NEW PATIENT ACUPUNCTURE INTAKE FORM

Name: ____ Date of Birth: _____________________

Emergency Contact: __________________ Phone #:_____________________ Relation: ______________

Address: ____

City: _______________________________________ State: _________________ Zip:_________________

Primary Phone #: ______________________________ Secondary #: _______________________________

Email Address: ____

Have you ever received Acupuncture before? Yes / No

What health concern(s) bring you in today? ____

____

____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was your medical diagnosis: ____

____

List any medications/supplements you are currently taking: _____________________________________

____

List any known allergies: ____

List any significant traumas (accidents, falls, injuries): ____

____

List any significant surgeries you have had:____

____

Do you have any type of bleeding disorder? Yes / No

Do you have a pacemaker? Yes / No

How many ounces of water do you drink in a day? ☐ 0-1 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ 8+

How much caffeine do you consume daily? ☐ None ☐ 1-2 ☐ 2-4 ☐ 5+

How much alcohol do you consume in a week? ☐ None ☐ 1-2 ☐ 2-4 ☐ 5+

How many hours of sleep do you get per day? ☐ 1-3 ☐ 4-6 ☐ 6-8 ☐ 8-9 ☐ 9+

How would you rate your energy levels? (Poor) 1 2 3 4 5 6 7 8 9 10 (High)

MUSCUOSKELETAL - Pain / Weak / Numb (check all that apply):

- ☐ Joints
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Shoulders
- ☐ Upper back
- ☐ Midback
- ☐ Lower back
- ☐ Pain all over
- ☐ Muscle spasms/cramps
- ☐ Joint stiffness
- ☐ Broken bones
- ☐ None of the Above

GENERAL HEALTH (Check all that apply):

- ☐ Feel too hot
- ☐ Feel too cold
- ☐ Chills/fever
- ☐ Avoid heat/cold
- ☐ Cold hands/feet
- ☐ Sweaty palms/feet
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Spontaneous sweating
- ☐ Lack of sweating
- ☐ Excessive thirst
- ☐ Lack of thirst
- ☐ Low energy
- ☐ Fatigue
- ☐ Hyper Thyroid
- ☐ Hypo Thyroid
- ☐ Weight loss
- ☐ Weight gain
- ☐ None of the above

HEAD (check all that apply):

- ☐ Concussion/Head Trauma
- ☐ Headaches/Migraines
- ☐ Jaw pain/TMJ

EYES & EARS (check all that apply):

- ☐ Impaired Hearing
- ☐ Hearing Loss
- ☐ Ringing in ears/Tinnitus
- ☐ Dizziness
- ☐ Spots in vision
- ☐ Poor night vision
- ☐ Double/blurred vision
- ☐ Eye pain/strain
- ☐ Watery eyes
- ☐ Dry or burning eyes
- ☐ Itchy eyes
- ☐ Red or inflamed eyes
- ☐ None of the Above

NOSE, THROAT, MOUTH (check all that apply):

- ☐ Sinus problems
- ☐ Nasal Obstruction
- ☐ Runny nose
- ☐ Sneezing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Mouth ulcers
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ None of the Above

SKIN and NAILS (check all that apply):

- ☐ Rashes
- ☐ Itching
- ☐ Color change of skin
- ☐ Bruise easily
- ☐ Slow wound healing
- ☐ Acne
- ☐ Boils
- ☐ Hives
- ☐ Hair loss
- ☐ Weak/brittle nails
- ☐ None of the Above

CARDIOVASCULAR (check all that apply):

- ☐ Irregular Heartbeat
- ☐ Bradycardia
- ☐ Tachycardia
- ☐ A-Fib
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Chest Tightness
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Poor Circulation
- ☐ Fainting Spells
- ☐ Blood Clots
- ☐ Swelling of ankles
- ☐ Varicose Veins
- ☐ Bleeding disorders
- ☐ None of the Above

RESPIRATORY SYSTEM (check all that apply):

- ☐ COVID-19 recovery
- ☐ Cough
- ☐ Phlegm
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing up blood
- ☐ Frequent colds/flu
- ☐ Recurrent sinus infections
- ☐ None of the Above

DIGESTIVE (check all that apply):

