STACEY SIMONE ACUPUNCTURE

Patient Information and Health History

Date_____ **Name**_____

Age_____ **Sex**_____ **Date of Birth**_____ **Marital Status**_____

Home Phone_____ **Cell Phone**_____

Email Address_____

Preferred Method of Appointment Notification: ☐ **Text Message** ☐ **E-Mail**

Emergency Contact_____

(Relationship) (Name) (Number)

Street Address_____

City_____ **State**_____ **Zip**_____

Name of your Primary Care Doctor_____

Who were you referred by? (Name)_____

Insurance Company Name_____

Policy #_____

Subscribers Name_____ **Subscribers D.O.B.**_____

[Please provide us with your insurance card so that we may make a copy]

Is this a No-Fault Case? ☐ **Yes** ☐ **No** (If yes, please complete the following)

Date of Accident_____ Insurance Company Name_____

Insured's Name _____

Claim Number _____

Policy Number _____

Representative's Name:_____ Phone:_____

Reason for today's visit: (briefly state the history of problem and when the symptoms began)

_____

_____

Past Medical History: Have you ever had any of the following medical problem?

Yes	No		Yes	No		Yes	No	
___	___	**Thyroid Disease**	___	___	**Cancer**	___	___	**Stroke**
___	___	**Rheumatoid arthritis**	___	___	**Hepatitis**	___	___	**Ulcers**
___	___	**High Blood Pressure**	___	___	**Diabetes**	___	___	**Colitis**
___	___	**Nervous Disorder**	___	___	**Tuberculosis**	___	___	**Asthma**
___	___	**Bleeding Disorder**	___	___	**Heart Disease**	___	___	**Lyme Disease**
___	___	**Endocrine problems**	___	___	**Kidney Stones**	___	___	**Arthritis**

Explain any positive responses above (and other medical problems not listed): _____

_____

Past Surgical History (list all surgeries**)** _____

_____

Medications (list) _____

_____

Known Allergies _____

_____

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Family Medical History: List medical problems of your relatives (ex. diabetes, cancer)

Grandparents_____

Mother_____

Father_____

Siblings_____ **Children**_____

Occupation_____ **Working Now?** Yes / No / Retired

Alcohol Use (circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of drug use (list) _____

Are you on a special diet? _____

Do you exercise / play sports? (describe briefly**)**_____

In each area, if you are not having any difficulties, please circle "No Problems". If you are experiencing any of the symptoms listed, PLEASE CIRCLE OR HIGHLIGHT the ones that apply.

General Health	**Allergies / Immunologic**	**Eyes & Ears**
No Problems	No Problems	No Problems
Lack of Energy	Seasonal allergies	Floaters
Unexplained weight gain or loss	Itching	Excessive tearing
Loss of appetite	Frequent infections	Blurred vision
Fever	Exposure to HIV	Glaucoma
Nights Sweats		Cataracts
		Difficulty with hearing
		Ringing in ears
		Ear pain
Nose, Mouth & Throat	**Lungs & Breathing**	**Stomach & Intestines**
No Problems	No Problems	No Problems
Sinus problems	Shortness of breath	Heartburn
Runny nose	Night sweats	Constipation
Post-nasal drip	Prolonged cough	Intolerance to certain foods
Nosebleeds	Wheezing	Excessive belching/gas
Sore throat	Sputum production	Diarrhea
Dry mouth	Prior tuberculosis	Abdominal pain
Bleeding gums	Pleurisy	Liver/gall bladder problems
Facial pain or numbness	Oxygen at home	Difficulty swallowing
	Coughing up blood	Nausea
	Abnormal chest x-ray	Vomiting
		Blood in stools
		Unexplained change in bowel habits

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In each area, if you are not having any difficulties, please circle "No Problems". If you are experiencing any of the symptoms listed, PLEASE CIRCLE OR HIGHLIGHT the ones that apply.

Heart & Blood Vessels	**Mood & Thinking**	**Neurological**
No Problems	No Problems	No Problems
High blood pressure	Insomnia	Frequent headaches
Low blood pressure	Irritability	Double vision
Irregular heartbeat	Depression	Change in sensation
Racing heart	Anxiety	Difficulty concentrating
Chest pains	Recurrent bad thoughts	Problems with walking or balance
Swelling of feet or legs	Mood swings	Dizziness
Pain in legs with walking	Hallucinations	Tremor
Cold hands/feet	Compulsions	Loss of consciousness
		Memory loss
		Seizures
		Uncontrolled motions
		Episodes of visual loss
Kidney, Bladder, Genitals	**Muscles, Bones, & Joints**	**Hematologic**
No Problems	No Problems	No Problems
Painful urination	Joint pain	Easy bleeding
Frequent urination	Aching muscles	Easy bruising
Urgency	Muscle cramps/spasms	Anemia
Prostate problems	Swelling of joints	Abnormal blood tests
Bladder problems	Heaviness of limbs	Leukemia
Dribbling		Unexplained swollen areas
Incontinence		
Impotence		
Endocrinologic		**Skin, Hair, Nails, & Breasts**
No Problems		No Problems
Intolerance to heat or cold		Persistent rash
Menstrual irregularities		Itching
Frequent hunger/urination/thirst		Hair loss or increase
Changes in sex drive		Changes in nails
		Breast changes

