INNER BALANCE ACUPUNCTURE LL
Sylvester Rich, MS LAc.

Notice of Privacy Practices

This notice together with our Practices Regarding Disclosure of Health Information, describe how health information about you may be used and disclosed. This also describes how you can gain access to your health information.
Please review this information carefully.

Understanding your health Record:
A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis, and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have spoken.

Your Health Information Rights:
Your health record is owned by the clinic, however, the content is always available to you for your review. You have the right to request a review of your file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

Our Responsibilities:
We are required to maintain the privacy of your health information and to provide you with a copy of this notice of our privacy practices. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I, _____, have received a copy of this notice of privacy practices and a copy of the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

Patient Name: _____ (please print)

Patient / Guardian Signature: _____

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Date: _____

Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent is not required in these circumstance.

Treatment – Information obtained by us will be entered into your treatment record and used in the course of your treatment. Your health information will be shared with other health practitioners as we, in the exercise of our professional judgment, deem is appropriate. Information regarding our assessment of your health and information regarding consultations, may also be retained in your file.

Payment – Your record will be used to receive payment for services. A bill or other payment information may be mailed to your home or to a third party provider. That information will likely contain diagnostic determination, practitioner impressions, and treatment procedures.

Quality Monitoring – We will use your health information to assess the care you have received and to compare outcomes. This information may also be used in conjunction with various scientific studies regarding your specific condition or Oriental Medicine itself.

The following disclosures are required by law and do not require your consent.

Food and Drug Administration (FDA) – We are required to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects, for surveillance to enable product recalls, repairs or replacements.

Workers Compensation – We will release health information to the extent required under the workers compensation law.

Public Health – We are required to disclose health information to public health entities or legal authorities responsible for tracking birth and morbidity, communicable disease, injury or disability, and matters relating to organ/cadaver donations.

Law Enforcement – we are required to provide your health information to law enforcement and professional oversight personnel under State and Federal law. Similarly, we will disclose such information in the event we believe there is a risk of harm to yourself or others.

We also consider the following uses as routine use and disclosure. If you do not want your health information used in the following circumstances, please immediately advise us in writing.

Business Associates – Professionals and others whose services we require in the normal course of our business. Examples include our accountant, lawyer, and pharmacy. We require these individuals to follow the same procedures / standards as our staff.

Communication with Family – we may contact a family member or some other person designated by you to assist them in enhancing your wellbeing.

Marketing and fundraising – we may periodically send information to you regarding treatment alternatives and other health related benefits we believe may be useful to you. We may also request your charitable support on behalf of alternative medicine research projects or other medically relating charitable events. This contact will not disclose information regarding your specific medical condition.

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Medical History

Please complete this form as part of your initial session. All information is confidential and protected under the HIPAA laws. If you have any questions, please don't hesitate to ask. If there is anything not asked on this form that you feel should be brought to our attention, please note this in the Comments section below.

Name	Home Phone	Date
Street	Cell Phone	Ht. Wt.
City	Work Phone	DoB Age
State Zip	Occupation	Education
Email	Emergency Contact	Emergency #
Marital Status	Number of Children	Religious Requirements
Referred by	Have you ever had Acupuncture before?	

Section 1 – Past Medical History (Please include dates)

@Hospitalizations (Med/Psych) _____

_____

@Significant Illnesses _____

_____

@Surgeries _____

_____

@Significant trauma (auto accidents, falls, etc) _____

_____

@Allergies (drug, chemicals, food) _____

_____

@Medicines Taken within the last two months (vitamins, OTC drugs, herbs) _____

_____

_____

@Occupational Stresses (chemical, physical, psychological, etc. _____

_____

Section 2

Exercise (types & frequency) _____

Describe your average daily diet

Habits (amount and frequency) Cigarettes _____ Coffee _____ Tea _____ Alcohol _____Drugs _____ Other_____

Family Medical History (check if applicable)

Alcoholism Drug Abuse Allergies _____

Asthma Diabetes Seizures Cancer & Type _____

Heart Disease Arteriosclerosis High Blood Pressure Low Blood Pressure Stroke

Section 3

Main Problem you would like to address (including initial cause, duration)

_____

Diagnosing physician _____Phone_____

Currently under the care of your physician for this condition? Yes ___ No ___ How Long? _____

Current Therapies & Results _____

How severe is your problem right now: 1 (minimal) – 10 (worst) _____

To what extent does this problem interfere you're your daily activities? (work, sleep, eating, sex…)

_____

What are your treatment goals?

