Remember to Breathe Health Center

2204 Garnet Ave. Suite 301, San Diego 92109 858.291.8581

This is a CONFIDENTIAL questionnaire to help me determine the best treatment plan for you.

PERSONAL INFORMATION

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ E-mail _____

I was referred by _____

☐ Yes, send me email/text appointment reminders
☐ Yes, I would like to receive the monthly email newsletter

Sex : ☐ Male ☐ Female Height _____ Weight _____ Birth date _____ Age ____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of children _____

Have you received acupuncture therapy before? ☐ Yes ☐ No When? _____

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

Illness	You	Your relative	Approx. date	Illness	You	Your relative	Approx date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Press.	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Disease	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ AIDS ☐ Chlamydia ☐ Herpes Date _____

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How long?	Prescribed by	Date/last checkup
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Check the box next to any of the following you are currently taking:

☐ antacids ☐ aspirin ☐ cold tablets ☐ diet pills ☐ hay fever medication ☐ ibuprofen ☐ laxatives
☐ oral contraceptives ☐ sleeping pills ☐ tranquilizers ☐ herbs ☐ vitamins

Please indicate the frequency of the following:

Tobacco: ☐ Yes ☐ No If yes, # cigarettes/day _____ Non-medical drugs: ☐ Yes ☐ No How often____
Alcohol: ☐ Yes ☐ No If yes, # drinks per week _____
Caffeine: ☐ Yes ☐ No # colas/day _____ # coffee/day _____ # tea/day _____

Please fill out back side and attached forms

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

_____

What other forms of treatment have you sought? _____

List any other health problems you now have: _____

_____

List any allergies or food sensitivities: _____

List any accidents, surgeries or hospitalizations: _____

Acknowledgement of Receipt of Privacy Policies

Please read Privacy Policy on next page

I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature (If signing for patient, please state your relationship to patient)

_____

Late Cancellations and No Shows

To better accommodate those patients on my waiting list I am initiating the following policy.

If you find it necessary to cancel or change an appointment, please allow at least 24 hours notice. Any changes or cancelations (or missed appointments) less than 24 hours in advance will obligate you to pay for the originally scheduled time. Should a substitute be found to fill your appointment, no charge will be made for the missed appointment. I will go out of my way to be fair and will hope that you will do the same.

Should you feel that this policy is unreasonable, please discuss it with me.

I agree to give a minimum of 24 hours notice if I need to reschedule or cancel a scheduled acupuncture appointment.

I understand that if I cancel my appointment or do not show up I will be charged a fee of $40 for a one hour appointment or $20 for a half hour appointment.

Patient Signature _____

Name: _____ Date: _____

Please mark as follows.

Never = leave blank | Sometimes = 1 (1-3 times per month) | Frequent = 2 (1-2 times per week) | Always = 3 (Almost daily)

WOOD	FIRE	EARTH
— Irritability/resentment/anger	— Heart palpitations	— Heaviness anywhere in body
— Depression	— Chest pain	— Fatigue
— Indecisive	— Dizziness	— overweight
— Headaches or migraines	— Insomnia	— Edema (Swelling)
— Dizziness or vertigo	— Easily startled	— Muscles feel tired often
— Tremors or restless legs	— Mental Restlessness	— Easy bruising &/or bleeding
— Visual problems	___Mental agitation	— Bad breath
— Red or dry or itching eyes	— Anxiety	— Excessive hunger
— Spots in front of eyes	___ Panic attacks	— Poor appetite
— Feeling of lump in throat	___ Depression	— Tendency to low blood sugar
— Pain or full feeling in lower ribs	— Tongue sores	— Difficulty digesting greasy foods
— Clenching of teeth at night	— Vivid dreams	— Nausea or vomiting
— Muscle cramping or twitching	— Difficulty in concentration	— Gas and belching
— Cold hands &/or cold feet	— Dreams are bothersome	__ Acid reflux
— Joints feel tight and stiff	— Lack of joy in life	— Bloating or abdominal pain
— Awaken between 1 to 3 a.m.	— Laughing for no reason	— Gum or mouth sores
— Irregular menstruation	___Easily excitable	— Tired or sleepy after eating
— Menstrual cramps	___ Talks constantly	— Constipation
— Soft or brittle nails	— Craving bitter foods	__ Loose stools
— Craving sour foods	— Avoiding bitter foods	— Indigestion or heartburn
— Avoiding sour foods		— Excessive worrying
__ Prefer cold to heat		— Over thinking
		— Tendency to be obsessive
		— Craving or avoiding sweets

Name: _____ Date: _____

Please mark as follows.

Never = leave blank | Sometimes = 1 (1-3 times/month) | Frequent = 2 (1-2 times/week) | Always = 3 (Almost daily)

METAL

___ Dry cough
___ Has much phlegm
___ Sticky sputum
___ Asthma
___ Sinus problems
___ Poor sense of smell
___ Nose bleeds
___ Itchy or painful throat
___ Dry mouth
___ Skin rashes
___ Oily skin
___ Dry or Itchy skin
___ Grief or sadness
___ Shortness of breath
___ Allergies
___ Low resistance to colds
___ Low physical stamina
___ Sweats easily w/ little exertion
___ No desire to talk
___ Craving spicy foods
___ Avoiding spicy foods

WATER

— Urinary problems
— Frequent urination
— Incontinence
— Lower back pain or weakness
— Arthritis, degenerative bones
— Weakness or pain in knees,
— Feel cold easily
— Low sexual energy
— Excess sexual desire
---- Erectile dysfunction
---- Premature ejaculation
___ Little desire to drink
___ Fearful or easily frightened
___ Poor memory
___ Mental confusion
___ Insomnia
___ Loss of hair
___ Loose stools
___ Hearing problems
___ Ringing in ears
___ Craving salty foods
___ Avoiding salty foods
___ Prefers heat to cold

WOMEN ONLY

Age at onset of menses? _____
Date of first day of last period?
_____
Are you pregnant? Y N
Number of children? _____
Premature births? _____
Number of miscarriages? _____
Caesarian sections? _____
Abortions? _____
Infertility problems? _____
Type of birth control? _____
Last OB/GYN exam? _____
Results? _____
_____

MEN ONLY

Decrease in urinary flow? _____
Premature ejaculation? _____
Infertility problems? _____
Nocturnal Emissions? _____
Impotence? _____
Pain or itching in genital area?
_____
_____
Prostate problems? _____
_____

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 indicated 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.

ACUPUNCTURIST NAME: Nicole Stone, L.Ac.

(Date)

PATIENT SIGNATURE X

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

Remember to Breathe, A Natural Health Center
Nicole Stone, L.Ac.
2204 Garnet Ave. Suite 301, San Diego 92109 858.291.8581

PRIVACY POLICY STATEMENT

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.
This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:
- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations.

You may specifically authorize us to use your protected healthcare information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminders, by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed of your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of our Protected Health Information.
4. You have the right to request that we amend your Protected Health Information. The request must be in writing.
5. You have the right to receive all notices in writing.

If you have any questions, complaints or want more information contact this office.
Nicole Stone, L.Ac.
2204 Garnet Ave. Suite 301, San Diego, CA 92109 858-291-8581
You may submit a written complaint to the U.S.A. Department of Health and Human Services