Total Acupuncture, LLC. Patient Intake

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

First Name: Middle Initial: Last Name:

Address: City: State: Zip:

Home Phone: Cell Phone: Email:

Birth Date: Age: Social Security #:

Gender: Male Female Marital Status: Single Married

Emergency Contact: Relationship: Phone Number:

Employer: Occupation:

Chief Complaint:

List past illnesses, surgeries and hospitalizations:

Please indicate with a check mark (✓) if any of the following pertain to you:

Anemia	Cancer	Chlamydia	Diabetes	Gonorrhea
Heart Disease	Hemophilia	Hepatitis	Herpes	HIV/AIDS
HPV	Hypertension	Seizures	Syphilis	Tuberculosis

24 HOUR CANCELLATION POLICY

In fairness to both new and returning patients our office maintains a 24 hour cancellation policy. When booking appointment visits, patients agree to pay the entire fee for visit if they fail to provide 24 hour prior notice of cancellation.

Patient Name (Print): Date:

Patient Signature:

(Or Patient Representative – Indicate relationship if signing for patient)

For Women

Are you pregnant? Yes_____ No_____

# of pregnancies _____ # of live births_____ # of abortions _____ # of miscarriages _____

Age of first period (menarche) _____ Age of last period (menopause) _____ # of days between periods_____ # of days of flow_____ Color of flow_____ Clots? Yes_____ No_____ Color_____

Average # of pads you use per day: 1st day_____ 2nd day_____ 3rd day_____ 4th day_____ + days_____

Have you been diagnosed with: Uterine Fibroids_____ Fibrocystic Breasts_____ Endometriosis_____

Ovarian cysts_____ Pelvic Inflammatory Disease_____ Other_____

Location of pain: Lower abdomen_____ Lower back_____ Thighs_____ Other_____

Nature of pain (if applicable indicate **B**efore, **D**uring or **A**fter menses):

Cramping_____ Stabbing_____ Burning_____ Aching _____ Dull _____

Bloating_____ Consistent_____ Intermittent_____ Bearing down sensation_____

Other symptoms related to menses (please check next to applicable symptoms):

Discharge_____ Vaginal Dryness_____ Headache_____ Nausea _____ Constipation _____ Diarrhea _____

Swollen Breasts _____ Mood swings _____ Ravenous appetite _____ Poor appetite _____ Hot flashes _____

Night sweats _____ Increased libido _____ Decreased libido _____ Insomnia _____

Patient Name (*Print*):

Total Acupuncture, LLC.
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Total Acupuncture, LLC. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Total Acupuncture, LLC. I understand that diagnosis or treatment of me by Jason Sargis may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Total Acupuncture, LLC. is not required to agree to the restrictions that I may request. However, if Total Acupuncture, LLC. agrees to a restriction that I request, the restriction is binding on Total Acupuncture, LLC. and Jason Sargis.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jason Sargis or Total Acupuncture, LLC. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my acupuncturist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Total Acupuncture, LLC.'s Notice of Privacy Practices prior to signing this document. The Total Acupuncture, LLC.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Total Acupuncture, LLC. The Notice of Privacy Practices for Total Acupuncture, LLC. is also provided in the office and on the Total Acupuncture, LLC.'s website at www.totalacupuncture.com. This Notice of Privacy Practices also describes my rights and the Total Acupuncture, LLC.'s duties with respect to my protected health information.

Total Acupuncture, LLC. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Total Acupuncture, LLC.'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature: (Or Patient Representative – Indicate relationship if signing for patient)	Date:
Office Signature:	Date:

ACUPUNCTURE 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 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, whether signatories to this form or not.

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, and nutritional counseling. 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 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. Unusual risks of acupuncture include spontaneous miscarriage, 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.

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 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 which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that 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.

I have been advised by Jason Sargis, L.Ac. as to the importance of consulting with a licensed physician regarding my condition.

Patient Signature_____
(Or Patient Representative) (Indicate relationship if signing for patient)

Date_____