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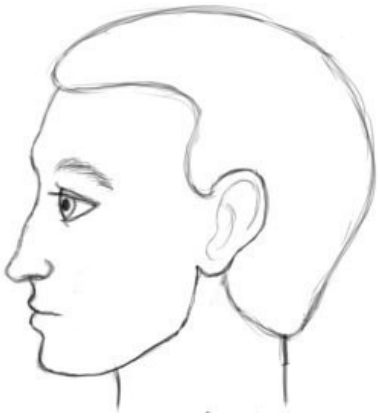
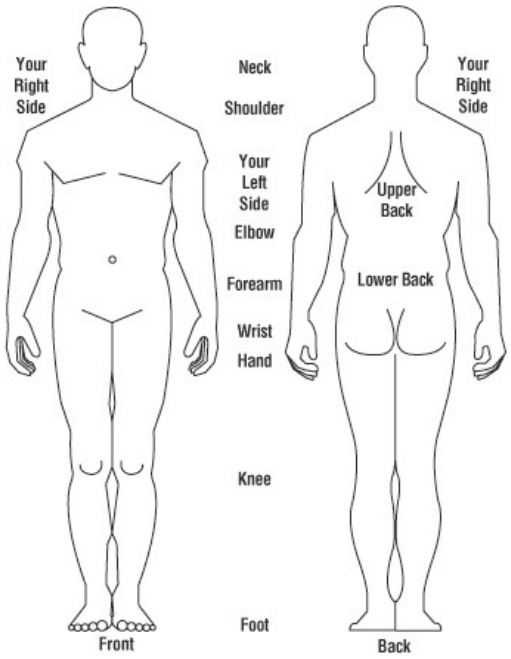
Pain Patients - Please indicate the location(s) of your pain with an X





When did the pain begin? _____

Was there trauma to the area? Y / N If yes, what happened? _____

Have you had surgery to the area? Y / N If yes, when? _____

What is the quality of your pain? ___Dull ___Achy ___Sharp/Stabbing
___Pressure ___Radiating - Where to?_____

Your level of pain (on a scale of 1 – 10)

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

STACEY SIMONE ACUPUNCTURE

Informed Consent for Acupuncture Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, patent herbal therapy, Tuina, guasha, and Qi Gong.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include, temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, pneumothorax or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and guasha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

Acupuncture is committed to your health and well-being. We believe that Oriental Medicine has a great deal to offer as a health care system, but in no way is it meant to replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition (s) for which you are seeking acupuncture treatment.

I do hereby consent that this facility will not be held responsible or liable for any injury, accident or loss of personal property. I hereby release this facility and its employees from any claim or cause of action which may have occurred as a result of a medical problem, known or unknown, which I have knowledge of presently or in the future.

I have read and agree to all the above policies.

Patient Name (printed)

_____

_____

Patient Signature Date

Representative's Signature _____ Relation to Patient_____

Patient Authorization Form

I hereby grant permission for the following:

- Phone calls to my home for the purpose of confirming/cancelling appointments or to discuss my care.
- Messages can be left on my answering machine.

Insurance Policy/Payments

- I agree that if my insurance refuses payment for treatment, due to any reason, I am responsible for my outstanding balance for services for which I have received.
- Should payment be mailed directly to my home, I will promptly contact Stacey Simone Acupuncture and mail payment or bring the insurance payment to my next appointment. I understand that these payments may be made out to me; therefore I will endorse them.

I have read and agree to all of the above policies.

Patient Name Printed _____

Patient Signature_____Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share the health data about you:

- Treatment - to give you medical treatment or other types of health services.
- Payment - to bill you or a third party for payment for services provided to you.
- Health Care Operations - for our own operations such as quality control, compliance, monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- You
- As required by federal, state, or local law
- If child abuse or neglect is suspected
- Public health risks (for public health activities to prevent and control disease)
- Lawsuits and disputes (in response to a court or administrative order)
- Law enforcement (to help law enforcement officials respond to criminal activities)
- Coroners, medical examiners and funeral directors
- Organ or tissue donation facilities if you are an organ donor
- To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- Patient directories- you can decide what health data, if any, you want to be listed in patient directories.
- Persons involved in you care or payment for your care – we may share your health data with a family member, a close friend, or other person that you have named as being involved in your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you :

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of Patient or Representative Date

Print Patient Name