325 E. Hillcrest Drive Ste #135, Thousand Oaks, CA 91360 • 805.768.4045 • EspirituAcuWellness@gmail.com

PATIENT INFORMATION AND HEALTH HISTORY

General Information (Please print)

NAME ____ DATE ______________

ADDRESS ____

CITY ____ ZIP ____________________

HOME PHONE ________________________ CELL PHONE ________________________

E-MAIL ADDRESS ____

BIRTH DATE ____________ AGE ______ GENDER ______________ Marital Status: __________

Emergency Information

CONTACT NAME ________________________ RELATIONSHIP________________________

CONTACT'S PHONE NUMBER ____

PRIMARY CARE PROVIDER'S NAME ____

CITY ________________________ PHONE NUMBER (if known) ________________________

TYPE OF CARE ____

SECONDARY CARE PHYSICIAN'S NAME(S) ____

Cancellation Policy

Espiritu Acupuncture and Wellness requires that all scheduled appointments be given at least 24 hours notice of cancellation. Failure to provide at least 24 hours notice will be subject to the cancellation charge of $50.00.

Initials of Participant or Guardian: __________

MEDICAL HISTORY QUESTIONNAIRE

What is your main reason for making this appointment?

When was your last medical exam or check up?

Who referred you to acupuncture?

	Yes	***No***	*Please explain any answer:*
Have you had acupuncture before?	☐	☐	______
Do you have the tendency to faint?	☐	☐	______
Do you have a pacemaker?	☐	☐	______
Do you have Hepatitis A, B, C, D, E?	☐	☐	______
Are you HIV+?	☐	☐	______
Do you believe you are pregnant?	☐	☐	______
Any traumas?	☐	☐	______
Any accidents?	☐	☐	______
Any surgeries?	☐	☐	______

Please further explain any of the answers above:

Family Medical History

Please indicate if any of your blood relatives **now have** or **have had** any of these conditions?

☐ Heart disease	☐ High/low blood pressure	☐ Emotional disorders	☐ Fainting
☐ Irregular heart rhythm	☐ High Cholesterol	☐ Paralysis	☐ Tuberculosis
☐ Chest pain/discomfort	☐ Heart murmurs	☐ Cancer	☐ Obesity
☐ Respiratory disorders	☐ Dizziness/vertigo	☐ Stroke	☐ Diabetes
☐ Excessive Fatigue	☐ Bleeding disorders	☐ Epilepsy	☐ Anemia

Physical Activity History

Please indicate the type and amount of exercise or activity that you do regularly. (What, how long, how often)

Dietary Habits

Please describe how you typically eat. (What, when, how often, food allergies, cravings)

GENERAL MEDICAL HISTORY

Please indicate if you have now or have any of these conditions by marking with a "C" for current and a "P" for past.

Head and Neck
__ Dizziness
__ Fainting
__ Enlarged Lymph glands
__ Headaches
Other ________________

Ears
__ Infection
__ Ringing
__ Loss of hearing
__ Pain
Other ________________

Eyes
__ Blurred vision
__ Changes in vision
__ Poor night vision
__ Spots or floaters
__ Inflammation/stys
Other ________________

Nose/throat/mouth
__ Bleeding
__ Sinus infections
__ Allergies
__ Sore throat
__ Hoarseness
__ Changes in taste
__ Difficulty swallowing
__ Changes in smell
__ Ulcers/Canker sores
__ Sore/bleeding gums
__ Toothaches
__ Teeth problems
Other ________________

Skin
__ Hives
__ Rashes
__ Allergies
__ Eczema
__ Psoriasis
__ Night sweat
__ Excess sweating
__ Dryness
__ Bruise easily
Other ________________

General
__ Fatigue
__ Thirst
__ Changes in appetite
__ Poor appetite
__ Aversion to cold
__ Aversion to wind
__ Frequent dreams/nightmares
__ Depression
__ Agitation
__ Irritability
__ Anxiety
__ History of psychiatric treatment
__ Poor memory
__ Difficulty concentrating
__ Sores that don't heal
__ Surgical implants
__ Unusual bleeding or discharges
__ Jaundice
__ Epstein Barr (EBV) or Mononucleosis (Mono)
__ Rheumatic fever
__ Thyroid disorder
__ Cancer
__ Anemia
__ Lupus
Other ________________

Neurological
__ Numbness
__ Tingling
__ Allergies
__ Seizures
__ Tremors
__ Paralysis
__ Epilepsy/convulsions
Other ________________

Infection History
__ Staph
__ MRSA
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes
__ TB
Other ________________

