

Acupuncture Registration

Name _____		Phone _____	
Address _____		*Email Address _____	
City _____	State: _____	Zip: _____	
Age _____	Birth date: _____	Physician Name _____	
Height _____		Physician address _____	
Weight _____			
Occupation _____		Marital Status: S / M / D / W _____	

Main problem(s) would you like to address?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

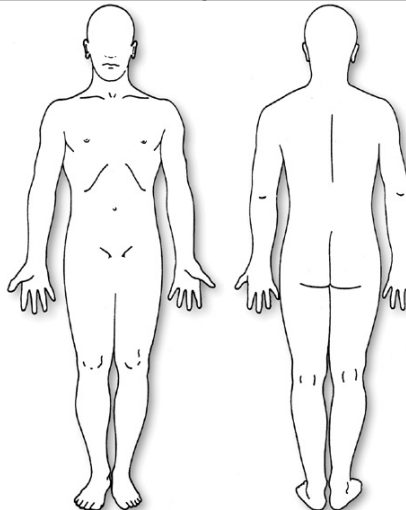
Please list all medications you are taking:

Lifestyle

Describe your daily diet:	Describe your Exercise Program
AM	
Afternoon	
PM	

Please put a
 X little pain
 XX moderate pain
 XXX severe pain

Mark painful or distressed areas on the charts below



Place a check by any that apply

Family Medical History

Allergies	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Stroke
Asthma	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Seizures
Other :						

Your General Medical History

Allergies	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Sweating easily	<input type="checkbox"/>	Other illness
Cancer	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	Night sweating	<input type="checkbox"/>	Accidents or Trauma
Diabetes	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Strong thirst	<input type="checkbox"/>	Surgeries:
Hepatitis	<input type="checkbox"/>	Light sleep	<input type="checkbox"/>	Tremors		
Heart Disease	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Bruising easily		
Stroke	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Fever or chills		

Head, Eyes, Ear, Nose, Throat

Headaches	<input type="checkbox"/>	Poor Vision	<input type="checkbox"/>	Ringling in ears	<input type="checkbox"/>	Nose bleeds
Migraines	<input type="checkbox"/>	Night blindness	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	TMJ
how often:	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	Mouth or tongue sores
Concussion	<input type="checkbox"/>	Poor hearing	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Dizziness

Cardiovascular

High Blood Pressure	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Swelling of Feet
Low Blood Pressure	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	Swelling of hands	<input type="checkbox"/>	Blood Clots

Respiratory

Asthma	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Phlegm (color?)
Emphysema	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Difficult breathing		

Gastrointestinal

Nausea	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Gas
Vomiting	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Belching
Abdominal pain	<input type="checkbox"/>	Acid reflux				

Genitourinary

Frequent Urination	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Pain on Urination	<input type="checkbox"/>	Prostate problems
Kidney Stones	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Blood in urination	<input type="checkbox"/>	Decreased flow

OBGyn

PMS	<input type="checkbox"/>	Irregular cycle	<input type="checkbox"/>	Premature births	<input type="checkbox"/>	# of Pregnancies
Clots	<input type="checkbox"/>	Light flow	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Birth control
Painful period	<input type="checkbox"/>	Heavy flow	<input type="checkbox"/>	Miscarriages		

Are You Currently Pregnant?

Neurological/Psychological

Seizures	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	Depression	<input type="checkbox"/>	High Stress
Dizziness	<input type="checkbox"/>	Lack of coordination	<input type="checkbox"/>	Anxiety		
Loss of balance	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Some Temper		

Skin And Hair

Dry Skin	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Shingles
Rashes	<input type="checkbox"/>	Itching	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	Psoriasis

Consent for Acupuncture and Herbal Medicine

I consent to Acupuncture treatment and other procedures associated with Traditional Chinese Medicine by Lea Inoue L.Ac Dipl CH.

I understand that methods of treatment may include, but are limited to Acupuncture, Moxabustion, Cupping, Electrical stimulation, Tui-na (Chinese Massage) Shiatsu (Japanese Meridian massage) Chinese Herbal Medicine, and Nutritional counseling.

I have been informed that **Acupuncture is a safe method of treatment**, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days.. Bruising is a common effect of cupping method. Unusual risks of acupuncture include dizziness, nerve damage, and organ puncture, including lung puncture (pneumothorax) and induced labor. Infection is another possible risk, although the clinic uses sterile needles and maintains a clean safe environment, other side effect and risk may occur.

Herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Traditional 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, hives, and tingling of the tongue.

I understand that some herbs need to be prepared and the tea consumed according to instructions provided orally and in writing. The herbs may have an unpleasant odor or taste. I will immediately notify Lea Inoue L.Ac Dipl CH of any unanticipated or unpleasant effects associated with the consumption of the herbs or herbal tea.

I will notify Lea Inoue L.Ac. Dipl CH if I become pregnant.

I understand that the clinical medical 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.

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

- I am currently pregnant and understand the risks of acupuncture and pregnancy.
- I have been given the Ok for Acupuncture Treatment from my Ob/Gyn Western Physician.

Patient Name(print)

Patient Signature/ Date

Minor Patient Representative

Name of Witness /Translator

Cancellation Policy

Please be advised that effective January 01, 2011 our office will enforce a 24 hour cancellation policy.

Lea Inoue L.Ac Dipl CH, goes to great lengths to determine the appropriate course of your care and to create your treatment plan. It is important to maintain your treatment as scheduled, in order to obtain optimal results. We understand the need to make changes; however, we will require a 24 hour notice of any cancellations in order to avoid a \$50.00 cancellation fee. This fee is the responsibility of the patient and cannot be billed to any insurance companies or other parties for payment.

Should you reschedule for the same date, the fee will be waived, providing there are time slots available. Failure to keep your scheduled visit for more than 3 times in a 12 month period will be grounds for termination of your care.

Thank you for making your health a priority,

Lea Inoue L.Ac Dipl CH

I have read and agree to this policy.

Signature _____ Date _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a “friendly” version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have 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. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to occasionally 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.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. 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.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. 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.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Acupuncture Guidelines

Please read these guidelines before coming in. Thank you

- Be prepared to discuss your health concerns.
- Please wear comfortable clothing such as sweats or shorts
- Please make sure you have eaten something. Patients on an empty stomach cannot be treated according to Chinese Medical practices.
- Working out at the gym or other strenuous physical activity is to be avoided after the treatment. Please schedule your workout accordingly
- Temperatures that shock the body are to be avoided post treatment. Hot tub, hot shower or cold shower after treatment is to be avoided after the treatment for at least 24 hours.
- Limit alcoholic beverages and smoking to the minimum after treatment
- This office does not take credit cards, cash or check is accepted. You may pay online ahead of time if this is convenient.
- If you should need to cancel your appointment, notify the office immediately as your time can be filled by another patient in need. At least 24 hours advance notice is kindly requested. Unfortunately, no-shows will not be re-booked.