Holistic Healing Acupuncture LLC

Dear Future Patient,

Welcome to Holistic Healing Acupuncture. We look forward to meeting with you at your first office visit.

Enclosed you will find new patient paperwork. Please take some time before your visit with us to fill it out to the best of your ability and be sure to bring the completed paperwork to your first appointment. We will use the intake form as a guide throughout your first office visit.

It is important to note that we have a "no scents" policy at the office. Some of our patients suffer from chemical sensitivities. Perfumes, strongly scented lotions, cigarette smoke or hair products may set off their symptoms should their visit follow yours.

Should you need to cancel this appointment or any future appointments, please be aware of our 24-hour notice cancellation policy. We request you call the office at least 24 hours prior to your scheduled appointment time if you are unable to make the appointment; ideally 48 hours. As you can imagine, "no shows" or last minute cancellations can be very burdensome to our practice. If you know you cannot make an upcoming appointment, the office encourages you to call as soon as possible so that we may use your appointment slot for another patient who may be waiting to get in to see us. All patients who do not show up for a scheduled appointment or do not cancel outside of this 24 hour window will be charged the scheduled visit fee.

Please feel free to reach us at the office if you have any questions prior to your visit. We look forward to working with you on your path to greater health.

1370 Hosford St. Suite A1 Hudson, WI 54016 || holistichealingacu@gmail.com || (651) 504-HEAL

# HOLISTIC HEALING ACUPUNCTURE
## ACUPUNCTURE INFORMED CONSENT TO TREAT

**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 named 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 above or any other office or clinic, whether signatories to this form or not.**

**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 be unpleasant in smell or taste. I will immediately notify a member of the clinical staff of any unpredicted or unpleasant effects associated with the consumption of the herbs,**

**I have been informed acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risk of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that I 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I become pregnant.**

**I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement 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 the results are not guaranteed.**

**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 written consent.**

**By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.**

PATIENT SIGNATURE **X**_____

**(Or Patient Representative)** **(Indicate relationship if signing for patient)**

## CONFIDENTIAL PATIENT INFORMATION

Name: _____ Sex:_____ Date of Birth:_____

Perm. Address_____ City: _____ State:____ Zip:_____

Phone Perm:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Address: _____

Were you referred by another physician? Yes No

Referring Physician's Name: _____ Phone:_____

Address, City, State, Zip:

_____

Who is your current Physician: _____Phone: _____

Employer: _____ Occupation:_____ Phone: _____

Nearest Relative not living with You: _____ Relation: _____ Phone: _____

Marital Status: Single Married Separated Divorced With Partner Widow(er)

Name of Spouse (or parent for minor child):_____

Emergency Contact: _____ Relationship: _____ Phone: _____

**I clearly understand and agree that all services rendered me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered me will be immediately due and payable.**

**Clinic Policy requires payment at time of services.**

_____ _____ _____

**Patient's Signature** **Parent or Guardian's Signature** **Date**

_____ _____

**Please Print Name** **Please Print Name**

**HIPAA Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health care professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care, quality and reviewing the competence of healthcare professionals.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. The identifiable health information relates to my past, present, or future physical mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a request a restriction on the use and disclosure of my protected Health Information for the purposes of treatment, and/or payment of healthcare operation of Holistic Healing Acupuncture (HHA), but the practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand that I have the right to read and discuss the Notice of Privacy Practices before I sign this consent form and have the right to revoke this consent, in writing, at any time except to the extent that HHA, has acted in reliance on the consent. The Notice of Privacy Practices describes the types of uses and disclosures my identifiable health information that will occur in my treatment, payment of bills, or in the performance of health care operations of HHA. At my request the Notice of Privacy Practices by requesting a copy during any office visit via fax or email.

