www.TheAcupunctureStudio.com

**Healing based on Simplicity. Pricing based on reality.**
**Welcome to our community!**

Thanks for coming in! We look forward to working with you. Community Acupuncture is a unique experience, so please take a few minutes to read this packet and fill out our health history questionnaire.

## Why does Community Acupuncture work?

1. Frequent Treatments
2. Sliding Scale
3. Community Setting
4. Commitment from us and Commitment from you.

Let us explain...

1. **Frequent Treatments**. Acupuncture is a PROCESS. Healthy changes happen over time, and acupuncture is no exception. Although individual situations will vary, you can generally expect to see progress as demonstrated by this chart.

| Being Treated For: | Example of Conditions | Treatment frequency | For how long: |
|---|---|---|---|
| Very Severe Discomfort | Acute back sprain, Daily migraines | Daily until change in condition | For several days |
| Serious Discomfort | Sprained ankle, acute digestive distress | Every other day until change in condition | A week or two |
| Moderate Discomfort | Knee pain while running, poor sleep | Twice weekly until change in condition | Over several weeks |
| Working on a Health milestone | Trying to get pregnant overcoming allergies | Twice weekly until change in condition | Over several weeks |
| Ongoing Episodic Condition | Occasional insomnia PMS | Weekly + as-needed for acute pain | Over a few months |
| Support for chronic issues | Stress, work-related Issues, chronic illness | Weekly | Ongoing/ as needed |
| General health | Life! | Weekly or bi-monthly | Ongoing/ as needed |

**These are only generalizations; talk with Brooke to find the best routine for you.**

2. **Sliding scale**. We have a sliding scale of $20-$30. You decide what you can afford, and there is never any need to prove your income. **The "right" amount to pay is whatever will allow you to come often enough to feel better (see above chart).** There is a one-time additional $10 paperwork fee for your first appointment. Because of our sliding scale, we don't do insurance billing; we'd rather let you decide how much to pay and how often to come, not the insurance company. We exist because our patients pay for their visits-Thank you! (We are happy to give you a receipt to give to your insurance company, Flex plan, etc.)

*Note: There is an additional $10 fee for the first treatment.*

3. **Community Setting.** In our clinic, treatments take place on recliners and tables in a large common room. It's a set-up that is not only surprisingly relaxing, but it is also practical; we can treat several people in the same hour and reduce the cost of your visit, and you can bring friends and family to the same visit! We encourage you to bring your own music with headphones, blankets or pillows to make you feel more comfortable (we have blankets and pillows as well). Although we work in a community space, as medical professionals we always adhere to strict standards of patient confidentiality, and ask our patients for the same common respect.

4. **Commitment from us and commitment from you**. We really want you to get better. We will do everything we can to use acupuncture to help you reach your health goals. We also promise to let you know as early as possible if acupuncture doesn't seem to be a good fit for you. What we ask in return is that you stay committed to your plan of feeling better, have patience...and have fun.

**ONE MORE THING...WE WANT YOU TO HAVE FREE TREATMENTS...**

We are always looking for things that will help our patients, our business and the environment. So, we give our patients the option to bring in their own sheet! If you do so, **we will give you a free treatment after bringing it in 10 times**. Just another example of us all working together to make a good situation better.

## ACUPUNCTURE STUDIO CANCELLATION POLICY

**The Acupuncture Studio requires 24 hours notice for any cancellation, or you will be charged for the appointment.**

# HEALTH HISTORY FORM

WWW.THEACUPUNCTURESTUDIO.COM

| PATIENT INFORMATION | CONTACT INFORMATION |
|---|---|
| Date_____ | Home phone _____ |
| | Work Phone _____ |
| Name_____ | Other/cell Phone _____ |
| Address _____ | Please circle the best phone to reach you for |
| City State Zip_____ | scheduling issues. May we leave messages? Yes/No |
| Age_____ Birth Date_____ | E-mail _____ |
| Occupation_____ | Would you like our Acupuncture Studio e-mail |
| Company Name_____ | newsletter? Yes / No |
| Primary Physician_____ | Another Person we may contact if needed: |
| Physician Phone Number_____ | Name _____ |
| How did you hear about us? _____ | Relationship _____ |
| _____ | Home Phone _____ |
| _____ | Work Phone _____ |

| HEALTH HISTORY | |
|---|---|
| What are your primary reasons for coming in for treatment?<br>1. _____<br>2. _____<br>3. _____<br>How is your sleep? _____<br>_____<br>How is your digestion? _____<br>_____<br>List medications/ supplements you are taking:<br>_____<br>_____<br>_____<br>**Check illnesses that have occurred in your blood relatives.**<br>_Diabetes _High Blood Pressure _Stroke<br>_Cancer _Heart Disease _Kidney Disease<br>_ Other :_____ | Check symptoms you have had in the last 3 months:<br>o Depression<br>o Difficulty in focusing<br>o Dizziness<br>o Easily startled<br>o Excessive worry<br>o Excessive anger<br>o Excessive fear<br>o Fatigue/tiredness<br>o Headaches<br>o Loss of sleep/poor sleep<br>o Loss or gain of weight<br>o Nervousness/irritability<br>o Overwhelmed by life<br>Check conditions you have or have had in the past:<br>o AIDS<br>o Allergies<br>o Anemia<br>o Arthritis<br>o Bleeding Disorders<br>o Breast Lump<br>o Cancer<br>o Diabetes<br>o Hepatitis/ Liver Disease<br>o How long has it been since you have had a complete medical exam?_____ |

