

Confidential Patient Information Sheet

Patient Information

Name _____ Date _____
 Address _____ City _____ State _____
 Zip _____ Home phone _____ Work phone _____ Cell _____
 Email _____ Have you had acupuncture before? Yes No
 Height _____ Weight _____ Age _____ Sex: Male Female Date of birth _____
 Occupation _____ Employer _____
 In emergency notify (name): _____ Emergency phone number: _____
 Marital Status: Single Married Domestic Partner Divorced Widowed Separated
 Primary Care Doctor _____ Last seen: _____
 How did you hear about Red Phoenix Acupuncture: Web Site Insurance Company Yellow Pages
 Sign/ Drive By Brochure Business Card Referred by: _____

Medical Insurance

Insurance Company: _____ *Insured's Name: _____
 *Insured's Date of Birth: _____ ID#: _____
 Group #: _____ *Insured's Employer: _____
 Patient's Relationship to Insured: SELF SPOUSE CHILD OTHER
 *If the primary member on the insurance plan is other than the patient, please include their information.

Medical History/ Lifestyle

Reason for your visit here today: _____

Are you being treated for this condition by anyone else: Yes No If Yes who _____

Have these treatments helped? Yes Somewhat Not much Not at all

Known or suspected allergies: _____

Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason	Date / Year(s)
_____	_____
_____	_____
_____	_____

(Daily Amount in the Past 2 Months)

Tobacco: Yes No Amount: _____ Alcohol: Yes No Amount: _____

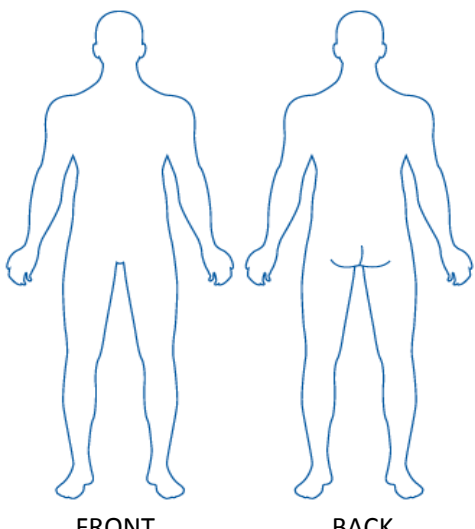
Caffeine: Yes No Amount: _____ Recreational Drugs: Yes No Amount: _____

Do you feel you are at or near your ideal weight? Yes No Do you have enough energy? Yes No

Exercise/ Hobbies: _____ Hours of work per week? _____

Highest level of education completed? High School Bachelors Masters Doctorate Other

How would you rate your current stress level? Extreme Very High High Moderate Low

<p>ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold 	<p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea 	<p>GENITO-URINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence 	<p>NEUROLOGICAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Tremors
<p>HEAD, EAR, EYE, NOSE & THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever 	<p>EMOTIONAL/MENTAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia 	<p>ENERGY & IMMUNITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies 	<p>RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Cold <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> COPD
<p>Pain - Please circle region</p>  <p>FRONT BACK</p>		<p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema <input type="checkbox"/> Valve Problems 	<p>INFECTIONS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hepatitis A/B/C/D <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Strep Throat <input type="checkbox"/> Flu/Cold <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Shingles
		<p>MEN ONLY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Impotence <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse 	<p>OTHER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hands / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Rheumatoid Arthritis
<p>WOMEN ONLY</p> <p>Are you pregnant right now? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Trying <input type="checkbox"/> Maybe Birth Control: _____</p> <p>Age at first period: _____ Date of last menses: _____ Age at menopause: _____</p> <p>Length of cycle (days): _____ Number of: Pregnancies: _____ Births: _____ Abortions: _____</p> <p>Miscarriages: _____ Hysterectomy: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Reason: _____</p> <p><i>Check all that apply:</i> <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Clotting <input type="checkbox"/> Painful Periods</p> <p><input type="checkbox"/> Heavy Flow <input type="checkbox"/> Scanty Flow <input type="checkbox"/> Bleeding Between Cycles <input type="checkbox"/> Irregular Cycles <input type="checkbox"/> Vaginal Discharge</p> <p><input type="checkbox"/> Breast Lumps/Tenderness <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Infertility <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> PMS</p>			

Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking: *Use another page if necessary.*

Supplement	Reason for taking	Potency	Frequency

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Red Phoenix Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not, I may be charged for the appointment. I hereby authorize payments to Red Phoenix Acupuncture for services rendered. If my insurance company has not paid within 90 days or denies payment, I understand that I am financially responsible for paying the account balance in full.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

Acknowledgement of Receipt 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 health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) 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:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) 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:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your 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 with 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:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) 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

Patient Birth Date

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine by a Doctor of Oriental Medicine at Red Phoenix Acupuncture.

Acupuncture / Moxibustion: I understand that acupuncture is performed by the insertion of single use sterile needles through the skin, application of low intensity laser light on the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Initial here _____ Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become 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.

Chinese Herbs: I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Red Phoenix Acupuncture as soon as possible.

Acupressure / Tui-Na Massage: I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful.*** However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect Dr. Amy Bonnett or the Red Phoenix Acupuncture staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____