**I consent to the use or disclosure of my identifiable health information by HHA, for the purposes of diagnosis or providing treatment to, obtaining payment for my healthcare bills, or to conduct health care operations. I understand that diagnosis or treatment at HHA may be conditioned upon my consent as evidenced by my signature on this document.**

| | | | |
|---|---|---|---|
| Signature of Patient | Date | Acupuncturist Signature | Date |

# PATIENT INTAKE FORM

Date: _____

**Patient Name**: _____ Age: _____ DOB: _____

List your health concerns in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

Name and telephone number of Primary Care physician: _____

Name of any other physicians you are currently under the care of:

_____

## Family History

| | Father | Mother | Siblings | Grandparents | Spouse | Children |
|---|---|---|---|---|---|---|
| Age if living: | | | | | | |
| Age when died: | | | | | | |
| Reason For death: | | | | | | |
| Cancer type: | | | | | | |
| High Blood Pressure: | Y N | Y N | Y N | Y N | Y N | Y N |
| Heart Attack / Stroke: | Y N | Y N | Y N | Y N | Y N | Y N |
| Hear Disease: | Y N | Y N | Y N | Y N | Y N | Y N |
| Asthma / Allergies: | Y N | Y N | Y N | Y N | Y N | Y N |
| Mental Illness: | Y N | Y N | Y N | Y N | Y N | Y N |
| TB: | Y N | Y N | Y N | Y N | Y N | Y N |
| Auto-Immune: | Y N | Y N | Y N | Y N | Y N | Y N |
| Diabetes Mellitus: | Y N | Y N | Y N | Y N | Y N | Y N |
| Osteoporosis: | Y N | Y N | Y N | Y N | Y N | Y N |

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4)_____

2) _____ 5)_____

3) _____ 6)_____

**Patient Name**: _____

**Please Note When & Why You Have Had Each of the Following:**

Last Blood Work Assessment: _____

Last Physical Exam: _____

X-Rays: _____ MRI/CAT Scan: _____ Ultrasounds: _____

HIV Test: _____ Last Dental Visit: _____ Last Eye Exam: _____

Did you receive a normal series of childhood vaccinations? Y N

Any vaccination reactions or other notes in vaccination history? _____

_____

Circle Currently **Y**es (**Y**), Currently **N**o (**N**), or **P**ast (**P**) regarding the use of the following:

Antacids: Y N P Steroids: Y N P

Do you presently smoke or chew tobacco? Y N

How many cigarettes_____ Cigars_____ Chewing Tobacco_____ Age when started_____

Did you smoke in the past if you don't smoke currently? Y N How Long_____

When did you quit? _____ Does anyone else smoke in your household? Y N

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes/Past: _____

Soda Pop: Y N P Ounces per day if Yes/Past: _____

Alcohol: Y N P Drinks per day, week, month (circle one): _____

Do you presently use or have you ever used recreational drugs? Y N

Type:_____ Drug Addictions: Y N P Drug Treatment: Y N P

**Current Prescriptions or Over the Counter Medications (Attach additional paper if needed):**

| Medication and dose | Reason prescribed | Prescriber | Length of time taking medication | Any side effects noted |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Current Supplements with Brands and Dosages:**

| Medication and dose | Reason prescribed | Prescriber | Length of time taking supplement | Any side effects noted |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Patient Name**: _____

Please indicate your energy on a scale of 1-10 (1=poor, 10=excellent): _____

If you are troubled by daytime fatigue, at what time do you experience this? _____

Present weight: _____ Weight one year ago: _____ Height: _____

Maximum weight and when: _____

Minimum adult weight and when: _____

Ideal weight: _____

**REGARDING THE NEXT LONG SECTION**: Please circle **Y**es (**Y**), **N**o (**N**), or **P**ast (**P**) regarding the use of the following:

**SKIN**

| | | | | |
|---|---|---|---|---|
| Rash: | Y N P | | Skin Cancer: | Y N P |
| Hives: | Y N P | | Normal Perspiration: | Y N P |
| Psoriasis/ Eczema: | Y N P | | Itchy: | Y N P |
| Dry: | Y N P | | Warts/Moles: | Y N P |

**HEAD**

| | | | | |
|---|---|---|---|---|
| Headache: | Y N P | | Migraine: | Y N P |
| Dandruff: | Y N P | | Past Head Injury: | Y N P |
| Oily/Dry Hair: | Y N P | | Hair Loss: | Y N P |

