Personal Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Primary Care Physician _____ PCP Phone _____

Are you presently under a doctor's care? Yes No If Yes, Please State Condition _____

Have you had acupuncture before? Yes No May we contact you via e-mail? Yes No

Focus

What is your primary reason for seeking care today? _____

_____

What was the initial cause? _____

When did it begin? _____

What makes it better? _____

What makes it worse? _____

Do you remember feeling healthy? Yes No

What are your other concerns or health goals? _____

_____

Medical History

List any past or future surgeries _____

List any significant trauma (accidents, falls, etc.) _____

Are you pregnant? Yes No Do you have a pacemaker? Yes No

Do you have any allergies? Yes No If so, to what? _____

Do you take medication? Yes No If so, list types and how often _____

Do you take supplements? Yes No If so, list types and how often _____

Please indicate if you have or have had any of the following conditions:

___ Pneumonia	___ Heart Attack	___ Measles	___ Gout	___ Bone Fracture
___ Tuberculosis	___ Blood Transfusion	___ Mumps	___ Mental Illness	___ Acute Abdominal Pain
___ Hepatitis	___ Anemia	___ Syphilis	___ High/Low BP	___ Neurological Changes
___ Seizure	___ Arthritis	___ HIV/Aids	___ Heart Disease	___ Hemorrhagic Disorder
___ Epilepsy	___ Obesity	___ Hyperthyroid	___ Cancer	___ Acute Respiratory Issue
___ Kidney Stone	___ Jaundice	___ Hypothyroid	___ Diabetes	___ Systemic Infection

Do you exercise regularly? Yes No If so, how? _____

Do you sleep well? Yes No Do you dream? Yes No

Pain Profile

Please indicate on the diagrams the areas where you experience your pain.

Is the pain:

☐ **Sharp** ☐ **Dull** ☐ **Fixed**

☐ **Burning** ☐ **Aching** ☐ **Moving**

☐ **Constant** ☐ **Intermittent**

Do the following lessen the pain?

