Acupuncture Accuracy
2323 S Troy St, Ste 3-107 :: Aurora, CO 80014 :: 303-598-1841 ::
www.acupunctureaccuracy.com

Patient Information

Name
____SSN____________________
(Last) (First) (Middle) (Strictly Confidential)

Home Address
____
(Street, Apt #) (City) (State) (Zip)

Home Phone (_______) ___________________________ Cell(_______)_____________________________

Phone number where we can leave you a message (_______) ___________________________________

Email
_____________________________________Employer______________________________
Work Address

____
(Street) (City) (State) (Zip)

Weight ____________ Height ____________ Gender F_______M_______ Age ________________

Birth Date ______________ Single____ Married____ Divorced ____ Separated____ Widowed ____ Partnership ____

Emergency Contact ____________________________________ Relationship to you ______________________

Ph (_______) ________________________ Location ____
Who referred you / how did you hear about Acupuncture Accuracy and Nature's Herbs?

____

Insurance Information

The insurance/billing information questions are necessary. Please provide your insurance ID card for photocopying.
I understand that if I am not paying for treatment at the time of service, I need to supply Acupuncture Accuracy and Nature's Herbs with my Social Security Number.

Insurance Company: ___________________________________ Phone: (______________________)

Insured's ID or SS# ___________________________________ Group # ________________________

Birth Date: _____ / _____ / _____

As a service to our patients, Acupuncture Accuracy and Nature's Herbs will submit the charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office. We may attempt to verify, in advance, that the patient's insurance company will pay for this clinic's treatments. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the full amount for services rendered. Although we will verify insurance coverage for our records, ***we strongly encourage our patients to call their insurance company to verify their coverage prior to their first appointment***.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Acupuncture Accuracy and Nature's Herbs. I also authorize my insurance company to release any information required to process claims.

I agree to be responsible for payment of service in the event my insurance company does not agree to pay for these services. (Not signing this document does not release you from responsibility of payment.)

____

Patient's or Authorized Person's Signature   Date

Health History

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.

What is the main problem that brings you to clinic? (what makes it better or worse; when did it start; what have you tried; how did this start; how are you limited by this condition)

____

____

____

____

____

From whom are you currently receiving health care? (name, address, phone of current physician(s))

____

____

____

What, if any, contagious disease do you have at this time? ___________________________________

Do you have any allergies to food or medications? Describe the reaction.________________________

____

____

Your Medical History:

Chronic Illness and past illness:

____

____

____

____

Check all that apply:

Diabetes [ ] High Cholesterol [ ] High Blood Pressure [ ]

Thyroid Disease [ ] Seizures [ ] Cancer [ ]

Hepatitis [ ] HIV [ ] Heart Disease [ ]

Vascular Disease [ ] Stroke/TIA [ ] Asthma [ ]

Surgery, major illnesses, hospitalizations, and major accidents (include dates):

____

____

____

____

Health and emotional state throughout your childhood:

____

Please list any medication / vitamins / supplements you are currently taking:

____

____

____

____

Lifestyle:

Breakfast (when, what)

____

Lunch:

____

Dinner (what time is your last meal):

____

Snacks(when, what, how much):

____

Amount and type of caffeinated drinks:____

Amount and type of alcohol____

Any other substances or history of dependency______________________________________

How many glasses of water do you drink a day?______________________________________

What is your occupation____

Do you enjoy your work? Yes No Why? ____________________________

____Number of hours/week working:__________

Do you exercise? Yes No Number of times/week: ____________________

Type of exercise: ____

Do you have trouble falling asleep? Yes No

Time to bed: ________ Time to rise: ________Hours of sleep do you get per night____________

Are you rested in the morning? Yes No

Do you wake during the night? Yes No Approximately what time? ________

Do you often awake more than once / night to urinate? Yes No

How is your support system? ____

Have you been treated for emotional or mental health issues?______________________________

____

Have you ever experienced any major traumas? Yes No

____

____

Interests and Hobbies:

____

Is there anything else I should know?

____

____

Family History

Age: ______ Father ______ Mother ______ Brother ______ Sister ______ Spouse ______ Child(ren)

Health(G=good P=poor):____Father _____Mother _____Brother _____Sister _____Spouse ____Child(ren)

List any major illnesses in primary relatives :____

____

____

Please list the main health problems you would like to address in order of importance:

1.____

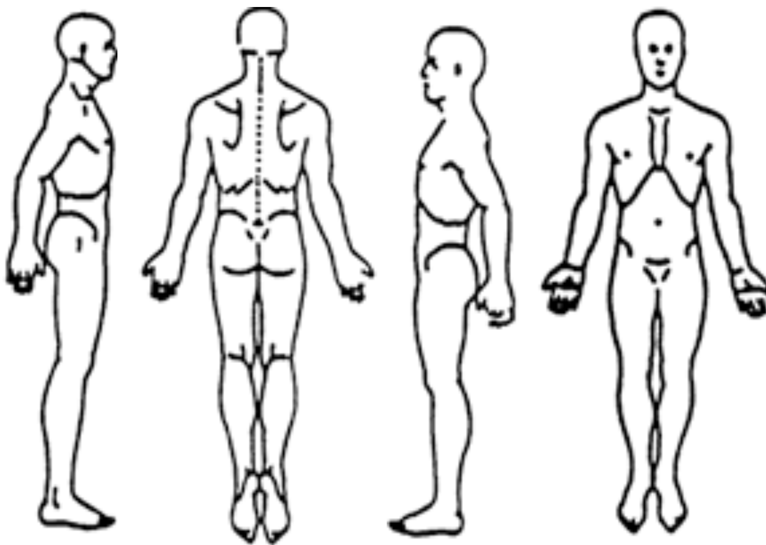
2.____

3.____

4.____

5.____

Please mark all areas of pain on the diagram:



