

Name _____ Age _____ DOB _____ / _____ / _____ Today _____ / _____ / _____

Address _____

Phone _____ E-mail address _____

Emergency Contact _____ Phone _____

Have you had acupuncture before? Yes No

Do you have Health Insurance? If so, what Company? _____ Plan? _____

How did you hear about Desiree or NeruoloQi Acupuncture? _____

Please list the reasons you are here today

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Please indicate if any of the following pertain to you:

- Hepatitis HIV High/ Low Blood Pressure Seizures Pacemaker
- Blood-Thinning Medication Pregnancy Implants Herpes Virus

Medication / Supplement

Why are you taking it?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other forms of treatment/therapy?

Please list any surgeries/illnesses / injuries & their dates.

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Please circle the conditions that apply to you

Digestion / Elimination

- | | | |
|--|------------------------------------|--------------------------|
| Increased or Decreased appetite | Increased or decreased thirst | Loose stools / diarrhea |
| Constipation / Dry / Incomplete stools | Gas / Bloating/ Belching | Acid Reflux / GERD |
| Crohn's/ IBS | Hemorrhoids / Hernia/ Prolapse | Gallstone/ Kidney stone |
| Liver Disease/ Hepatitis / Cirrhosis | Difficult Urination/Prostate Issue | Urinary Tract Infections |
| Other _____ | | |

How many times a day do you urinate? _____ Is it clear /dark / pale yellow/Cloudy/ Frothy?
 How often do you have a bowel movement? _____ day / week. Any remarkable color? _____

Emotion

- | | | | | |
|-----------|-------------|--------------------|------------|---------|
| Worry | Anger | Depression/Sadness | Fear | Grief |
| Confusion | Poor memory | PTSD | Stress | Anxiety |
| ADHD | Addiction | Obsession | Compulsion | |

Other Psychological Diagnosis: _____

Whole body

- | | | |
|----------------------------------|--|-------------------|
| Fatigue/ Poor Energy When? | Morning/ Afternoon/ Evening/ After meals | |
| Insomnia/ Wake at night | Wake to Urinate | Waking not rested |
| Night Sweats | Hot Flashes | Chills |
| Cold Hands/ Feet | Edema (Face/ Legs/Hands) | Low/ High Libido |
| Dry Skin/ Rashes/ Acne | Other _____ | |

Cardiovascular / Respiratory

- | | | |
|---------------------|--------------------------|--------------------------|
| High cholesterol | Heart Attacks | Stents/ Other Operations |
| Stroke | Cough | Heart palpitations |
| Shortness of breath | Asthma / COPD/ Emphysema | Chest pain/ Tightness |
| Poor Circulation | Other _____ | |

Head/ Face

- | | | |
|--------------------------------|-----------------------------|-----------------|
| Ringling in the ears/ Tinnitus | Hearing impairment | Vision Problems |
| Allergies | Sinus infection/ congestion | |
| Other _____ | | |

