Clinic Registration

General Information

FULL NAME: _____ DATE: _____

DATE OF BIRTH:_____AGE:_____SEX: Male Female

ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____ HOME/CELL PHONE:_____

WORK PHONE:_____ EMAIL ADDRESS:_____

HEIGHT:_____ WEIGHT:_____

Emergency Contact Name:_____ Relationship:_____ Phone Number:_____

Do you have insurance coverage that you would like to submit? No Yes Insurance Company Name:

Has the patient had an acupuncture/massage (circle) treatment before? No Yes If so, when and for what condition?

Is the patient presently under a doctor's care? No Yes , Explain:

Are there any other therapies which the patient is receiving services? No Yes, Explain:

Demographics

What is the patient's marital status? (Please check most current status)
☐ ……Married or living with significant other
☐ ……Divorced/Separated
☐ ……Widowed
☐ ……Never been married
☐ ……..Declined to disclose

How much schooling has the patient completed? (Please check one)
☐ ……Completed less than high school
☐ ……Graduated from High School
☐ ……Completed 1-3 years of college
☐ ……Graduated from a 2-year Associate degree program or technical school
☐ ……Graduated from college
☐ ……Completed post-graduate or professional program
☐……..Declined to disclose

Please identify the patient's race, as defined by the federal government. (Please check one)
☐ ……Asian or Pacific Islander
☐ ……Black/African American
☐ ……Hispanic
☐ ……American Indian or Alaskan Native
☐ ……White
☐ ……Other _____
☐…… Declined to disclose

Primary Reason for Visit

Please tell us what the patient's primary reason for seeking care at our office?

On a scale of 0-10 how would you rate your pain? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)
What was the initial cause?

When did it begin?

Is it constant or comes and goes?

What makes it better?

What makes it worse?
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Stretching ☐Other:

This problem interferes with the patient's following daily activities?
☐Work ☐Daily routine ☐Emotional ☐Recreation ☐ Social life ☐ Relationship ☐Sleep

What services has the patient received for this condition?

Is the patient interested in?
☐Pain Relief ☐Preventative Care ☐Oriental Nutrition ☐Maintenance Care ☐Stress Relief

What are the patient's health goals?

Family Health History: Do/did any members of the patient's immediate family (mother, father, sister, brother) have any serious health conditions?
No
Yes, Please describe your relation to this individual and their condition(s)

Surgical History: Please list any surgeries the patient has had in the past and dates:

Injury History: Please list any auto, workman's compensation, or other injury or trauma with date and descriptions.

Medications, allergies, over the counter drugs or vitamins, or special diets the patient is currently taking: (Include dose, purpose and if prescribed)

Infectious Diseases and Vaccine History:

Please indicate if the patient has had the following diseases and/or vaccinated for these diseases. ☐ Up to date all vaccines

Chicken Pox	Yes	No	Vaccinated	Rotavirus	Yes	No	Vaccinated
Diphtheria	Yes	No	Vaccinated	Rubella	Yes	No	Vaccinated
Haemophilus Inf. Type B	Yes	No	Vaccinated	STD	Yes	No	Vaccinated.
Hepatitis B	Yes	No	Vaccinated	Small Pox	Yes	No	Vaccinated
Measles	Yes	No	Vaccinated	Tetanus	Yes	No	Vaccinated
Mumps	Yes	No	Vaccinated	Whooping Cough	Yes	No	Vaccinated
Polio	Yes	No	Vaccinated	Other:			
Pneumoncoccal	Yes	No	Vaccinated				

Health History

Please list or check any health problems the patient currently has or has had. Answer to the best of your knowledge.