Describe: quality of the pain, timing, radiation, what makes it better/worse

Pain scale: 0=none 10=worst imaginable 0 1 2 3 4 5 6 7 8 9 10

____

____

Systems review (Please circle all that apply):

0=Never 1=rarely 2=occasionally 3=frequently 4=always

0 1 2 3 4 Spontaneous sweat
0 1 2 3 4 Allergies
0 1 2 3 4 Asthma
0 1 2 3 4 General weakness
0 1 2 3 4 Dry nose/mouth/skin/throat
0 1 2 3 4 Feel worse after exercise
0 1 2 3 4 Nightmares
0 1 2 3 4 Feel Heart Beating
0 1 2 3 4 Insomnia
0 1 2 3 4 Sores on tip of tongue
0 1 2 3 4 Chest pain traveling to shoulder
0 1 2 3 4 Digestive problems
0 1 2 3 4 Low appetite
0 1 2 3 4 Loose stools
0 1 2 3 4 Mouth sores
0 1 2 3 4 Gas/bloating after food
0 1 2 3 4 Gums (bleeding/swollen)
0 1 2 3 4 Organ prolapsed (diagnosed)
0 1 2 3 4 Often sick or have allergies
0 1 2 3 4 Tired after meals
0 1 2 3 4 Overweight
0 1 2 3 4 Heavy sensation
0 1 2 3 4 Dizziness0
0 1 2 3 4 Dry mouth/throat
0 1 2 3 4 Symptoms worse with stress
0 1 2 3 4 Breast tenderness
0 1 2 3 4 Tight feeling in chest
0 1 2 3 4 Alt. diarrhea/constipation
0 1 2 3 4 Muscle twitches/spasms

0 1 2 3 4 Fatigue
0 1 2 3 4 Catch colds easily
0 1 2 3 4 Shortness of breath
0 1 2 3 4 Cough
0 1 2 3 4 Nasal discharge
0 1 2 3 4 Sinus congestion
0 1 2 3 4 Chest pain
0 1 2 3 4 Feel Low in Spirits
0 1 2 3 4 Headaches
0 1 2 3 4 Restlessness
Overall body temperature High Med Low
0 1 2 3 4 Prone to worry
0 1 2 3 4 Ravenous appetite
0 1 2 3 4 Acid reflux
0 1 2 3 4 Fatigue after eating
0 1 2 3 4 Bruise easily
0 1 2 3 4 Thirst
0 1 2 3 4 Belching/vomiting
0 1 2 3 4 Crave sweets
0 1 2 3 4 Pain worse w/rain
0 1 2 3 4 Acne
0 1 2 3 4 Foul smelling stools
1 2 3 4Thirsty for cold drinks
0 1 2 3 4 Excessive sweating
0 1 2 3 4 Irritable
0 1 2 3 4 Numb extremities
0 1 2 3 4 Dry eyes
0 1 2 3 4 Ear ringing
0 1 2 3 4 Anger easily

0 1 2 3 4	Neck/shoulder tension	0 1 2 3 4	Red eyes
0 1 2 3 4	Feel better after exercise	0 1 2 3 4	Do you feel warm
0 1 2 3 4	Dry skin	0 1 2 3 4	Brittle nails
0 1 2 3 4	Dizziness/lightheaded	0 1 2 3 4	See floaters
0 1 2 3 4	Loosening or thinning hair	High Normal Low	Libido
0 1 2 3 4	Premature grey hair	0 1 2 3 4	Morning diarrhea
0 1 2 3 4	Sore, cold or weak knees	0 1 2 3 4	Feel cold
0 1 2 3 4	Low back pain	0 1 2 3 4	Edema
0 1 2 3 4	Frequent urination	0 1 2 3 4	Urinary incontinence
0 1 2 3 4	Night sweats	0 1 2 3 4	Ear problems
0 1 2 3 4	Hot flashes	0 1 2 3 4	Pain better with heat
0 1 2 3 4	Face flush	Yes No	Impaired memory
0 1 2 3 4	Heat in palms or soles	Yes No	Infertility
0 1 2 3 4	Afternoon fever	Yes No	Hair loss

Have any of these been a recent change from your normal?_________________________________

____

Urination: Please circle any of the following symptoms you are currently experiencing.

