NATURAL HEALING & ACUPUNCTURE INC.

PATIENT RECORD

NAME :_____ BIRTHDATE :_____/_____/_____
[LAST] [FIRST]

SOCIAL SECURITY NUMBER: _____ - _____ - _____ DRIVER'S LICENSE NUMBER: _____

HOME ADDRESS: _____CITY:_____

STATE/ZIP:_____ SEX: ☐ M / ☐ F AGE:_____ REFERRED BY: _____

HOME PHONE : (_____)_____ WORK PHONE : (____)_____CELL PHONE (_____)_____

[☐] CHECK TO RECEIVE NEWSLETTER E-MAIL:_____

OCCUPATION:_____ EMPLOYER:_____

SPOUSE/PARTNER/EMERGENCY CONTACT INFO:

NAME :_____ BEST PHONE: (_____)_____

YOUR DOCTOR'S NAME:_____ SPECIALTY:_____

DOCTOR'S PHONE NUMBER:(_____)_____ DOCTOR'S CITY & STATE: _____

IS YOUR CONDITION DUE TO: ☐ ACCIDENT ☐ JOB INJURY ☐ OTHER

FOR ACUPUNCTURE PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS			
1.	Do you have a tendency to faint?	☐ Yes	☐ No
2.	Do you have a pacemaker	☐ Yes	☐ No
3.	Do you bleed for a long time?	☐ Yes	☐ No
4.	Have you ever had hepatitis?	☐ Yes	☐ No
5.	Are you HIV +?	☐ Yes	☐ No
6.	Are you hungry now?	☐ Yes	☐ No
7.	Are you exhausted now?	☐ Yes	☐ No
8.	[Women] Are you pregnant?	☐ Yes	☐ No

For patients without insurance:
We will collect in full at the time of the visit.

For patients with insurance:
As a courtesy, we will accept your insurance assignment whenever possible once your coverage is verified. We will file your claim forms & assist you in every way we can. It may be necessary for us to charge a co-pay for services rendered if your insurance policy does not cover the full cost of the treatment

If you need to cancel an appointment, please inform the office at least 24 hours in advance to avoid a full charge of service. A missed appointment without 24-hour cancellation will also be charged a full fee.

Patient's Signature **Date**

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Natural Healing & Acupuncture, Inc. is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect any copy of your health information.

You have the right to request Natural Healing & Acupuncture, Inc. amend your protected health information. Please be advised, however, that Natural Healing & Acupuncture, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information by Natural Healing & Acupuncture, Inc.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to the Notice of Privacy Practices

Natural Healing & Acupuncture, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Natural Healing & Acupuncture, Inc. is required by law to comply with this notice.

Natural Healing & Acupuncture, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, you may request this at the front desk or by calling (310) 473-7474.

Complaints

Complaints about your privacy rights, or how Natural Healing and Acupuncture, Inc. has handled your health information should be directed to the receptionist by calling this office at (310) 473-7474. If the receptionist is not available, you may make an appointment by calling for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave, SW Room 509 HHH Building, Washington, DC 20201

I have read the Privacy notice and understand my rights contained in this notice. By the way of my signature, I provide Natural Healing & Acupuncture, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described by the Privacy notice.

Patient's Name (print) Patient's Signature & Date

NATURAL HEALING & ACUPUNCTURE INC.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbs, and nutritional counseling.

I freely choose to undergo facial acupuncture treatments, knowing that there are no guaranteed results. I also understand that there could be bruises (hematoma), puffiness, redness, blood, pain or other symptoms at the site of the needles on the face or in the body during or after the treatment. I completely understand all these ramifications and freely agree to under these treatments.

Initials:_____

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.
I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

NAME:_____
(PLEASE PRINT)

PATIENT'S SIGNATURE:_____

DATE SIGNED:_____

ARE YOU PREGNANT? [ ] YES [ ] NO

To *be completed by the* patient's *representative if the patient's a minor or* is *physically or legally* incapacitated:

PATIENT:_____
(PLEASE PRINT)

PATIENT'S REPRESENTATIVE:_____

RELATIONSHIP OR AUTHORITY OF PATIENT:_____

WITNESS:_____

NAME OF CLINIC: **NATURAL HEALING & ACUPUNCTURE - 2001 S BARRINGTON AVE, Ste. 220 Los Angeles, CA 90025**

NAME[S] OF TREATING ACUPUNCTURIST[S]: **DENISE WIESNER, L.Ac., CARLA VIDOR, L.A.c.**

LAST UPDATE: 8/14/14 1:23 PM

Initial Evaluation Form

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released without your authorization

Name:_____ Date:_____

Birthdate:_____ Age:_____ Height:_____ Weight:_____

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Based upon the chief complaint when did the problem start?