- ☒ Temporary relief of symptoms/pain control
- ☒ Eliminate root or cause of problem (if possible)
- ☒ Maintenance care (periodic balancing / tune-up to keep in good health.

Comments:_____

_____

Signature_____**Date**_____

Who should we thank for referring you? _____

How do you **FEEL** about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments
Significant Other						
Family						
Diet						
Sex						
Work						
Exercise						
Spiritually						
Self						

Inner Balance Acupuncture

General
- — Chills
- — Fever
- — Body aches
- — Poor appetite
- — Insomnia
- — Fatigue
- — Poor Circulation
- — Cold Hand / Feet
- — Excessive thirst
- — Bodily heaviness
- — Vertigo or Dizzy
- — Weight Loss / Gain
- — Night sweats
- — Spontaneous sweating
- — Bruise easily
- — Stress
- — Other_____

Head, Eyes, Ears, Nose, Throat
- — Headaches
- — Concussions
- — Eye pain
- — Red / Itchy eyes
- — Spots in eyes
- — Poor / Burred vision
- — Night Blindness
- — Ringing ears
- — Nasal congestion
- — Sinus problems
- — Hay fever
- — TMJ pain
- — Facial pain
- — Bleeding gums
- — Sores on lips / tongue
- — Dry mouth
- — Recurrent sore throat
- — Hoarse voice
- — Lumps in throat
- — Other_____

Respiratory
- — Difficulty breathing
- — Shortness of breath
- — Cough
  Wet / dry ____
  Color _____
  Think / thin
- — Coughing blood
- — Wheezing
- — Other_____

Cardiovascular
- — High blood pressure
- — Low blood pressure
- — Chest pain
- — Tachycardia
- — Difficulty breathing
- — Palpitation
- — Irregular heartbeat
- — Phlebitis
- — Other _____

Gastrointestinal
- — Nausea / Vomiting
- — Stomach pain
- — Acid regurgitation
- — Indigestion
- — Bad breath
- — Bloating
- — Gas
- — Diarrhea
- — Constipation
- — Bloody stools
- — Black stools
- — Mucous in stools
- — Hemorrhoids
- — Laxative use
- — Intestinal pain / cramping
- — Rectal pain
- — Other _____

Musculoskeletal
Pain & weakness, numbness in:
_hands _wrist
_elbow
_shoulder _neck
_back
_hips _knee
_legs
_feet _ankle
_ Other _____

Skin and Hair
- — Rashes
- — Fungal infections
- — Eczema
- — Ulcerations
- — Hives
- — Scars
- — Acne
- — Psoriasis
- — Hair loss
- — Changes in moles

Neuro-psychological
- — Seizures
- — Numbness
- — Poor memory
- — Easily stressed
- — Irritable
- — Anxiety
- — Depression
- — Suicide thoughts / attempt
- — Other _____

Genital-Urinary
- — Frequent urination
- — Urgent urination
- — Painful urination
- — Blood in urine
- — Incomplete urination
- — Kidney stone
- — Bedwetting
- — Increased libido
- — Decreased libido
- — Impotence
- — Other _____

Gynecological
- — Irregular periods
- — Painful periods
- — PMS
- — Vaginal discharge
- — Vaginal sores
- — Other _____

OB/GYN
Age of menarche ____
Duration of flow _____
Length of cycle _____
Date of last period ____
Currently pregnant
Yes __ No __
Pregnancies _____
Live births _____
Premature births ___
Abortions/Miscarriage
_____
Date of last PAP _____
Age of Menopause ___

Diagnostic Conditions
- — AIDS
- — Alcoholism
- — Anemia
- — Anorexia
- — Arthritis
- — Asthma
- — Bleeding disorders
- — Bronchitis
- — Bulimia
- — Cancer
- — Cataracts
- — Chemical Abuse / Dependency
- — Chicken pox
- — Diabetes
- — Emphysema
- — Epilepsy
- — Glaucoma
- — Goiter
- — Gonorrhea
- — Gout
- — Heart Disease
- — Hepatitis
- — Herpes
- — High Cholesterol
- — HIV Positive
- — Kidney Disease
- — Liver Disease
- — Measles
- — Migraine
- — Mononucleosis
- — Multiple Sclerosis
- — Mumps
- — Pacemaker
- — Pneumonia
- — Polio
- — Prostate Problem
- — Psychiatric Problem
- — Rheumatic Fever
- — Seizure
- — Stroke
- — Thyroid Problems
- — Tuberculosis
- — Ulcers
- — UTI
- — Venereal Disease
- — Other _____