NATURAL HEALTH CARE CENTER

PERSONAL INFORMATION:

Name: _____ Gender: M____F____ Marital Status: M___S___ D___W___.

Birthday: _____/_____/_____ Age: _____ Occupation: _____

Home Address: _____

Telephone: Home _____ Office _____Cell _____

Email Address: _____

Emergency contact person and phone number: _____

Have you received Acupuncture therapy before? _____ When_____ and where_____

Referred by _____ Health insurance _____

PERSONAL HEALTH INFORMATION:

Major complaint: 1. _____

2._____

List of the doctors you have seen and the *diagnosis* related to your major complains:

_____

List of medications / Herbs currently you are taking which is related to your major complains:

_____

List of allergic food, drugs, and herbs:

_____

FAMILY ILLNESS:

Cancer_____, High blood pressure_____, Heart disease _____, Diabetes _____,

Seizure _____, Emotional problems _____, Drug / alcohol /tobacco abuse _____.

INFORMATION FOR WOMEN ONLY:

Menstruation started at _____year old, ended at _____year old. _____days per cycle, and each cycle lasts for _____days. The color _____, amount _____, and clots _____ of the period.

Number of miscarriage / abortion _____, and number of children_____.

CHECK ANY CURRENT CONDITONS (mark as C) AND THOSE YOU HAD IN THE PAST (mark as P):

RESPIRATORY & CIRCULATION SYSTEM ___ Coughing ___ Running nose ___ Shortness breath ___ Excessive phlegm, color_____ ___ Asthma /wheezing ___ Chest Pain ___ Palpitation ___ Irregular Heart beat ___ Coronary Heart Disease ___ High Blood Pressure ___ Low Blood Pressure ___ Problem in Blood Vessels ___ Others	**DIGESTIVE & HEMOPOIETIC SYSTEM** ___ Nausea ___ Vomiting ___ Gas Distention ___ Heart burn ___ Constipation ___ Diarrhea ___ Epigastric /Abdominal Pain ___ Hypochondria Pain ___ Ulcer ___ Cholecystitis ___ Hepatitis A/B/C ___ Gall Bladder Stone ___ Cirrhosis ___ Anemia ___ Others	**URINARY & REPRODUCTIVE SYSTEM** ___ Frequency of Urination ___ Incontinence of Urine ___ Enuresis ___ Urinary Retention ___ Pain with urination ___ Blood in Urine ___ Kidney Stone ___ Bladder Infection ___ Prostate problems ___ Testicular pain ___ Seminal Emission ___ Impotence ___ Decreased libido ___ Others
METABOLISM, ENDOCRINE IMMUNITY & OTHERS ___ Diabetes ___ Gout ___ Hyperlipemia ___ Hyperthyroidism ___ Hypothyroidism ___ Over Weight ___ Fatigue ___ Drinking alcohol _____/time ___ Smoking ____pack /day ___ Use of Narcotics / Cocaine ___ Others:_____	**MUSCULOSKELETAL SYSTEM** ___ Joint pain ___ Muscle pain ___ Shoulder / neck Pain ___ Ribs pain ___ Leg Cramps ___ Upper back pain ___ Lower back pain ___ Cervical Spondylopathy ___ Arthritis ___ Tennis Elbow ___ Carpal Tunnel Syndrome ___ Sprain ___ Others: _____	**SURGICAL & SKIN DISEASE** ___ Hemorrhoid ___ Appendisitis ___ Gangerine ___ Varicos veins ___ Eczema ___ Herpes ___ Acne ___ Skin rashes ___ Itching / dry skin ___ Shingles ___ Psoriasis ___ Hair loss ___ Others
GYNOCOLOGY ___ Dysmenrrhea ___ Amenorrhea ___ Irregular Menstruation ___ Leukorrhea ___ Pelvic Inflammation ___ Viginal dryness ___ P.M.S. ___ Menopause Syndrome ___ Uterus Fibroid ___ Ovarian Cyst ___ Breast Cyst ___ Infertility ___ Morning Sickness ___ Threatened miscarriage ___ Wrong position of fetus ___ Difficulty labor ___ Insufficient lactation ___ Postpartum body pain ___ Breast infection ___ Others: _____	**EYE, EAR, NOSE & THROAT** ___ Poor vision ___ Dry eyes / Floaters ___ Night blindness ___ Red eyes ___ Eye pain ___ Cataract ___ Glaucoma ___ Sore throat ___ Dry mouth ___ Excessive saliva ___ Swollen glands ___ Enlarge thyroid ___ Nose bleeding ___ Sinus problem ___ Ringing in ears ___ Poor hearing ___ Earaches ___ T.M.J. ___ Others: _____	**NERVE & PSYCHICAL SYSTEM** ___ Poor memory ___ Headache ___ Insomnia ___ Dizziness ___ Numbness in the limbs ___ Facial Spasm ___ Paralysis ___ Stroke ___ Epilepsy ___ Difficult to balance ___ Anxiety ___ Depression ___ Bipolar ___ Panic attacks ___ Stress Syndrome ___ Others _____

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INFORMED CONSENT TO ACUPUNCUTRE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Xiuxia Yang, a Licensed Acupuncturist. I have discussed the nature and purpose of my treatment with her. I understand that methods of treatment may include but not limited to Acupuncture, Moxibustion, Cupping, Electrical Stimulation, Tui Na (Chinese Massage), and Chinese herbs.

"Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. The potential benefits of acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

Electrical Stimulation uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity and moderate pulsation will be felt.

Indirect Moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists.

Acupressure/TuiNa involves rubbing, kneading, pressing, and stroking, etc. Which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.

Cupping involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe, 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, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify my Acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify my Acupuncturist if I am or become pregnant.

I do not expect my Acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my Acupuncturist to exercise judgment during the course of treatment which Xiuxia Yang thinks at the time, based upon the facts known to her, is in my best interests.

By voluntarily signing below I show that I have read, or have had read to me, this 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 condition and any future condition(s) for which I seek treatment.

Patient name: _____ Patient signature: _____

Xiuxia Yang Physician in China, C.A. Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information, Our office is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information. Prior to making important changes to our privacy practices, we will make available on request a revised Notice of Privacy Practices

How we may use and disclose medical information about you

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures, but not all possible uses or disclosures are listed.

For treatment: We may use and disclose medical information about you to provide you with acupuncture and Chinese herbs. Example: In treating you for a specific condition, we may need to know if you have any disc problems that could influence with acupuncture points we chose for treatment purpose.

For payment: We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment of your insurance company for payment.

Health care operations: We may use and disclose medical information about you for health care operation s to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other uses or disclosures that can be made without consent or authorization: As required during an investigation by law enforcement agencies; to avert a serious threat to public health and safety; As required by military command authorities for their medical records; To worker's compensation or similar programs for processing of claims; In response to legal proceeding; to a coroner or medical examiner for identification of body; If an inmate, to the correctional institution or law enforcement official; As required by the US Food and Drug Administration (FDA); Other healthcare providers' treatment activities; Other covered entities' healthcare operations activities (to the extent permitted under HIPAA); Uses and disclosures required by law; Uses and disclosure in domestic violence or neglect situations; Health Oversight activities; Other public health activities. We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and disclosure of protected health information requiring your written authorization: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization to use or disclose medical information about you, and you may revoke that authorization in writing at any time.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.
This office reserves the right to change its practices and effect new provisions that enhance the privacy standard of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file to give the opportunity to sigh the new form.

Patient Name: _____,

Signature: _____, Date: _____