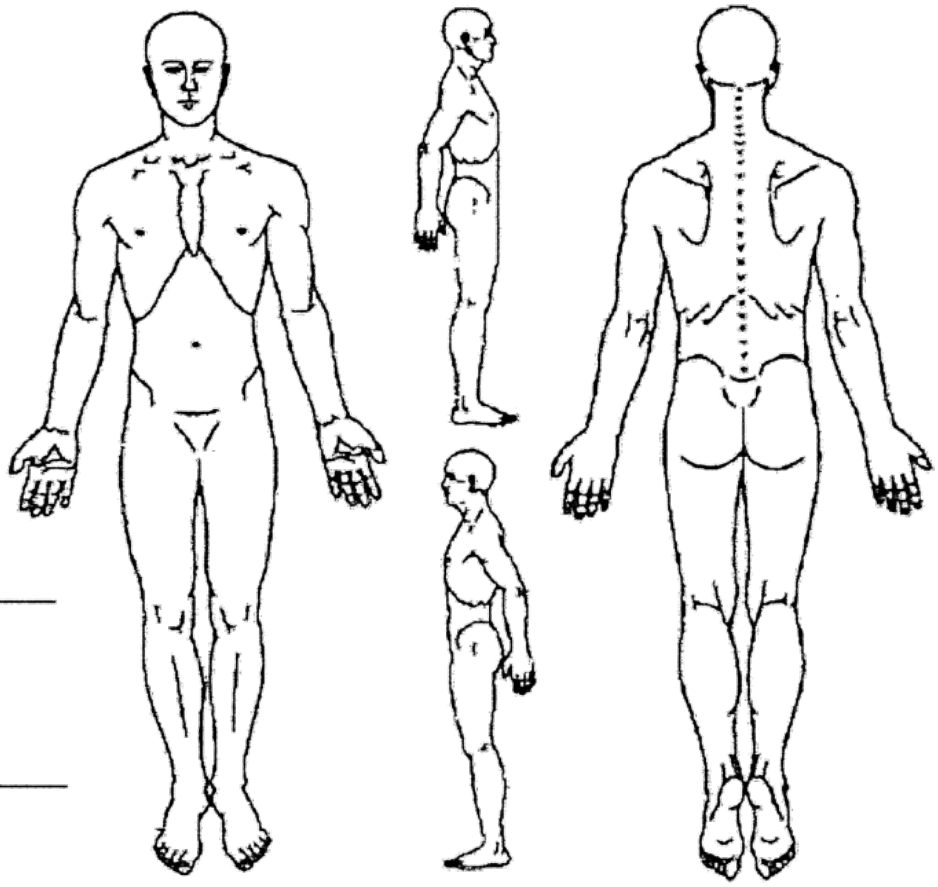
☐ **Heat** ☐ **Cold** ☐ **Pressure**

☐ **Movement** ☐ **Rest** ☐ **Other** _____

Do the following worsen the pain?

☐ **Heat** ☐ **Cold** ☐ **Pressure**

☐ **Movement** ☐ **Rest** ☐ **Other** _____



Signs and Symptoms

Please check any that pertain to you on a REGULAR BASIS:

Spleen Function

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Low Appetite
- ☐ Abdominal Bloating
- ☐ Gas
- ☐ Abdominal Gurgling
- ☐ Fatigue after meals
- ☐ Bruise Easily
- ☐ Hemorrhoids
- ☐ Previous Organ Prolapse
- ☐ Over-thinking
- ☐ Worry

Stomach Function

- ☐ Large Appetite
- ☐ Mouth/Canker Sores
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Heartburn
- ☐ Hiccups
- ☐ Stomach Pain/Reflux
- ☐ Vomiting

Heart Function

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Anxiety
- ☐ Restlessness
- ☐ Frequent Dreams
- ☐ Insomnia
- ☐ Sores on tip of tongue

Lung Function

- ☐ Cough
- ☐ Nose Bleed
- ☐ Nasal Mucous (Color: _____)
- ☐ Sinus Congestion
- ☐ Dry Nose
- ☐ Alternating fever and chills
- ☐ Spontaneous Sweating
- ☐ Dry Throat
- ☐ Sore Throat
- ☐ Dry Skin
- ☐ Grief

Liver Function

- ☐ Anger
- ☐ Depression
- ☐ Irritability
- ☐ Alternating diarrhea/constipation
- ☐ Lump in Throat
- ☐ Chest Tightness
- ☐ Bitter Taste in Mouth
- ☐ Numbness
- ☐ Tingling
- ☐ Muscle spasms or cramps
- ☐ Seizures
- ☐ Dizziness/Vertigo
- ☐ Ringing in Ears (high pitch)
- ☐ Itchy Eyes
- ☐ Bloodshot Eyes
- ☐ Dry Eyes
- ☐ Watery Eyes
- ☐ Floaters in Vision
- ☐ Poor Night Vision
- ☐ Itching/Swelling in Genitalia
- ☐ Brittle Nails

Kidney Function

- ☐ Cold Hands/Feet
- ☐ Sweaty Hands/Feet
- ☐ Afternoon flushes
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ Want to close eyes during day
- ☐ Sore Knees
- ☐ Weak Knees
- ☐ Low Back Pain
- ☐ Poor Memory
- ☐ Frequent Cavities
- ☐ Frequent Broken Bones
- ☐ Wake at night to urinate
- ☐ Ringing in ears (low pitch)
- ☐ Hair Loss
- ☐ Fear

Energy (Kidney/Lung)

- ☐ Shortness of breath
- ☐ General Weakness/Fatigue
- ☐ Get sick easily

Other

- ☐ Frequent headaches
- ☐ Easily hot
- ☐ Easily cold

Dampness

- ☐ Heavy Feeling of Head
- ☐ Heavy Feeling of Body
- ☐ Mental Fogginess
- ☐ Swollen Joints
- ☐ Congestion
- ☐ Nausea
- ☐ Snoring

Urination

- ☐ Normal Color
- ☐ Dark Yellow
- ☐ Very Light Yellow
- ☐ Cloudy
- ☐ Bloody
- ☐ Burning
- ☐ Painful
- ☐ Strong Odor
- ☐ Frequent
- ☐ Dribbling
- ☐ Incontinence

Bowel Movements

- ☐ Regular (1+/day)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Loose/Watery
- ☐ Incomplete
- ☐ Bloody
- ☐ Strong Odor

Females Only

☐ Menopausal (If yes, please answer questions below about your past period history.)

