Acupuncture & Massage Therapy

...harmonizing health through touch

Rachel Field, LAc, CMT
(619)933-2688

Contact Information

Name _____ Title: Mr. / Mrs. / Miss / Dr.

Home Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Mailing Address (if different from above) _____

Occupation _____ How many hour per week do you normally work? _____

Employer Name & Address _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

Referred by:

Name _____ Phone _____ Relationship _____

Personal Information:

Sex: M F Height: _____ Weight: _____ Date of Birth _____ Age: _____

Marital Status: Married Single Divorced Widowed

Children: Yes No If yes, how many _____

Medical/Health History

Please indicate the use and frequency of the following: Have you had acupuncture previously? Yes ___ No ___

Alcohol Yes / No Amount ____ Recreational or other Drugs Yes / No & what type _____ Amount

____Water:Yes / No Amount ____

Coffee/Black Tea:Yes / No Amount ____ Tobacco:Yes / No Amount ____ Soda Yes / No Amount ____

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?/Age?
Cancer				Diabetes			
Hepatitis				Heart Disease			
High Blood Pressure				Seizures			
Rheumatic Fever				Emotional Disorders			

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No # of pregnancies _____
Age of last period (menopause) _____ # 0f live births ____ # of abortions ____ # of miscarriages ___
Number of days between periods ____ Date of last gynecologic exam _____ Pap Smear _____
Number of days of flow _____ Mammogram _____ Bone Density Scan _____
Color of flow _____ Results _____
Clots? ☐ Yes ☐ No Color _____
Average number of pads per day:1st day ____ 2nd day ____ 3rd day ____ 4th day ____ 5th day____
Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other
Location of Pain ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _____

Nature of Pain (please indicate before during or after menses)

Cramping _____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

Other symptoms related to menses

☐ Discharge
☐ Nausea
☐ Swollen breasts
☐ Poor appetite
☐ Increased libido
☐ Vaginal dryness
☐ Constipation
☐ Mood swings
☐ Hot flashes
☐ Decreased libido
☐ Headaches
☐ Diarrhea
☐ Ravenous appetite
☐ Night sweats

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____
Lab results _____-
Frequency of urination: Day time _____ Nighttime _____ Color of urine: ☐ clear ☐ murky ☐ odor _____

Symptoms related to prostate

☐ Prostate problems
☐ Rectal dysfunction
☐ Back pain
☐ Delayed stream
☐ Increased libido
☐ Groin pain
☐ Dribbling
☐ Decreased libido
☐ Testicular pain
☐ Incontinence
☐ Premature ejaculation
☐ Retention of urine
☐ Impotence
Other _____

Symptom Survey for Everyone

The following is a list of symptoms that you may or may not ever experience. Please indicate as flows:
No mark ( ) = never experienced Check mark (✔) = sometimes experience Plus sign (+) = frequently experience

____ lack of appetite
____ excessive appetite
____ loose stool or diarrhea
____ digestive problems
____indigestion
____vomiting
____belching burping
____heartburn/reflex
____feeling the retention of food in the stomach
____tendency to become obsessive in work relationships
____insomnia, difficulty sleeping
____heart pa;palpitations
____cold hands and feet
____ night mares
____ mentally restless
____ laughing for no apparent reason
____ angina pain
____ abdominal pain
____ chest pain
____ sciatic pain
____ headaches
____ pain or coldness in the genital area
____ cough
____ asthma
____ shortness of breath
____ decreased sense of smell
____ nasal problems
____ skin problems
____ feelimgs of claustrophobia
____ bronchitis
____ colitis or diverticulitis
____ constipation
____ hemorrhoids
____ recent use of antibiotics
____ eye problems
____ jaundice (yellowish eyes or skin)
____ difficulty digesting oily foods
____ gall stones
____ light colored stool
____ soft or brittle nails
____ easily angered or agitated
____ spasms or twitching
____ Difficulty in making plans/decisions
____ low back pain
____ knee problems
____hearing impairment
____ ringing in ears
____ kidney stones
____ decreased sex drive
____ hair loss
____ urinary problems
____ edema
____ fatgue
____ blood in stool
____ black tarry stool
____ easily bruised
____ difficult in stop bleeding
____ tendency to catch colds
____ intolerance to weather changes
____ allergies
____ hay fever
____ dizziness
____ tendency to faint
____ high cholesterol levels
____ sudden weight loss