**NOSE**

| | | | | |
|---|---|---|---|---|
| Frequent Colds: | Y N P | | Nose Bleeds: | Y N P |
| Chronic Congestion: | Y N P | | Post Nasal Drip: | Y N P |
| Polyps: | Y N P | | Seasonal Allergies: | Y N P |

**EYES**

| | | | | |
|---|---|---|---|---|
| Dry/ Watery: | Y N P | | Dark Under Eyelids: | Y N P |
| Double Vision: | Y N P | | Cataracts: | Y N P |
| Glaucoma: | Y N P | | Styes: | Y N P |

**MOUTH/THROAT**

| | | | | |
|---|---|---|---|---|
| Canker Sores: | Y N P | | Cold Sores: | Y N P |
| Persistent Sore Throat: | Y N P | | Gum Disease: | Y N P |
| Dentures: | Y N P | | Cavities: | Y N P |
| Odd Taste in Mouth: | Y N P | | Hoarseness: | Y N P |
| Chronic Dry Mouth: | Y N P | | Swollen Glands: | Y N P |

**Patient Name**: _____

## RESPRITORY

| | | | | |
|---|---|---|---|---|
| Cough: | Y N P | | TB: | Y N P |
| Shortness of Breath w/ exertion: | Y N P | | Bronchitis: | Y N P |
| Shortness of breath sitting or lying down: | Y N P | | Pneumonia: | Y N P |
| Wheezing: | Y N P | | Asthma: | Y N P |

## CARDIOVASCULAR

| | | | | |
|---|---|---|---|---|
| High Blood Pressure: | Y N P | | High Cholesterol: | Y N P |
| Low Blood Pressure: | Y N P | | Murmurs: | Y N P |
| Arrhythmias: | Y N P | | Palpitations: | Y N P |
| Edema: | Y N P | | Chest Pain: | Y N P |

## URINARY TRACT

| | | | | |
|---|---|---|---|---|
| Incontinence: | Y N P | | Discharge/Blood: | Y N P |
| Urgency: | Y N P | | Kidney Stones: | Y N P |
| Frequent Infections: | Y N P | | Do you get up to Urinate at Night? | No<br>1x 2x 3x |

## GASTROINTESTINAL

| | | | | |
|---|---|---|---|---|
| Change in Appetite: | Y N P | | How often do you Have a Bowel Movement? | |
| Indigestion: | Y N P | | Recent BM Change: | Y N P |
| Bloating: | Y N P | | Diarrhea/Constipation | Y N P |
| Nausea: | Y N P | | Hemmorhoids: | Y N P |
| Vomiting: | Y N P | | Gall Bladder Disease: | Y N P |
| Heartburn | Y N P | | Date of Last Colonoscopy: | |
| Pancreatitis: | Y N P | | | |

## MALE GENITALIA

| | | | | |
|---|---|---|---|---|
| Testicular Pain/ Swelling: | Y N P | | Sexually Active: | Y N P |
| Hernia: | Y N P | | Prostate Disease/ Symptoms: | Y N P |
| Discharge: | Y N P | | Do you Perform Testicular Self-Exam | Y N |
| Impotency: | Y N P | | | |

**Patient Name**: _____

## FEMALE GENITALIA

| | | | | |
|---|---|---|---|---|
| Age Periods Began: | | | How Often Period Occurs: | |
| How Long Period Lasts: | | | Heavy Menstrual Bleeding | Y N P |
| Menstrual Cramping: | Y N P | | | Y N P |
| PMS: | Y N P | | Food Cravings: | Y N P |
| Times Pregnant: | | | Number of Births: | |
| Miscarriages: | | | | |
| Last Pap Smear: | | | | |
| Any Abnormal Paps: | Y N | | When was Abnormal | |
| Menopausal Since what Age: | | | | |
| Sexually Active: | Y N P | | Healthy Libido: | Y N P |
| Vaginal Dryness, Itching or Irritation: | Y N P | | Pain w/ Intercourse | Y N P |
| STD: | Y N P | | Vaginitis | Y N P |
| Bone Density Test: | Y N Date: | | Mammography: | Y N |