Gastrointestinal
__ Indigestion
__ Nausea
__ Bloating
__ Stomach pain
__ IBS
__ Colitis
__ Crohn's disease
__ Pancreatitis
__ Bowel movement changes
__ Frequent diarrhea
__ Frequent constipation
__ Dry hard stools
__ Soft sticky stools
__ Loose stools
__ Bloody stools
__ Excessive hunger
__ Hemorrhoids
__ Vomiting blood
__ Peptic ulcer
__ Recent changes in weight
__ Food cravings
Other ________________

Cardiovascular
__ Palpitations
__ Chest pain or tightness
__ Rapid heartbeat
__ Heart disease
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Cold hands/feet
__ Pacemaker
__ Hoarseness
__ High blood pressure
__ Stroke
Other ________________

Respiratory
__ Chronic cough
__ Coughing up blood
__ Coughing up phlegm
__ Difficulty breathing
__ Wheezing/asthma
__ Frequent colds
__ Emphysema
__ Pneumonia
__ COPD
Other ________________

Women
__ Frequent vaginal infections
__ Infertility
__ Pain/itching of genitals
__ Genital lesions/discharge
__ Pelvic inflammatory disease
__ Abnormal pap smear
__ Irregular periods
__ Emotional changes with menses
__ Clots in menses
__ Painful menstrual cramps
__ PMS
__ PCOS
__ Abnormal bleeding
__ Menopausal symptoms
__ Breast lumps/cysts
__ Breast swelling/pain
Other ________________
When was your last period?
____
How many days between periods? ________________
Color? ________________
Clots? ________________

Men
__ Pain/itching of genitals
__ Genital lesions/discharge
__ Impotence
__ Premature ejaculation
__ Prostate problems
__ Infertility
Other ________________

Urinary
__ Frequent urination
__ Frequent UTI
__ Weak stream
__ Changes in bladder habits
__ Kidney disease
How many times do you urinate per day ? __________
How many times do you urinate at night ? __________
Other ________________

Please explain any situation above:

Do you have any other condition not listed above? ***Yes / No*** If yes, please state:

MUSCULOSKELETAL MEDICAL HISTORY

Please indicate if you have any of these conditions by marking with a "C" for current and a "P" for past.

General
__ Chest pain/discomfort
__ Chest Pain with cough
__ Pain when coughing
__ Pain in the ribs
__ Epigastric Pain
__ Lower abdominal Pain

Shoulder
__ Pain L/R (circle one)
__ Pain with movement
__ Pain with overhead movement
__ Loss of movement
__ Shoulder "gives out"
__ Swelling
__ Frozen shoulder
__ Dislocation
__ Tendonitis
__ Bursitis
__ Rotator cuff
Other ________________

Hands/Wrist
__ Cold/Hot hands
__ Numbness/Tingling
__ Loss of grip strength
__ Pain with movement
__ Swelling
__ Carpal tunnel
__ Arthritis
Other ________________

Abdomen
__ Hernia
__ Tenderness
__ Belly button pain when coughing or sneezing

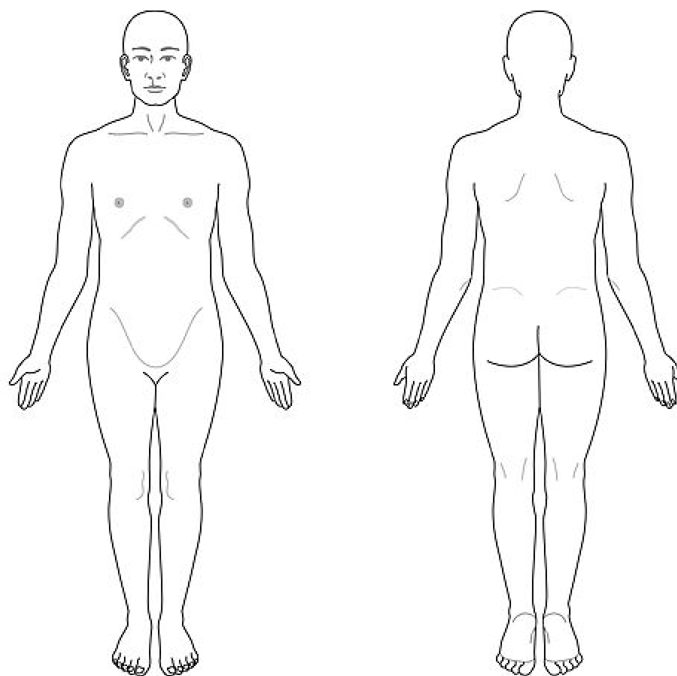
Upper/Mid Back
__ Pain when lifting
__ Pain while standing
__ Pain while twisting
__ Pain as you stand up
__ Disk problems
__ Degenerative disc
__ Herniated
__ Stenosis
__ Scoliosis
__ Spinal fusion
Other ________________