STD History
____ Herpes
____ HPV
____ HIV

Please answer the following:

1. I have a pacemaker ☐ Yes ☐ No

2. I am taking: Coumadin / Warfarin / Plavix / Lithium / ESkalith / Lithobid / Libonate / Lithotabs

3. I have implants: ☐ Yes ☐ No
   If yes, location & how long? _____

Medications

Please list any prescription or OTC medications or supplements and herbs you are currently taking:

Rx/Supplement/herbs	Dosage	Reason for taking the item	How long	Prescribed by	Date last check up

FOR OFFICE USE ONLY BELOW

Notes:

Name _____ **Date** _____

Choose one or two (symptoms physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

Symptom 1: _____

0 1 2 3 4 5 6

As good as it could be As bad as it could be

Symptom 2: _____

0 1 2 3 4 5 6

As good as it could be As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you from doing. Score how bad it has been in the last week.

Activity : _____

0 1 2 3 4 5 6

As good as it could be As bad as it could be

Lastly how would you rate your general feeling of well-being during the last week?

0 1 2 3 4 5 6

As good as it could be As bad as it could be

How long have you had symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years.

Are you taking any medications for this problem? Please circle: YES / NO

If yes: Please write in name of medication, and how much a day or week:_____

_____

Is cutting down this medication: Please circle:

not important a bit important very important not applicable

Is avoiding medication for this problem:

not important a bit important very important not applicable

How long have you had symptom 2, either all the time or on and off? Please circle:

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years.

Are you taking any medications for this problem? Please circle: YES / NO

If yes: Please write in name of medication, and how much a day or week:_____

_____

Is cutting down this medication: Please circle:

not important a bit important very important not applicable

Is avoiding medication for this problem:

not important a bit important very important not applicable

What are the main health problems for which you are seeking treatment?

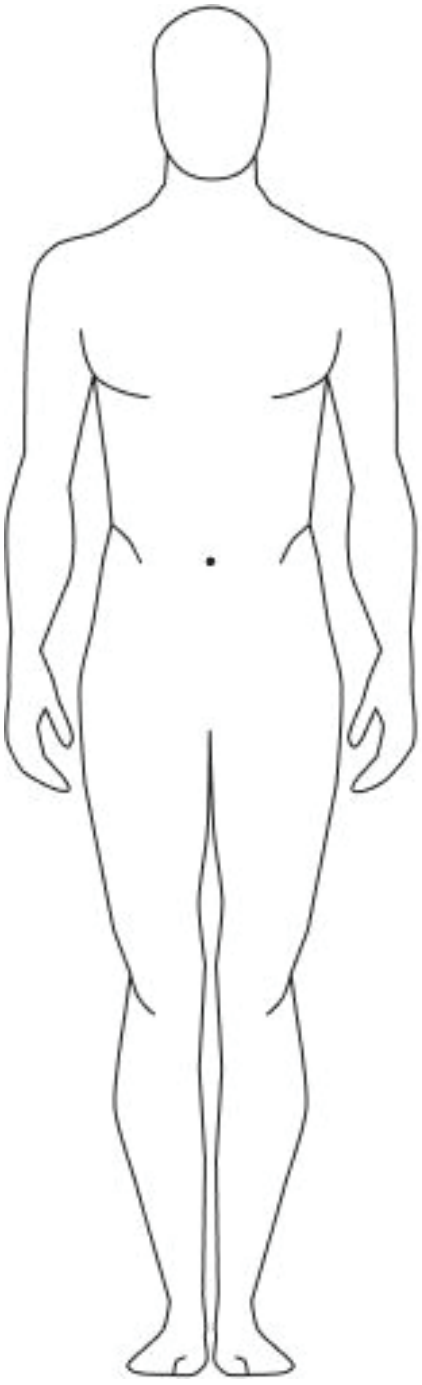
List any food sensitivities or food cravings you have:

List any accidents, surgeries, or hospitalizations (include approximate date):

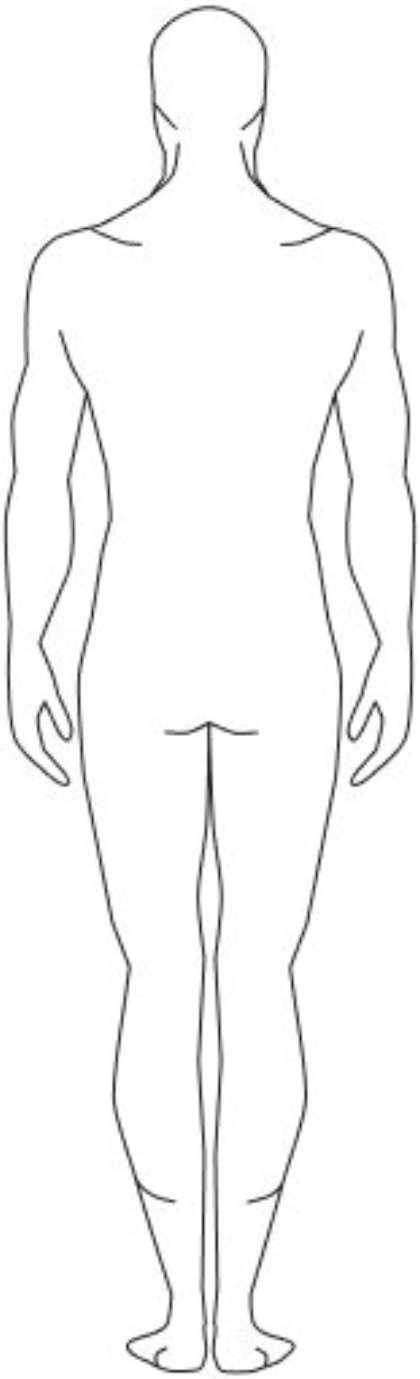
How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad		Great	Good	Fair	Poor	Bad
Significant other	_____	_____	_____	_____	_____	Self	____	_____	_____	_____	_____
Family	____	_____	_____	_____	_____	Sex	____	_____	_____	_____	_____
Diet	____	_____	_____	_____	_____	Work	____	_____	_____	_____	_____
Exercise	____	_____	_____	_____	_____	Spirituality	____	_____	_____	_____	_____

Use the following for comments:



FRONT



BACK

Please mark accordingly indicating the area(s) of concern. Give a brief description of your current symptoms. Include date condition began:

Policies and procedures

Your Visit - Enjoy Being Acupuncture & Massage Therapy is committed to providing superior care for our patients. Our policies and procedures are designed to ensure that you enjoy a truly delightful experience with the utmost professionalism.

Existing & New Medical Conditions - In order to provide you with the best possible experience as well as assure your safety and comfort, it is imperative that you communicate any and all medical/health conditions past and present. It is the responsibility of the patient to keep the practitioner informed of any new medical treatment he/she is undergoing including new medications, cancer treatments, etc. We require that you provide to Enjoy Being Acupuncture & Massage Therapy written permission from the treating physician enabling any new or continued treatment.

Appointments & Cancellations - You may schedule an appointment by calling 619-933-2688. Confidentiality is our highest priority. At no time Enjoy Being Acupuncture & Massage Therapy will share or sell your name or contact information. **Please note: if you arrive later than your scheduled appointment time your service may be shortened.** In the event you need to cancel your scheduled appointment, we ask for a minimum of 24 hours notice. Less than 24 hours notice, a $60 late cancellation fee will be charged. Clients who fail to arrive for a scheduled appointment will be charged a $80 no-show fee. Should an emergency situation arise, please share that with us, fee waivers will be dealt with on an individual basis. We ask that all cell phones be set to vibrate in the reception area and turned off in the treatment room. To ensure availability of your desired appointment time we suggest you schedule your next appointment before leaving.