HEALTH HISTORY...CONTINUED
Please check symptoms you have or have had in the last year:

**MUSCLE/ JOINT BONE**
- Tremors or cramps
- Swollen joints

Pain, weakness or numbness in:
- Arms
- Back/ Hips
- Legs
- Feet
- Neck
- Shoulders
- Other_____

**EYES/ EARS/ NOSE/ THROAT/ RESPIRATORY**
- Asthma
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay Fever
- Hoarseness
- Gum Trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems
- Other_____

**SKIN**
- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats
- Other_____

**GENITO/ URINARY**
- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido
- Other_____

**CARDIOVASCULAR**
- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles
- Other_____

**GASTROINTESTINAL**
- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall Bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Other_____

**FOR MEN ONLY**
- Erection difficulties
- Penis discharge
- Prostate trouble
- Other_____

**FOR WOMEN ONLY**
- Bleeding between periods
- Clots in menses
- Excessive menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow
- Other_____

Could you be pregnant? Yes / No

## I. Patient Advisory To Consult A Physician

Our office is committed to your health and wellbeing. While Oriental Medicine has a great deal to offer as a health care system, **it cannot totally replace the resources available through Medical Doctors**. Therefore, we recommend that you consult a physician regarding any condition(s) for which you are seeking acupuncture treatment.
To comply with Article 160, Section 8211 1.(b) of NYS Education law, we request that you read and sign the following statement:
WE, THE UNDERSIGNED, DO AFFIRM THAT _____ (PATIENT) HAS BEEN ADVISED BY BROOKE WOOD L.Ac., TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____
Signature of Patient Date

_____
Signature of Licensed Acupuncturist

## II. Notice of Privacy Policies

**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.**
Each time you visit the Acupuncture Studio, a record is made of your visit. This record contains your health history, current symptoms, examination results, oriental medical diagnosis and treatment plans. This information serves as:
- A basis for planning your care and treatment. - A tool to assess the appropriateness and quality of care you receive.
- A legal document describing the care you received, written in a format appropriate to Acupuncture Oriental Medicine.
***Your rights under Federal Privacy Standard.*** Although your health record is the physical property of the Acupuncture Studio, you have certain rights with regard to the information contained therein. You have the right to:
- Request restrictions on the use and disclosure of your health information for treatment, payment, and health care operations. Health care operations consist of activities necessary to carry out the operation of the Acupuncture Studio. This right does not include those required by law such as reporting of communicable disease such as tuberculosis.
- You may ask us to communicate with you by alternative means. If the method is reasonable, we must grant your request. -You have a right to receive and keep a copy of this notice of privacy practices. If you do request a copy, the law requires you to acknowledge the receipt of your copy. -You have the right to inspect and copy your health information upon request. - You have the right to request a correction of your health information unless we did not create the record or if the record is accurate and complete. -You have the right to obtain an accounting of non-routine uses or disclosures.-You have the right to revoke authorization to use or disclose your health information at any time.
***Our responsibility, under the Federal Privacy Standard.*** In addition to providing you with your rights, the federal standard requires the Acupuncture Studio to:
- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this practice. - Train our personnel concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who breach privacy/confidentiality policies.
- Lessen the harm of any breach of privacy or confidentiality.

I understand that I have been given, and have the right to review the Acupuncture Studio's Notice of privacy practices prior to signing this document. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____
Signature of Patient or Representative Patient's Date of Birth

_____ _____
Printed Name Date

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# ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other clinical procedures within the scope of the practice of acupuncture on me (or 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 clinic or office, whether signatories to this form or not.

I understand that methods of treatment may include but are not limited to, acupuncture, moxibustion, cupping, and electrical stimulation. I understand that *if* moxibustion, cupping or electrical stimulation are added to my treatment plan, these methods will be thoroughly discussed with the acupuncturist prior to their beginning. 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. Burns are a potential risk of moxibustion. Bruising is a common side effect of cupping. Extremely unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another extremely unusual yet possible risk.

It should be noted that The Acupuncture Studio uses sterile, single-use, disposable needles and always 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. **I will notify a clinical staff member who is caring for me if I am or become pregnant.**

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

By voluntarily singing 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 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 condition(s) for which I seek treatment.

**Acupuncturist Name:** Brooke N. Wood

**Patient Signature:** **Date:**
(or patient representative)