Knee
__ Pain L / R (circle one)
__ Swelling or redness
__ Pain with movement
__ Loss of flexibility
__ Pain bearing weight
__ Pain going down stairs
__ Pain going up stairs
__ Pain or stiffness after sitting for long periods
__ Stiff when getting out of bed
__ Knee gives out or locks
__ Grinding noise or feeling
__ Stiff when getting out of bed
__ Knee Replacement ***L*** / ***R***
__ Meniscus
__ ACL / PCL / MCL
__ Tendonitis
__ Bursitis
Other ________________

Arms/Forearms/Elbow
__ Cold/Hot hands
__ Numbness/Tingling
__ Loss of strength
__ Loss of movement
__ Pain with movement
__ Tennis or golfer's elbow
__ Psoriasis
__ Arthritis
__ Fractures or breaks
__ Dislocation
Other ________________

Low Back
__ Sudden pain
__ Pain comes on when constipated
__ Pain as you defecate
__ Pain radiates to groin
__ Pain worse in morning
__ Stiff when getting out of bed
__ Unable to twist/turn at waist
__ Degenerative disc
__ Pinched nerves
__ Stenosis
__ Sciatica
__ Herniated
__ Spinal fusion
Other ________________

Please mark with an "X" where you **currently** have pain.



Rate your pain (circle one)
(Mild) ***1 2 3 4 5 6 7 8 9 10*** (Severe)

Quality of pain (circle one)
Dull Achy Sharp Burning Stabbing Numb

Radiating Tingling Cramping Other

Neck
__ Pain with movement
__ Pain with tilting
__ Pain with twisting
__ Whiplash
__ Loss of flexibility
__ Stiff getting out of bed
__ Stiff neck
__ Grinding/popping noise
__ Degenerative disc
__ Pinched nerves
__ Stenosis
__ Herniated
__ TMJ
__ Spinal fusion
Other ________________

Hips/Pelvis/Legs
__ Hernia
__ Fractures or breaks
__ Dislocation
__ Hip Replacement
__ Groin pain with coughing
__ Stiff when getting out of bed
Other ________________

Feet/Ankles
__ Psoriasis
__ Numbness/Tingling
__ Sprained ankle
__ Arthritis
__ Achilles tendonitis
__ Fractures or breaks
Other ________________

Please further explain any situation stated above:

Do you have any other condition not listed above? *Please explain:*

MEDICATIONS

Please list all medications, herbal supplements, nutritional supplements, or vitamins and minerals that you take regularly as well as the reason why you are taking them.

Date:	Medication:	Reason:	Dose and How often:		Date of last dose:	Prescribed by:	Start date:

NOTICE OF PRIVACY POLICIES

This office is dedicated to providing services for your health and protecting your privacy. This notice will remain in effect until it is replaced or amended by changes in the law.

Personal Information is gathered from you in the following ways:
Information received from you.
Information received from other healthcare providers.

This information is used for the purposes of treatment, payment and healthcare operations. This office will use and disclose information about you only for those purposes.

You may specifically authorize us to use protected health information (PHI) for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any entity that you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters or appointment reminders, by telephone, email, or mail. Please inform us if you do not want us to contact you for any of the above reasons. We do **NOT** sell your information or share your information with unrelated companies.

Disclosure
This office may use or disclose your PHI when required by law.

Patient Rights
Upon written request, you have the right to access, review, or receive copies of your healthcare records.
For paper copies there is a copy fee of $0.25 per page and this office will need 10 working days to process it.
Upon written request you have the right to receive a list of items this office has disclosed.
You have the right to request that this office place additional restrictions on disclosure of your PHI.
You have the right to request that we amend your PHI; this request must be submitted in writing.
You have a right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact the office. Send written complaints to the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of the Notice of Privacy Practices

I, (print full name) ______________________________________, have read, reviewed, understand and agree to the statement of the Notice of Privacy Policy for healthcare services in this acupuncture office, Espiritu Acupuncture and Wellness.