Prices - Enjoy Being Acupuncture & Massage Therapy is dedicated to harmonizing health for all. We have structured our fee schedule to ensure competitive and affordable pricing so that anyone who wishes to experience the health benefits of acupuncture and massage therapy can easily do so. All prices are subject to change.

Payment - Payment and services are due and payable when services are rendered. We except Visa, MasterCard, Discover, cash, Venmo, and personal checks. There is a $50 fee for all returned checks. Gift certificates are available for purchase. Gift certificates must be use one year from the date of purchase and must specify which service/procedures are rendered. Gift certificates may not be used in combination with any other discounts, including discounted treatment packages and may not be used for products sold in the office.

Return Policy - We do not offer refunds for services rendered, gift certificates, prepaid discounted treatment packages. No exceptions.

Children - We understand that there may be occasions your child/children, not being treated, will be accompanying you. **We do not provide childcare services.** Children are allowed in the treatment rooms, if they are quiet and respectful. **At no time are they to touch or play with any equipment.** Come prepared with something to occupy their time, DVDs, iPad tablets, etc., are welcome. **As to not disrupt your treatment or the treatment of others we require that all electronic devices be used with headphones.**

Hygiene & Attire - Please arrive clean wearing comfortable, loose fitting clothing. Be advised if proper clothing is not worn, your treatment may be adversely affected.** It is very important to eat a small meal and drink water at least two hours prior to your treatment.

Signature: _____ Date _____

Print Name: _____

Client Consent

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 acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back up for the acupuncturist named below, Including those working at the clinic or office listed below or any other office or clinic, where in signatories to this form are not.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese Herbal Medicine. Qi Gong (Chinese exercise),nutritional counseling and Theta healing. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify Rachel Field, LAc, CMT (the practitioner) or an associate 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 generally a 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. Highly unusual risks of acupuncture include nerve damage and organ puncture, Including lung puncture (pneumothorax) infection is another possible risk, Although the clinic uses sterile disposable needles and maintains a clean and safe environment. Spontaneous miscarriage is highly unusual, but is another possibility. I will notify the practitioner or clinical staff immediately if I should become pregnant.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements which are from (plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of 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, rashes, hives, and tingling of the tongue.

I do not expect the practitioner or clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which the practitioner and associates thinks at the time, based upon the facts then known is in my best interest. I understand that the results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 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.

Signature: _____ Date _____

Print Name: _____

HIPAA Notice of Privacy Practices
This notice describes how medical information about you maybe used and disclosed and how you can get access to this information Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you including demographic information,that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information maybe used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the physician’s practice and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected healthcare information, as necessary, to a home health agency that provides care for you. For example, your protected healthcare information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that you’re relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose protected health information in the following situations without your authorization. These situations include: as Required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug administration requirements:
Legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker’s Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your practitioner has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights
Do you have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes: Information compiled in reasonable anticipation of, or the use in a civil, criminal, or administrative action are proceeding, and protected health information that is subject to Law that prohibits access to protected health information.

Your practitioner is not required to agree to a restriction that you may request. If your practitioner believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right or obtain a paper copy of this notice from us, upon request, even if you agree to accept this notice alternatively i.e. electronically.

You may have the right to have your practitioner amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting for certain disclosures we have made, if any, of your protected health information.

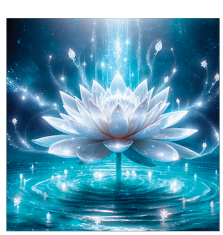
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

HIPAA Acknowledgment and Appointment Reminders
I acknowledge that I have been provided access to Enjoy Being Acupuncture Massage Therapy "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document. I understand that someone may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone. Information stripped of any personal identifiers may also be used for research and educational purposes. By signing this form, I am giving Enjoy Being Acupuncture Massage Therapy and Rachel Field, LAc, CMT or any agents working with her, authorization to contact me with these reminders and to utilize my information for research and educational purposes.

Signature: _____ Date _____

Patient's signature verifies receipt of HIPAA Notice of Privacy Practices



Enjoy being

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