_____

If pain, rate on a scale of 1-10 Circle one

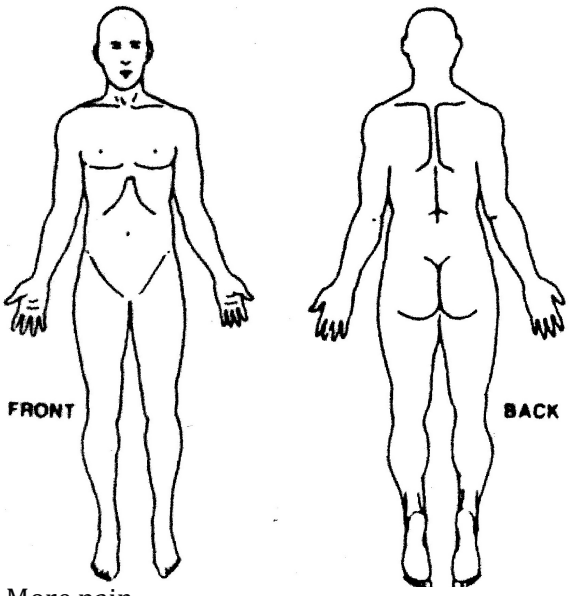
Less pain

0 1 2 3 4 5 6 7 8 9 10

More pain

Minimal Slight Moderate Severe

PLEASE MARK YOUR AREAS OF PAIN



How long have you had this condition? _____ Have you had this condition in the past?_____

What makes it better?_____

What makes it worse?_____

Is your condition: (circle one) Getting worse ☐ Constant ☐ Comes and goes ☐

Medications you are currently taking:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Other medications:_____

Herbs/Supplements you are currently taking:_____

List surgeries/Operations you have had and when? _____

Date of your last physical examination:_____ By whom?_____

Medical History (Do you have or have you ever had?)

- ☐ Arthritis
- ☐ Asthma
- ☐ Anemia
- ☐ Heart Trouble
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Stroke
- ☐ Kidney or Bladder Trouble
- ☐ Gallstones
- ☐ Ulcers
- ☐ Fatigue/Fibromyalgia
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Sudden Weight Loss
- ☐ Sudden Weight Gain
- ☐ HIV +

Other:_____

Family History: (Has any member of your family had any of the above?) YES ☐ NO ☐ (Circle one)

If yes, which member & what did they have?_____

Energy Level: Please rank your overall energy level on a scale from 1(low) to 10 (high):

0 1 2 3 4 5 6 7 8 9 10

Do you experience an energy slump (circle if applies): After Meals ☐ After Lunch ☐

Stress: What causes it? _____

☐ None ☐ Moderate ☐ Severe

Sweating: ☐ Night Sweats ☐ Excessive Sweating ☐ Sweating with Slight Exertion ☐ Rarely Sweats

Circulation: Feelings of…

- ☐ Hot areas?_____
- ☐ Cold areas?_____
- ☐ Cold limbs
- ☐ Bruises easily
- ☐ Bleeds easily

Other :_____

Skin: (check all that apply)

- ☐ Dry itchy
- ☐ Moist/Clammy
- ☐ Frequent rashes
- ☐ Burning
- ☐ Hair thinning
- ☐ Acne
- ☐ Dry scalp
- ☐ Bruises easily
- ☐ Hives

Other :_____

Scars: (list all scars from accidents and surgeries)_____

Sleep: (Circle all that apply) Falling asleep ☐ Staying asleep ☐ Excessive dreaming ☐