Chronic or Acute Infectious Diseases
- ☐ Hepatitis
- ☐ HIV
- ☐ Chills
- ☐ Fever
- ☐ Sore throat
- ☐ Low energy/fatigue
- ☐ Spontaneous sweating
- ☐ Night sweating
- ☐ No sweating
- ☐ Aversion to heat/cold
- ☐ Frequent colds
- ☐ Growth disorder

Heart, Lung and Circulation
- ☐ Asthma
- ☐ High blood pressure
- ☐ Previous heart attack
- ☐ Chest pain
- ☐ Palpitation
- ☐ Irregular heartbeat
- ☐ Stuffiness in the chest
- ☐ Low blood pressure
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Varicose veins

Digestion
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Acid reflux
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Excess thirst
- ☐ Tired after eating
- ☐ Mouth or tongue sore
- ☐ Stomachaches
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Gas
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Recent change in number or consistency of bowel movements

Psychosocial
- ☐ Depression
- ☐ Anxiety
- ☐ Violence toward self/others
- ☐ Forgetfulness
- ☐ Poor memory
- ☐ Trouble concentrating
- ☐ Stress
- ☐ Irritability
- ☐ Easy to anger
- ☐ Sadness
- ☐ Crying
- ☐ Much fear

Skeleton and Joint Problems

S=Sharp Pain/stabbing
D=Dull Pain
N=Numbness
T=Tingling
R=Refers pain
A=Aching pain
B=Burning pain
- ☐ Head
- ☐ Neck
- ☐ Shoulder
- ☐ Upper back
- ☐ Arm
- ☐ Hand/finger
- ☐ Lower back
- ☐ Hips
- ☐ Leg
- ☐ Knee
- ☐ Feet/toe
- ☐ Stiffness
- ☐ Numbness
- ☐
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ General weakness
- ☐ Swelling of joints

Genitourinary
- ☐ Difficult or painful urination
- ☐ Kidney stones
- ☐ Cloudy urine
- ☐ Dark or scanty urine
- ☐ Dilute urine
- ☐ Scant urine
- ☐ Burning urination
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

Nervous system
- ☐ Headaches
- ☐ Migraine
- ☐ Dizziness
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Fainting
- ☐ Seizures
- ☐ Convulsions
- ☐ Paralysis
- ☐ Tics
- ☐ Tremors
- ☐ Balance issues
- ☐ Recent clumsiness
- ☐ Vertigo

Eyes, ears, nose and throat
- ☐ Loss of vision or hearing
- ☐ Ringing in ear
- ☐ Severe dental problems
- ☐ Vision problems
- ☐ Ear problems
- ☐ Ear infections
- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Allergies
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ TMJ
- ☐ Teeth grinding
- ☐ Teeth problems
- ☐ Cough
- ☐ Itchy or scratch throat
- ☐ Sore or painful throat
- ☐ Strep throat
- ☐ Vision see halos

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Moles that have changed
- ☐ Dry skin
- ☐ Itchiness
- ☐ Rashes/hives
- ☐ Eczema
- ☐ Bruises easily
- ☐ Acne
- ☐ Brittle nails
- ☐ Dry or brittle hair

Chronic immune system deficiencies
- ☐ Cold
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes

Sleep
- ☐ Insomnia
- ☐ Difficult falling asleep
- ☐ Waking at night
- ☐ Waking early
- ☐ Excessive or vivid dreams
- ☐ Night terrors
- ☐ Sweating at night

Exercise and Body weight
- ☐ Exercise regularly
- ☐ Exercise excessively
- ☐ Underweight
- ☐ Normal weight
- ☐ Over weight

Eating and Health habits
- ☐ Vegetarian
- ☐ Health diet
- ☐ Craves fried foods
- ☐ Craves sour foods
- ☐ Craves sweet food
- ☐ Craves salty food
- ☐ Prefer warm/cold
- ☐ Food allergies
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Drink pop/soda
- ☐ High Stress level
- ☐ Exercises regularly

Female health
- ☐ Heavy period
- ☐ Light period
- ☐ Long period
- ☐ Short period
- ☐ No period
- ☐ Irregular periods
- ☐ Bleed between period
- ☐ Painful periods
- ☐ Vaginal pain
- ☐ Painful sexual intercourse
- ☐ Pain during ovulation
- ☐ Premenstrual symptoms
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal sores
- ☐ Urinary tract infection
- ☐ Candida/yeast infection
- ☐ Use of contraceptive
- ☐ Prolapse uterus/bladder
- ☐ Low sexual energy
- ☐ High sexual energy
- ☐ C-section delivery of children
- ☐ Difficult labors
- ☐ Premenopausal
- ☐ Menopause
- ☐ Pregnant/Trying to get pregnant

Age of first menstrual period:
Date of last menstrual period:
Days of cycle:
Length of period:
Number of pregnancies:
Number of miscarriages:
Number of abortions:
Number of children:

Male Health
- ☐ Impotence
- ☐ Hernia
- ☐ Genital pain
- ☐ Genital itching
- ☐ Genital sores
- ☐ Low sexual energy
- ☐ High sexual energy
- ☐ Gout/foot fungus

Bonnie M. Abel Bolash, M.Ac., L.Ac.