- ☐ Nausea
- ☐ Vomiting
- ☐ Low appetite
- ☐ Excessive hunger
- ☐ Fatigue after meals
- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Stomach ulcers
- ☐ Acid reflux/heartburn
- ☐ Diarrhea/Loose Stool
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gallstones
- ☐ Bloody stools
- ☐ Eating disorder
- ☐ Less than1BM/day
- ☐ None of the Above

URINARY TRACT (check all that apply):

- ☐ Frequent urination
- ☐ Frequent night urination
- ☐ Dribbling
- ☐ Poor bladder control
- ☐ Burning/painful urination
- ☐ Pale urine
- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Blood in urine
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Interrupted flow
- ☐ Frequent UTI
- ☐ Kidney/bladder stones
- ☐ None of the Above

PSYCHO-EMOTIONAL (check all that apply):

- ☐ Difficulty falling/staying asleep
- ☐ Vivid/disturbing dreams
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Irritability
- ☐ Anger
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Restless
- ☐ Frequent worry
- ☐ Feel sad often
- ☐ Cry uncontrollably
- ☐ Fearful often
- ☐ PTSD
- ☐ None of the Above

LIFESTYLE (check all that apply):

- ☐ Eat lots of meat
- ☐ Eat lots of processed food
- ☐ Eat/crave lots of fatty food
- ☐ Eat/crave lots of sweets
- ☐ Drink coffee
- ☐ Tobacco use
- ☐ Drink Alcohol
- ☐ Use drugs
- ☐ None of the Above

Please check any CURRENT or PAST conditions you have experienced:

- ☐ Addictions
- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bladder Disease
- ☐ Bleeding disorder
- ☐ Breast lumps
- ☐ Breathing difficulties
- ☐ Bulimia
- ☐ Bursitis
- ☐ Cancer
- ☐ Candida
- ☐ Chronic bronchitis
- ☐ Chronic fatigue syndrome
- ☐ Colitis/IBS
- ☐ Crohn's
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hernia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Hypotension
- ☐ Hysterectomy
- ☐ HIV positive
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Measles
- ☐ Mental Illness
- ☐ Migraines
- ☐ Mono
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Nephritis
- ☐ Neuralgia
- ☐ Neuropathy
- ☐ Nervous disorder
- ☐ Panic attacks
- ☐ Pneumonia
- ☐ Polio/meningitis
- ☐ Prostate problems
- ☐ Rheumatism/arthritis
- ☐ Scarlet fever
- ☐ Shingles
- ☐ Small Pox
- ☐ Stroke
- ☐ Suicidal thoughts
- ☐ Syphilis
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vein conditions
- ☐ Venereal disease
- ☐ None of the Above

WOMEN'S HEALTH HISTORY

MENSTRUATION

Age when menses began: ___________________

Menstruation lasts _____________________days

I have a:

Regular cycle of ______________days

Irregular cycle of _____to _____days

During your period, do you experience any:

- ☐ Dysmenorrhea (Cramps)
- ☐ Fatigue
- ☐ Breast tenderness
- ☐ Sleep Disturbance
- ☐ Other: ____________________________

During your period, the flow is:

Light/spotting on days ___________________

Medium on days ________________________

Heavy on days __________________________

What color is the blood?

Light Red on days ______________________

Bright Red on days _____________________

Dark Red on days ______________________

Brown on days _________________________

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N

Have you recently stopped or started birth control? Y / N

If so, when? _____________________

Are you trying to conceive? Y / N

Have you given birth in the last year? Y / N

Are you currently lactating? Y / N

Have you had any:

- ☐ High-risk pregnancies
- ☐ Difficult labor/deliveries
- ☐ Postpartum depression/concerns

MENOPAUSE

Are you perimenopausal? Y / N

Do you currently experience any:

- ☐ Night sweats/Cold flashes
- ☐ Hot flashes (daytime)
- ☐ Sleep Disturbance
- ☐ Spotting
- ☐ Other: ____________________________

Are you postmenopausal? Y / N

What year was your last period? ____________

Thank you for choosing Calla Lily Day Spa!

ACUPUNCTURE INFORMED CONSENT TO TREAT

Introductions - I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

Method of Treatment - I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

Risks - I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

Medical Changes - I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

Alternative Treatments - I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

Financial Responsibilities - The cost of an acupuncture and additional services involves several charges for the services provided. The total includes fees charged by your acupuncturist and the cost of acupuncture supplies. Depending on whether the cost of your acupuncture is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered.