Other: _____ How many hours do you sleep per night?_____

Head: Headaches/Migraines (what area?) _____

☐ Dizzy ☐ Memory loss ☐ Loss of balance

Other :_____

Eyes: ☐ Eye pain ☐ Blurred vision ☐ Dry eyes ☐ Darkness under eyes

Other: _____

Ears: ☐ Poor hearing ☐ Earaches ☐ Ear infections ☐ Ear ringing

Other: _____

Nose: ☐ Frequent nose bleeds ☐ Sinus issues ☐ Frequent colds

Other:_____

Throat: ☐ Sore Throat ☐ Difficulty swallowing ☐ Swollen tongue ☐ Hoarseness ☐ Jaw Problems

Other: _____

Chest: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Pain/pressure in chest

☐ Issues breathing at night ☐ Palpitations ☐ Persistent cough ☐ Coughing blood

☐ Coughing phlegm Other:_____

Bowels: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools

☐ Hemorrhoids ☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems

Number of bowel movements a day?_____

Urine: Color:_____ Amount:_____

☐ Frequent Urination ☐ Hard to urinate ☐ Pain or burning on urination ☐ Frequent infection

☐ Daytime ☐ Water retention ☐ Strong smelling urine ☐ Blood in urine

☐ At night

Musculoskeletal: Pain in:

☐ Neck	☐ Upper Back	☐ Muscle spasm/cramps
☐ Shoulder	☐ Weak Ankles	☐ Loss of grip
☐ Between Shoulders	☐ Mid Back	☐ Loss of feeling in Hands/Feet
☐ Arms/Wrists	☐ Stiff all over	☐ Swollen Knees/Elbows
☐ Hands/Fingers	☐ Lower Back	☐ Leg cramps at night
☐ Hip	☐ Sciatica	☐ Painful Joints
☐ Knee	☐ Tingling in Feet	☐ Weakness in Legs
☐ Big Toe	☐ Bones sore/painful	☐ Bursitis

Neurological:

☐ Nervousness	☐ Mood swings	☐ Suicidal
☐ Depressed	☐ Poor coordination	☐ Seizures
☐ Easily angered	☐ Memory confusion	☐ Tremors
☐ Easily irritated	☐ Muscle weakness	☐ Nerve pain
☐ Frequent crying	☐ Poor concentration	☐ Numbness/tingling in limbs
☐ Worry/anxiety	☐ Feel weak and shaky	☐ Shingles

Other: _____

Females:

Last monthly period? _____ Last PAP test?_____ Form of birth control?_____

Age started menses?_____ Age stopped? _____ Color:_____

No. Pregnancies?_____ No. Deliveries?_____ No. Miscarriages?_____ No. Abortions?_____

Females [Cont.]:

☐ Water retention ☐ Low or no sex drive ☐ Hot flashes ☐ Food cravings
☐ Mood changes ☐ Miss periods ☐ Painful Breasts

Discharge:

☐ Yellow ☐ White ☐ Itching ☐ Thick ☐ Odor

Males:

☐ Low sex drive ☐ Lack of sex drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges
☐ Premature ejaculation ☐ Pain or burning while urinating ☐ Prostate trouble

Appetite:

☐ Excessive appetite ☐ Tired/weak if meal is missed ☐ Excessive thirsty
☐ Poor appetite ☐ Appetite keeps changing ☐ Never thirsty

Specific food cravings:_____

Digestion:

☐ Stomach gas ☐ Stomach pain ☐ Bad breath
☐ Lower bowel gas ☐ Stomach cramps ☐ Sores in mouth
☐ Heartburn ☐ Nausea ☐ Weight gain
☐ Burning/belching ☐ Vomiting ☐ Weight loss
☐ Bitter/sour taste in mouth ☐ Abdominal bloating… How long after eating?_____
☐ Food Allergies

Nutrition: List some of your favorite foods: _____

_____

Do You?

☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal?_____

How many glasses of water do you drink?_____

Do you use?

☐ Alcohol Glasses per week: _____ Type: _____

☐ Tobacco No. of packs per day: _____ How many years?_____

Do you:

☐ Eat raw fruits and vegetables at least 2x/day?
☐ Eat green or yellow vegetables at least 2x/day?
☐ Eat frequently between meals?
☐ Chew your food thoroughly before swallowing it?
☐ Drink juice, milk or other drinks instead of water when thirsty?
☐ Always add salt?
☐ Eat meat or dairy products 2 or more times a day?
☐ Eat the same foods almost every day?
☐ Eat when you are not hungry?
☐ Eat until you feel full?
☐ Occasionally go on a crash diet?

Patient Signature _____