Musculoskeletal

Lower back pain

Arthritis

Knee pain/ problems

Joint Pain _____

Muscle Pain _____

Other _____

Gynecology

Date of last period ___/___

Irregular Period

Difficult / Painful Period

Light / Heavy Flow

History Miscarriages

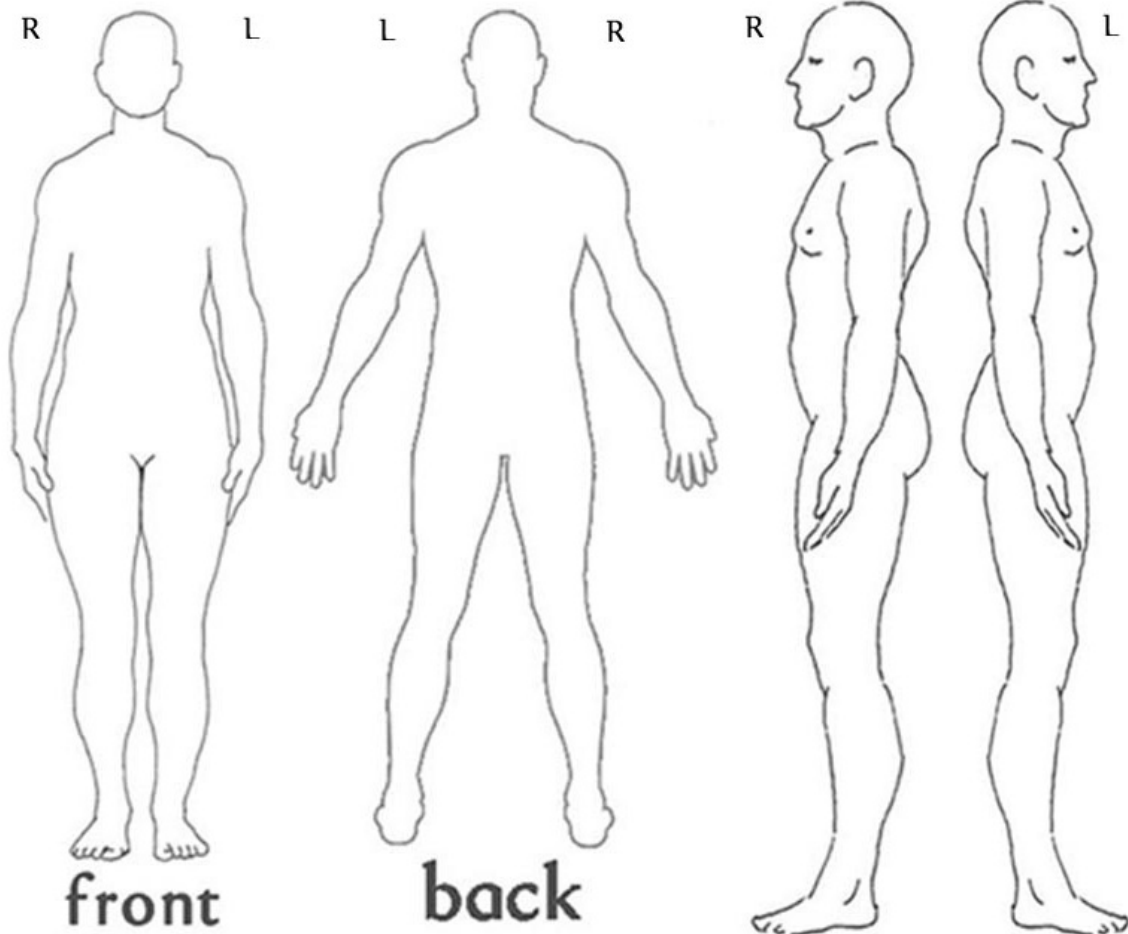
Fibroids/ Cysts

Hysterectomy (age _____)

Age at menopause _____

Other _____

Please circle or fill in the areas you have Pain/ Numbness / Stiffness/ Discomfort etc.



I consent to receive acupuncture treatment and other associated therapies by Desiree Sale LAc. I understand that methods of treatments may include, but are not limited to, Acupuncture, Moxibustion, Cupping, Gua Sha, Electrical Stimulation, use of oils and balms, and Nutritional Counseling.

Acupuncture and its adjunct modalities have the effect of normalizing physiological functions, improving states of pain, and of treating illness by balancing internal disharmony. I understand that Acupuncture is the insertion of thin, sterile needles into designated points along the body's surface. Acupuncture is considered a safe method of treatment. There is occasional bruising, numbness or tingling or other sensations at the site of needle insertion. This is normal and may occur during or after treatment. Gua Sha and Cupping are likely to produce bruising that is part of the healing process and will vanish within a few days. Moxibustion may cause cutaneous burns. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. In even more rare circumstances, spontaneous miscarriage and pneumothorax have occurred. I understand that while this document describes the major risks of treatment, other side effects may occur. I also understand that most people experience a sense of well being and relaxation during and after their treatment.

I will promise to notify the acupuncturist if I am or become pregnant since this will affect the course of treatment. I also promise to notify my practitioner if I am following a new diet, prescription drug or supplement regimen, as this too will affect my course of treatment.

I wish to rely on the acupuncturist to exercise their best judgment during the course of treatment. I understand that their diagnoses and treatment are based upon information I have given my practitioner. What my acupuncturist does from there is what they believe is in my best interests. I understand that results are not guaranteed.

I understand that all my records will be kept confidential and will not be released without my written consent. If cases are used for research or publishing purposes, identities, including personal and identifying information will be altered.

In the State of New York Acupuncturists must advise patients to consult a physician for any conditions they are seeing an acupuncturist to treat.

I, the undersigned, do affirm that I have been advised by, Desiree Sale LAc, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

I understand that if my third party payor does not pay for my treatment, then I, the patient, am financially responsible for my care. If this is the case, I will pay the outstanding balance of my care in one lump sum or in installments.

I understand that if I **do not appear for, or cancel my appointment within 24 hours** of the agreed upon time, that I will be charged a **cancellation fee of \$25**.

By signing below, I show that I have read or have had read to me this consent to treatment, and have been told about the benefits and risks of acupuncture and adjunct procedures. I have also 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 of Patient or Representative _____ Date _____

Signature of Practitioner, Desiree Sale LAc _____ Date _____

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. The privacy of your medical information is important to us. You may be aware that U.S. government regulations established under HIPAA (Health Information Portability and Accountability Act) govern the protection of health information. This notice describes how it may be used, as well as certain rights you have as a patient.

Use And Disclosure Of Protected Information

All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential. Patient chart and financial data will be seen only by the practitioner. There is no electronic transfer of your medical data. For treatment purposes, private information will be provided to another practitioner only after your written consent is given. Your medical information may be used, without further notice to you, or specific authorization by you, where required by law: • for public health purposes; • to report child abuse; • in judicial or administrative proceedings; • by a health oversight agency for oversight activities authorized by law; • under law enforcement purposes; • by a coroner or medical examiner; • to avert serious threat to health or safety; • under military authorities if you are a member of the armed forces of the United States. New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information. We may contact you by mail or telephone, at your residence, to remind you of appointment (s). No reference to medical service will be made. Occasionally, we may call to give instructions or to notify you that herbs or supplements are in the office. If you wish for us to make use of alternative methods of communicating with you, please provide that information on the signature sheet.

Rights That You Have

You have the right to inspect and obtain copies of your medical information. A reasonable fee will be charged for copying. You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. If we disagree with requested amendment, we will notify you of such disagreement, and we will further notify you of your rights. You have the right of request an accounting of any disclosures we make of your medical information, except for: disclosures we make directly to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or for emergency or notification purposes.

Obligations That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it currently is in effect. Please sign the attached acknowledgement of receipt as we are required under law to show that we gave you this information.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in the office, and have also been informed of how I may gain access to and control this medical information.

Signature of Patient or Representative Date

Signature of Practitioner, Desiree Sale LAc Date