Disclaimer - Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

Consent For Acupuncture Treatment

1. I hereby authorize ________SARAH JOHNSON____________ to perform acupuncture and additional accessory techniques. I have received the ACUPUNCTURE INFORMED CONSENT TO TREAT.
2. I recognize that during the course of the acupuncture treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above acupuncturist to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. It has been explained to me in a way that I understand:
   A. The above treatment or exposure to be undertaken
   B. There may be alternative procedures or methods of treatment
   C. There are risks to the procedure or treatment proposed

I Consent To The Treatment Or Procedure And The Above Listed Items (1-4). I Am Satisfied With The Explanation.

______________________________ ______________________________

Patient *(or Person Authorized to Sign for Patient)* **Practitioner**

______________________________ ______________________________

Date **Date**

Health Insurance Portability and Accountability Act & Patient Rights Form

Introduction – Calla Lily Day Spa is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and private practices with respect to your protected health information.

In order to maintain the level of services that you expect from her office, we may need to share limited personal medical and financial information in the following cases;

> **Payments** - in order to secure payment we may disclose healthcare information to your insurance company or with Workmen's Compensation and your employee as well if payment is not made as arranged by our offices by utilizing outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected healthcare information.
>
> **Treatment** - your healthcare information may be disclosed to other healthcare professionals within the practice or other medical practitioners that you authorize.
>
> **Emergencies** - in the event of an emergency, we may need to notify family member or other person responsible for your care that you have been in an emergency situation.
>
> **Public Health -** as required by law, we may disclose your health information to public health authorities for the purpose of preventing or controlling disease, reporting child or elderly abuse or neglect, reporting to domestic violence or reporting disease or infectious exposure.
>
> **Judicial and administrative proceedings or law-enforcement** - for example, in the case of complying with the court order or subpoena.
>
> **Other Communications -** for example, we may call your home to remind you of an appointment. No protected health information will be provided on this call except for the date and time of your scheduled appointment.

Protection - Safeguards in place at our office include; limited access to facilities where information is stored. Policies and procedures for handling information. Requirements for third parties to contractually comply with privacy laws how medical files and records including email, regular mail, telephone, and faxes sent are kept on permanent file.

Included - In administrating your healthcare, we would gather and maintain information that may include; nonpublic personal information. Information about your financial transactions with us. Medical history, treatment notes, medical test results, and any letters, faxes, emails or telephone conversations to or from this office, to or from other healthcare practitioners, from healthcare providers, insurance companies, Workmen's Comp. and your employer, and other third parties' administrators. We value our relationship and respect your right to privacy.

As a patient you have the following rights:

1. **Right to inspect and Copy -** Upon written request you have the right to access, review or receive copies of your health care records.
2. **Right to an accounting of disclosure -** Upon written request you have the right to receive a list of items this office has disclosed about your Protected Health Information.
3. **Right to request restrictions -** You have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
4. **Right to request confidential communications -** Patients have the right to have their Protected Health Information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon their request. For example, patients can ask that we only contact them at work or by mail.
5. **Right to Amend -** You have the right to request that we amend your Protected Health Information, in the event that you believe the health information we have is incorrect or incomplete. This request must be in writing. Please be advised, however, that we are not required to agree to amend Protected Health Information. We may deny the request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny the request if the patient asks us to amend information that:
    A. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
    B. Is not part of the health information that we keep.
    C. You would not be permitted to inspect and copy.
    D. Is accurate and complete.

If the patient requests to amend health information has been denied, the patient will be provided with an explanation of our denial reason(s) and information about how to disagree with the denial.

6. **Right to a paper copy -** You have the right to receive a paper copy of this Notice of Privacy Practices at any time upon request.

Please read the following and initial in the space provided:

______ I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosure of my Protected Health Information.

______ I have the right to revoke this consent, in writing, at any time, exempting the acupuncturists and practice to the extent that they have already relied upon this consent.

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA) and Patients' Rights

I acknowledge receipt of a copy of the Notice of Privacy Practices (HIPAA) and Patients' Rights.

______________________________	______________________________
Patient *(or Person Authorized to Sign for Patient)*	**Practitioner**
______________	______________
Date	**Date**