Regular menstrual cycle? ☐ Yes ☐ No Do you experience PMS? ☐ Yes ☐ No

Number of pregnancies: _____ If yes, please list symptoms: _____

Number of live births: _____ _____

Is bleeding: ☐ Heavy ☐ Light ☐ Moderate ☐ Bright Red ☐ Dark Red ☐ Light Red ☐ Clotted

Do you experience cramping? ☐ Yes ☐ No If yes, is cramping worse ☐ *before* or ☐ *during* menstruation?

☐ Endometriosis ☐ PCOS ☐ Frequent UTI/Yeast Infections ☐ Changes in libido

Males Only

Please check any that pertain to you:

☐ Incontinence ☐ Impotence ☐ Prostate Problems

☐ Changes in libido ☐ Premature Ejaculation ☐ Testicular Pain

Informed Consent to Treat

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 the patient named below, for whom I am legally responsible) by either Jacqui Kinzig and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associate with or serving as back-up for Jacqui Kinzig, including those working at Sustaining Health Acupuncture.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, supplement recommendations, and nutritional counseling. I understand that herbs may need to be prepared and consumed according to the instructions provided. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping and gua sha. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although same may be toxic.

I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatment, and have had an opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I may seek treatment.

_____ _____

Signature of Patient (or Patient Representative) Date

PAYMENT AND CANCELLATION POLICY

I understand that payment is due *in full* at the time of service unless other insurance payment arrangements have been made. A super bill will be provided at my request.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 859-475-6841, email us at office@sustaininghealthacupuncture.com, or use the cancellation feature of our online appointment scheduler.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, for the second occurrence we will charge the patient a $25 missed appointment fee. For the third and any future occurrences, we will charge the full priced of the missed appointment.

We understand emergencies happen! Please call us as soon as possible if something comes up and you need to change your appointment time. Our goal is to work with you to ensure timely and effective healthcare.

Thank you for your understanding!

_____ _____

Signature of Patient (or Patient Representative) Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received or declined a copy of the Notice of Privacy Practices for Sustaining Health Acupuncture, LLC.

_____ _____

Signature of Patient (or Patient Representative) Date

Sustaining Health Acupuncture
Notice of Privacy Practices

THIS NOTICE DESRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your protected health information (PHI) may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, we may consult with your primary care physician regarding your case.

Payment: Your PHI may be used to seek payment for services provided to you. For example, we may send a report of progress to your insurance company.

Health Care Operations: Your PHI may be used as necessary for normal healthcare operations. For example, your address will be stored on our computer, and we may contact you via address or telephone.

Law Enforcement: Your PHI may be disclosed when required by law.

Other Uses and Disclosures: Except as above, your PHI will be made only with your consent, authorization or opportunity to object unless required by law. If you change your mind after authorizing a use or disclosure of your PHI you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Your Rights

You have certain rights under the federal privacy standards. These include:

- The right to inspect and copy your PHI.
- The right to request a restriction on the use and disclosure of your PHI.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to amend or submit corrections to your PHI.
- The right to receive an accounting of how and to whom your PHI has been disclosed.
- The right to receive a printed copy of this notice.

Sustaining Health Acupuncture, LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all PHI we maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator
Sustaining Health Acupuncture, LLC
2985 Liberty Rd Unit 14104
Lexington, KY 40509

Effective Date

This notice is effective on or after July 31, 2012.