Burning Urgent Retention Insufficient change in amount Profuse
Dribbling Up to urinate more than 1x a night change in color

Bowel Movement: usual time ________________________________ Feels complete? Yes/No

Consistency: Well-formed Hard Loose Alternating Dry

Stools: Undigested food Blood Mucus

Women's Health:

At what age did you get your first period: _________Date of last menstrual cycle:__________________

Are you currently on birth control? Yes No If yes, what kind? ______________________

Are you pregnant now? Yes No History of sexually transmitted disease______________

Number of days from the start of one period to the start of the next:_____Number of days of flow:______

Have you ever had an IUD or D&C?____________ Last PAP& mammogram ________________

Are your menstrual cycles spaced regularly? Yes No Flow is: Light Normal Heavy

Color is: Light red Red Dark Red Purple Brown Do you have blood clots? Yes No

Do you have pain or cramping? Yes No If yes, when? Before During After period

Do you have breast lumps? Yes No Fibrocystic breasts? Yes No

Do you experience any PMS symptoms? Water retention Breast tenderness or swelling Mental depression Irritability Food cravings Migraines Other

Vaginal discharge between periods?(color, amount) ______________________________

Number of pregnancies: ____________________ Number of abortions: ____________________

Number of live births: ____________________ Number of miscarriages: ____________________

Are you in menopause? Yes No When? ______________________________

If you are experiencing menopausal symptoms, please describe:

____

____

For infertility: How long have you been trying?______________________________

Do you have a Western diagnosis?______________________________

Any Western drugs or procedures?______________________________

Has you partner been evaluated? ______________________________

Men's Health:

Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe:______________________________

Check all that apply:

[ ] Erectile dysfunction [ ] Difficulty with orgasm [ ] Pain/swelling of the testicles

[ ] Frequent need to urinate at night [ ] Premature ejaculation

[ ] Feeling of coldness or numbness in genitalia [ ] Diagnosis of Prostate problem/cancer?

How often do you get up at night to urinate? ______________________________

Have you sought out medical treatment, and if so, what?

____

____

How does this condition effect your daily living? (social, work, sleep, sex)

____

Notice of Patient Privacy
Health Insurance Portability and Accountability Act (HIPAA)

The Federal law that protects the confidentiality of your health information is called the Health Insurance Portability and Accountability Act (HIPAA). According to law, your "protected health information", or PHI, is any information about you that can identify you. This includes your health records, name, telephone number, and address; and dates such as your birth date, start of treatment and appointments. In compliance with HIPAA, Acupuncture Accuracy and Nature's Herbs protects how your health information can be used in the clinic as well as via correspondence to you by phone, fax, mail and email. In essence, your health information will not be shared with anyone without your written consent, unless required by state of federal law.

The clinic has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. We agree to provide patients with access to their records in accordance with state and federal laws.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the health care provider.
6. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
7. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request. If services are paid in full by cash, you may restrict that information to any insurer for purposes other than for treatment.
8. This clinic will notify government authorities if the patient or the patient's family is a victim of abuse, neglect or domestic violence. This disclosure will only be made: if the clinic is compelled by ethical judgment, when required or authorized by law, or with the patient's agreement.
9. This clinic may be required to disclose to government officials a patient's health information if necessary to complete an investigation related to public health and safety or national security.

I agree to the policies set forth in this form, and any subsequent policy changes made in office policy.

____ Date:____________________

Informed Consent for Treatment at Acupuncture Accuracy and Nature's Herbs

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 acupuncturists at Acupuncture Accuracy and Nature's Herbs, licensed acupuncturists who now or in the future, treat me while employed by, working or associated with or serving as back-up for this clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, gua sha, electrical stimulation, Tui-Na (Chinese massage), massage therapy, Oriental herbal medicine, heat lamp therapy, ear pellets, bleeding therapy, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including but not limited to, bruising, numbness or tingling, dizziness, nausea, fainting, swelling, soreness, and weakness. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include, but are not limited to, infection, burns, scars, hematoma, spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). The clinic uses sterile disposable needles and maintains a clean and safe environment. Bums and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that needles are not to be manipulated by me, and that excessive motion may move needles. I will communicate immediately any problems I perceive during the treatment. I may ask questions about my treatment, and have the right to refuse any part of a treatment. I understand that the treatments provided in this clinic are not a substitute for a medical evaluation and treatment.

Please notify the clinic of the following conditions: pregnancy, bleeding disorders, use of anticoagulant medications ("blood thinners"), implanted devices such as a pacemaker or shunts, allergies, infections, immune suppression, immune disease, hepatitis, conditions that may effect your responsiveness such as epilepsy or blood-sugar disorders, or any other conditions you think might be necessary to communicate.

I understand that the herbs must be consumed according to the instructions provided orally and in writing. I will immediately notify a member of the clinical staff if any unanticipated or unpleasant effects associated with the consumption of the herbs occurs, and stop taking the herbal medicine until I am told otherwise. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or 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 judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing this document, I indicate 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 for any future condition's for which I seek treatment.

I understand that if I do not cancel my appointment at least 24 hours in advance, I will be responsible for the full cost of the treatment scheduled.

______________________________ __________________

Printed -- Name of Patient Date

______________________________ ______________________________

Signature -- (of Patient or Guardian) Printed Name of Guardian, if different from Patient

______________________________ ______________________________