______________________ ____
Date **Signature of Patient or Personal Representative**

_______________ ***AM / PM*** ____
Time **Print Name**

Description of Personal Representative's Authority:

____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, (print full name) ______________________________, with my consent, Espiritu Acupuncture and Wellness may use and disclose my protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) when applicable. Please refer to Espiritu Acupuncture and Wellness' Notice of Privacy Practices for a more complete description of such uses and disclosures.

The PHI is any information that includes, but is not limited to:
-Demographics information.
-Information gathered by this practice as it relates to my past, present, and future physical or mental health.
-Information gathered by this office for past, present, and, future payments for providing healthcare services.
-Healthcare operations purposes will include quality assessment activities, business management and other general operations, procedures, or activities.

I have the right to review and have read the Notice of Privacy of Practices prior to signing this consent. Espiritu Acupuncture and Wellness reserves the right to revise its Notice of Privacy of Practices at any time.

With my consent, Espiritu Acupuncture and Wellness or any of its agents may call my home or any other designated location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments, and any call pertaining to my clinical care, including laboratory results amongst others.

With my consent, Espiritu Acupuncture and Wellness or any of its agents may mail to my home or any other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are clearly marked personal and confidential.

With my consent, Espiritu Acupuncture and Wellness or any of its agents may email me appointment reminders and patient statements. I have the right to request that Espiritu Acupuncture and Wellness or any of its agents restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Espiritu Acupuncture and Wellness or any of its agents to use and disclosure of my PHI to carry out TPO.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Espiritu Acupuncture and Wellness or any of its agents may decline to provide me treatment.

______________________ ______________________________
Date **Signature of Patient or Personal Representative**

______________ ***AM / PM*** ______________________________
Time **Print Name**

Description of Personal Representative's Authority:

____

OFFICE POLICIES SUMMARY

Welcome to Espiritu Acupuncture and Wellness. Our goal is to make you comfortable and give you the best care possible. At any time, please do not hesitate to ask any questions that you might have regarding your visit, your billing, or about any of our policies.

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area with similar qualifications. Please ask to see our fee schedule. We except cash, credit cards, and personal checks. Please note, there will be a $25 charge for any returned check.

Initials: ______

CANCELLATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50.00 fee for any missed appointment or any cancellation with less than 24 hours notice.

Initials: ______

FINANCIAL AGREEMENT ASSIGNMENT OF BENEFITS

I, (print your full name) ____, am receiving or about to receive healthcare services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand that I will be responsible for all "non-covered" services and/or coinsurance/co-pays associated with my office visit. In addition, I also authorize insurance payments of medical benefits to Espiritu Acupuncture and Wellness.

By signing below, I agreed to comply with the office policies stated above which I have read and understood. I also authorize the use of my signature below on all insurance submissions.

____________________ ____

Date **Signature of Patient or Personal Representative**

______________ ***AM / PM*** ____

Time **Print Name**

Description of Person Representative's Authority:

____

Informed Consent
(Please Read)

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 name above, for whom I am legally responsible) by an acupuncturist of Espiritu Acupuncture and Wellness and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back up for the Espiritu Acupuncture and Wellness, including those working at this clinic or office listed below or any other office of 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, tuina (Chinese massage), ear acupuncture/stimulation, Chinese medicine, Chinese herbal medicine, corrective exercises and methods and nutritional counseling.

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 site that may last for a few days, and dizziness or fainting. The possible but 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, seeds and instruments 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, stomach ache, vomiting, diarrhea, rashes, hives and tingling of the tongue in addition to many others. I will notify the clinical staff member who is caring for me if I become pregnant or suspect that I may be pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks, complaints and/or complications of treatment, I wish to rely on the clinic staff to exercise judgement 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 the results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but that all of my records will be kept confidential and will not be released without my written consent.

In addition to being treated at Espiritu Acupuncture and Wellness, I may also understand that I may be treated in the public space. Although, I will be receiving treatment in a public place, I understand that the acupuncturist will take all reasonable measures under the circumstances to maintain my privacy. However, I acknowledge and accept that my privacy cannot be guaranteed.

My photographic/video images, and/or testimonial may be used for: Social media and/or advertising. I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purpose by Espiritu Acupuncture and Wellness. I understand that the information disclosed pursuant to this authorization may be subject to disclosure and may no longer be protected by HIPPA privacy regulations. I understand that this authorization may be revoked at any time, but such revocation must be in writing and received by the practice via registered mail. Any revocation affects disclosure moving forward and is not retroactive. This authorization expiries 99 years from signing date.

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 I've had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

____ ____________________
Signature of Patient or Parent/Legal Guardian Date

____ ____________________
Printed Name of Patient or Parent/Legal Guardian Relationship to Patient