Acupuncture Registration

Name		Phone
Address		*Email Address
City	State:	Zip:
Age	Birth date:	Physician Name
Height		Physician address
Weight		
Occupation		Martial 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:

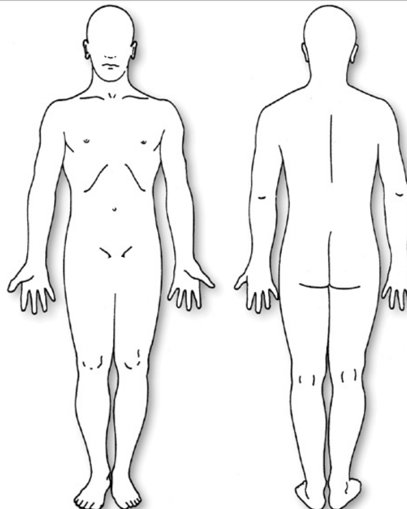
Lifestyle

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	Diabetes	Heart disease	Stroke
Asthma	Cancer	High Blood Pressure	Seizures
Other :			

Your General Medical History			
Allergies	Thyroid disease	Sweating easily	Other illness
Cancer	Venereal disease	Night sweating	
Diabetes	Insomnia	Strong thirst	Accidents or Trauma
Hepatitis	Light sleep	Tremors	
Heart Disease	Weight gain	Bruising easily	Surgeries:
Stroke	Weight loss	Fever or chills	

Head, Eyes, Ear, Nose, Throat			
Headaches	Poor Vision	Ringing in ears	Nose bleeds
Migraines	Night blindness	Earaches	TMJ
how often:	Floaters	Sinus Problems	Mouth or tongue sores
Concussion	Poor hearing	Sore throat	Dizziness

Cardiovascular			
High Blood Pressure	Chest Pain	Fainting	Swelling of Feet
Low Blood Pressure	Irregular Heartbeat	Swelling of hands	Blood Clots

Respiratory			
Asthma	Bronchitis	Pneumonia	Phlegm (color?)
Emphysema	Cough	Difficult breathing	

Gastrointestinal			
Nausea	Diarrhea	Ulcers	Gas
Vomiting	Constipation	Hemorrhoids	Belching
Abdominal pain	Acid reflux		

Genitourinary			
Frequent Urination	Impotence	Pain on Urination	Prostate problems
Kidney Stones	Incontinence	Blood in urination	Decreased flow

OBGyn			
PMS	Irregular cycle	Premature births	# of Pregnancies
Clots	Light flow	Infertility	Birth control
Painful period	Heavy flow	Miscarriages	
Are You Currently Pregnant?			

Neurological/Psychological			
Seizures	Poor memory	Depression	High Stress
Dizziness	Lack of coordination	Anxiety	
Loss of balance	Concussion	Some Temper	

Skin And Hair			
Dry Skin	Eczema	Hives	Shingles
Rashes	Itching	Hair Loss	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.