Current Method of Birth Control:

Please list any types of hormonal birth control used in the past and how old you were when you used this method:

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## MUSCULOSKELETAL

| | | | | |
|---|---|---|---|---|
| Weakness: | Y N P | | Arthritis: | Y N P |
| Stiffness: | Y N P | | Leg Cramps: | Y N P |
| Tremors: | Y N P | | Pain: | Y N P |

## NERVOUS

| | | | | |
|---|---|---|---|---|
| Paralysis: | Y N P | | Sciatica: | Y N P |
| Tingling/ Numbness: | Y N P | | Carpal Tunnel Syndrome: | Y N P |
| Seizures: | Y N P | | Fainting: | Y N P |

## EMOTIONAL HEALTH

| | | | | |
|---|---|---|---|---|
| Depression: | Y N P | | Anger/Irritability: | Y N P |
| Suicidal: | Y N P | | High-Strung/Tense: | Y N P |
| Anxiety: | Y N P | | Fear/Panic | Y N P |
| Eating Disorder: | Y N P | | Psychiatric Hospitalization | Y N |

**Patient Name**: _____

## Past health history

What was your health like as a child? _____

Were you breastfed as a baby? Y N

What was your health like as a teen/adolescent? _____

Estimated number of rounds of antibiotics (fill in the blank with a number for each category below):

as a child: as an adult: in the last year:

Have you ever taken a probiotics (L. acidophilus, B. bifidum): _____

## Exercise

How often do you exercise? _____ What Type? _____

For How Long? _____ Hobbies: _____

## Sleep

How long per night? _____ If you wake up frequently what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleepwalk: Y N P Grind Teeth: Y N P Snore: Y N P

## Diet

What special diet do you follow, if any (Vegetarian, Vegan, Food allergy, Atkins, etc.)?

_____

Eating Habits (circle any that apply):

Skip breakfast 3 meals a day 2 meals a day Graze (small, frequent meals)

Eat constantly whether hungry or not Generally eat on the run Crave sweet Crave salt

What do you drink during the day and how much (Coffee, tea, soda, water, juice, etc.)?

_____

How often do you eat at restaurants? _____

## Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

## Social Life

Stress level (1=best, 10=worst): 1 2 3 4 5 6 7 8 9 10

What are your major sources of stress? _____

_____

How do you best cope with stress? _____

_____

What is your occupation? _____

How many hours do you work per week? _____ Do you enjoy your work? _____

If you have a partner, what is the quality of your relationship? _____

Known Allergies (medications, environment, foods): _____

_____

How committed are you to making changes? _____

Is there anything else we should know about you or what you are hoping to get from the experience of working with one of our practitioners?

_____

_____

_____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

**Signature of patient, parent of minor, or personal representative**

_____ _____

**Relationship** **Date**

# NOTICE OF PRIVACY PRACTICE

**To our patients:**
This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Account ability Act of 1996 (HIPAA).

**Our commitment to your privacy:**
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information

2. Lawsuits and similar proceedings in response to a court administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

**Your rights regarding your health information**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have a right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that maybe used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Holistic Healing Acupuncture, 1370 Hosford St. Suite A1 Hudson, WI 54016. We must respond to this request within 30 days.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Holistic Healing Acupuncture, 1370 Hosford St. Suite A1 Hudson, WI 54016. You must provide us with a reason that supports your request for amendment. Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our medical director, Dr. Laura Jones, at Whole Health Concord. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

**Shared information within Holistic Healing Acupuncture**

In order to provide you with the best quality health care we do at times consult with our colleagues. Information regarding your medical history or current treatment plan may be shared with the other doctors at Whole Health Concord.

If you have any questions regarding this notice or our health information privacy policies, please contact our medical director, Dr. Laura Jones, at Whole Health Concord.

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to view it.

Name Birthdate

Signature Date