commission for Acupuncture and Oriental Medicine. She is a member of the Iowa Association of Oriental Medicine and Acupuncture.

Sara Pamela Star is in full compliance with all rules and regulations promulgated by the Iowa Department of Public Health. She has never had any license, registration or certificates suspended or revoked. The practice of acupuncture is regulated by the Iowa Board of Medical Examiners, 400 S.W. 8th St. Suite C, Des Moines, IA 50309. Telephone 515-281-5171.

Star Acupuncture Clinic is a fragrance free clinic so please refrain from wearing scents.

Fees & Appointments I understand that the initial acupuncture consultation fee is $155.00 and a subsequent treatment is $88.00. A discount for seniors, students, and children is offered. All clients are asked to pay in full at the time of the treatment. 24 hour notice is required for all cancellations or you will be billed for half the visit rate. All expenses for herbal supplements are in addition to the cost of the treatment. A sliding fee scale is available based on individual circumstances.

Voluntary I hereby voluntarily consent to be treated by acupuncture. The procedure involved in the treatment has been explained to me. I understand I may be treated with the insertion of needles and/or the application of heat to the skin (moxibustion), cupping, electroacupuncture, and acupuncture. Star Acupuncture Clinic, in order to insure the safety of clients, uses only pre-sterilized, pre-packaged disposable needles. I understand that I am free to discontinue treatment at any time.

Potential Benefits/Side Effects Potential Benefits – Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention or elimination of the presenting problem. Potential Side Effects -Discomfort at the site of insertion of the needle, bruising, slight bleeding, fainting, temporary discomfort or pain and temporary aggravation of symptoms existing prior to treatment. Consultation with an appropriate physician may be indicated either in response to an emergency or as deemed necessary by the discretion of a licensed physician.

Confidentiality Confidentiality of my treatments and records will be preserved at all times.

I have read the above information and my signature endorses my understanding of the conditions. I have felt free to ask any questions regarding this process, and it has been satisfactorily explained to me.

Signature _____ Date _____

Signature _____
Of Patient
Representative
Or Guardian