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763-537-4955

Informed Consent for Treatment

I understand that Acupuncture practice is a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment. Its treatment techniques include the insertion of acupuncture needles through the skin and the use of other methods of acupuncture point stimulation, including the use of heat, Oriental massage, and electrical stimulation. Additionally, herbal supplemental therapies, dietary guidelines, breathing techniques and exercise based on Oriental Medical principles may also be used. Oriental Medicine is a healing art that perceives the circulation and balance of energy in the body as being fundamental to the wellbeing of the individual. It implements the theory through specialized methods of analyzing the energy status of the body and treating the body with acupuncture and other related modalities for the purpose of strengthening the body, improving physiological function and reducing pain.

I understand that acupuncturist do not make Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

I understand that there may be some conditions that require a referral to a licensed healthcare provider for the safety of my health, and I will cooperate if such referral is needed. The following conditions will require a referral to a licensed healthcare provider: uncontrolled hypertension; acute, severe abdominal pain; acute, undiagnosed neurological changes; unexplained weight loss or gain in excess of 15% of the body weight in less than a three-month period; suspected fracture or dislocation; suspected systemic infection; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without a previous history.

I hereby authorize Bonnie Bolash, Master of Acupuncture, Licensed Acupuncturist by the Board of Medical Practice license number 1176, to perform, diagnosis and treat according to the professional standards of Oriental medicine and professional judgment. This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures. I understand that there are possible unforeseen risks to the performance of the procedures of Oriental medicine. I have been informed that possible side effects of *acupuncture treatment* are rare and may include, but are not limited to, bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness; brief generalized fatigue or nausea; temporary worsening of some symptoms; risk of infection; needle sickness; or broken needles. *Herbal remedies* may have side effects including, but not limited to gastrointestinal disturbances. *Moxibustion* can cause burns. *Massage* can cause increased muscle soreness, spasms, bruising, and generalized fatigue or nausea and temporary worsening of some symptoms. *Electro acupuncture* may cause electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. *Cupping* therapy may cause circular bruising and blisters.

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I may make an educated decision regarding the duration and appropriateness of continuing care and that I may refuse any therapy at any time. All of my questions have been answered to my satisfaction.

Current Illness or Injury:_____

I **HAVE/HAVE NOT** (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have provided Bonnie Bolash, LAc. with an accurate diagnosis of my condition.

I **DO/DO NOT** (circle one) have a pace maker or bleeding disorder.

I AM/AM NOT (circle one) currently pregnant. Please let practitioner know if you do become pregnant.

_____ _____ _____
Patient Name or Minor Child Name Date of Birth Date

Patient Signature or Parent Signature for treatment of Minor_____

Cost for Treatment: **Evaluation** $30.00 **Acupuncture Treatment** $70.00
Acupressure Massage 30 minute appointment $40.00
updated 7/1/2016

Bonnie M. Abel Bolash, M.Ac., L.Ac.

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CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR PRIVACY PLEDGE: We are concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us. Ways that we may use or disclose your health care information include, but are not limited to:

- Another health care provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered
- The use of that information within our practice for quality control or other operational purposes.
- Business associates that we contract with to perform a service for your benefit.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, lab or imaging results, information about our clinic facilities, treatment alternatives or other health-related information that may be of interest to you.
- The use of communication including birthday cards, newsletters, emails, postcards, letters, text messages or telephone calls,

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any or your authorizations at any time; however, you revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE THE RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, OUR OFFICE WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT.

I acknowledge receipt of the Notice of Privacy Practices and I hereby give consent to Bonnie Bolash, LAc. or staff to disclose my personal health information as noted above.

_____ _____ _____
Print Patient Name or Minor Child Name Date of Birth Date

Patient Signature or Parent Signature for treatment of Minor_____

Please add my email to your email list:_____

It is okay for your office to contact me by email: _____
Signature Date: