COMPREHENSIVE EXAMINATION

NAME _____ Date email

Address _____ City/ Zip

Phone (_____) _____ Referred by _____

Birth Date: _____ Height _____ Weight _____

Major Complaint/s _____

_____

_____

Other Complaints: _____

_____

Date on onset (when your first noticed your problem)? _____

Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

How long have you had this condition? _____

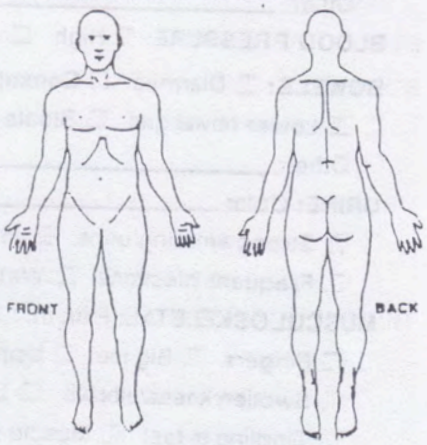
Have you had this in the past? ☐ Yes ☐ No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and Goes

PLEASE MARK YOUR AREAS OF PAIN



Medications/Drugs/Herbs you are currently taking: _____

_____

List Surgeries/Operations you have had and dates: _____

List any infectious diseases

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): ☐ Arthritis ☐ Asthma ☐ Anemia ☐ Heart trouble ☐ Cancer
☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers ☐ High blood pressure
☐ Chronic fatigue ☐ Hepatitis ☐ Jaundice ☐ Sudden weight loss ☐ Sudden weight gain

Other: _____

FAMILY HISTORY: (Has any member of your family had any of the above)? ☐ Yes ☐ No If yes, which member and what did the have? _____

ENERGY LEVEL: ☐ High (Time of day) _____ ☐ Low (Time of day) _____

STRESS: ☐ None ☐ Moderate ☐ Severe What causes it? _____

SWEATING: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating _____

CIRCULATION: Feelings of ☐ Hot ☐ Cold What area? _____

☐ Bleed easily ☐ Cold limbs Other: _____

SKIN: ☐ Dry ☐ Itchy ☐ Moist/clammy ☐ Burning ☐ Changing moles or lumps (cysts/tumors) ☐ Boils
☐ Frequent skin rashes ☐ Acne ☐ Hair loss/thinning ☐ Dry scalp ☐ Skin puffy/wrinkled
☐ Bruises easily (black and blue spots) ☐ Hives Other: _____

SCARS: (List ALL scars from accidents or surgeries) _____

_____

SLEEP PROBLEMS: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming

Other: _____ How many hours do you sleep a night? _____

HEAD: ☐ Headaches (what area?) _____ ☐ Dizziness ☐ Memory loss ☐ Loss of balanc

Other: _____

EYES: ☐ Eye pain ☐ Dry eyes ☐ Blurred vision ☐ Darkness under eyes Other: _____

_____

EARS: ☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections ☐ Ringing/buzzing in ears

Other: _____

NOSE: ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds Other: _____

_____

THROAT: ☐ Sore throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Jaw problems ☐ Teeth/gum problems ☐ Swollen tongue

Other: _____

CHEST: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Mucus rattles when breathing ☐ Trouble breathing at night

☐ Pain/pressure in chest ☐ Palpitations ☐ Persistant cough ☐ Coughing blood ☐ Coughing phlegm

Sputum color _____ Consistency _____

Other: _____

BLOOD PRESSURE: ☐ High ☐ Low ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools ☐ Hemorrhoids

☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems ☐ Number bowel movements a day _____

Other: _____

URINE: Color _____ Amount _____ Frequent urination ☐ Daytime ☐ At night

☐ Strong smelling urine ☐ Hard to urinate ☐ Pain or burning on urinating ☐ Blood in urine

☐ Frequent infections ☐ Water retention Other: _____

MUSCULOSKELETAL: Pain in: ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Arms/hands ☐ Hip ☐ Knee

☐ Fingers ☐ Big toe ☐ Upper back ☐ Mid back ☐ Lower back ☐ Bones sore/painful ☐ Loss of grip

☐ Swollen knees/elbows ☐ Leg cramps at night ☐ Weakness in legs ☐ Weak ankles ☐ Stiff all over

☐ Tingling in feet ☐ Muscle spasm/cramps ☐ Loss of feeling in hands/feet ☐ Painful joints ☐ Bursitis

Other: _____

NEUROLOGICAL: ☐ Nervousness ☐ Depressed ☐ Easily angered ☐ Easily irritated ☐ Frequent crying

☐ Worry/Anxiety ☐ Mood swings ☐ Memory confusion ☐ Poor concentration ☐ Suicidal ☐ Tremors

☐ Numbness/tingling in limbs ☐ Poor coordination ☐ Muscle weakness ☐ Feel weak and shaky ☐ Seizures

☐ Neuralgia (nerve pain) ☐ Shingles Other: _____

_____

FEMALES: ☐ Pregnant? ☐ yes ☐ No Last monthly period _____ Last PAP test _____

Form of birth control: ☐ None ☐ Pill Other _____

Age started menstrual cycle _____ Age stopped _____ ☐ Menstrual pain ☐ Low backache

☐ Irregular ☐ Clotting ☐ Heavy bleeding ☐ Light scanty bleeding ☐ Color _____

☐ Water retention ☐ Mood changes ☐ Miss periods ☐ Low or no sex drive ☐ Painful breasts ☐ Hot flashes

☐ Food cravings Other: _____

Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid Other: _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____

No. Cesareans _____ Operations: ☐ Cervix ☐ Uterus ☐ Ovaries Other: _____

MALES: ☐ Low sexual drive ☐ Lack of sexual drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges

☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostrate trouble Other: _____

_____

APPETITE: ☐ Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed

☐ Excessive thirst ☐ Never thirsty Other: _____

Specific food cravings? ☐ Yes ☐ No If yes, what? _____

Other: _____

DIGESTION: ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ Burning/belching ☐ Stomach pain

☐ Stomach cramps ☐ Nausea ☐ Vomiting ☐ Bad breath ☐ Sores in mouth ☐ Weight gain ☐ Weight loss

☐ Bitter/sour taste in mouth ☐ Abdominal bloating How long after eating? _____

Food allergies? ☐ yes ☐ No If yes, to what? _____

_____

NUTRITION: List some of your favorite foods _____

_____

Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? ☐ Yes ☐ No How often? _____

Do you plan your meals according to the "Four basic food groups"? ☐ Yes ☐ No

How many glasses of water do you drink a day? _____ ☐ Filtered ☐ Bottled

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the

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notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

1. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

- Is required to abide by the terms of this Privacy Notice.

- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

- Will distribute any revised Privacy Notice to you prior to implementation.

- Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____

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INFORMED 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 above 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 above, 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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.

By:_____ Date:_____
(or Patient representative)

Description of Representative's Authority:_____

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After Your First Treatment

What should I do (or not do) after my appointment?
Rest. Avoid exercise if possible, and if exercising, only exercise moderately. Avoid caffeine and alcohol consumption after your appointment. Eat healthy, nourishing foods; avoid greasy, heavy, and processed foods. This is all to ensure you feel your best after your treatment.

When will Chinese and Natural medicine start to work?
Nature is slow. After a natural disaster such as a forest fire, the forest doesn't pop back up the next day. Or if a pregnant mother has a miscarriage and loses her baby, another baby doesn't spontaneously manifest the next day. In the same way treating injuries and disorders naturally is a slow process, so be patient with your body and the natural processes of healing.
I often liken Chinese medicine to physical therapy - it's a retraining of the body, specifically the neural, neuromuscular and reflex aspects of the body, whether you are using acupuncture, herbs, or both. Some people and conditions tend to respond to acupuncture pretty quickly - others take time. Sometimes the body responds right away at the first appointment, and you'll feel relief immediately. Sometimes it takes a couple of sessions to get to the core of the issue, and then we start to see progress. if the problem is chronic, it can take longer.

How often should I come?
It depends on if the issue is acute or chronic.
Acute problems usually take 3 to 5 sessions if the patient is healthy and on NO medications, longer if there is already a disease process involved.
For chronic cases, I usually recommend once to twice per week initially depending on the severity of the condition. After a few weeks we re-evaluate depending on progress made. The rule of thumb for is that for every year there has been a problem, it is one month of treatment. Usually however, I experience it to be less. In both cases treatment is best when herbs or nutritional supplements are combined with the acupuncture treatment. Chinese medicine says that herbs and acupuncture are like the two wings of a bird. Both are needed for the bird to fly. Many over-the-counter vitamins are of poor quality and they are probably not working because otherwise there wouldn't be any issues. Here at the Acupuncture and Natural Health Center, we use physicians-only supplements that have been tested for purity and effectiveness already in the Natural and Chinese medicine field.
And, after any issue is managed, regular tune-ups will help keep the body well and vital, in the same way regular maintenance and tune ups keep your car running smoothly.

Any questions?
Please don't hesitate to call. I will answer your call as soon as possible within 24 hours.

Thank you for your trust and confidence in Natural and Chinese Medicine!