INVIGORATE
ACUPUNCTURE

Health History Questionnaire

Date ____/____/____

Please help us provide you with a complete evaluation by taking the time to fill out this form. All of your answers will be held absolutely confidential.

Name: _____ _____Date of Birth: __/__/_____

Address:_____

Phone:_____ Email:_____ Occupation:_____

Emergency Contact:_____ (Phone)_____

Do you have an electronic implant like a pacemaker or any other condition which might contra-indicate the use of electrostimulation treatment? ___ Yes ____No

What is your main complaint for this visit and when did this problem begin?

What improves your main complaint (movement, rest, heat, ice etc):

What aggravates your main complaint (stress, foods, time of day, heat, cold etc) :

Describe any previous diagnosis or treatments you have received for this complaint:

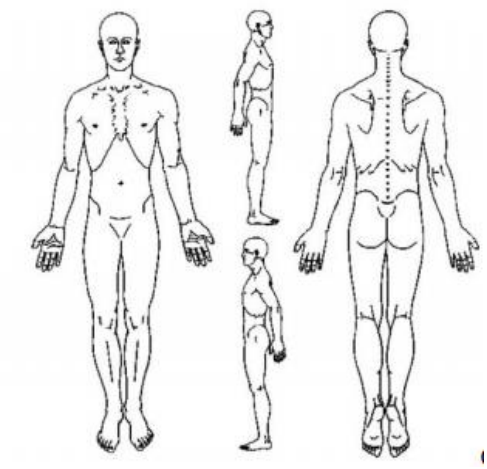
Please list all current or occasional drugs and supplements:
Current:

Occasional:

Please list any allergies:

Please list significant surgeries or injuries:

Pain Diagram: Please mark the diagram
A=Ache B=Burning



The Pain is (check all that apply):
□ **Sharp** □ **Dull** □ **Aching** □ **Shooting**
□ **Numb** □**Burning** □**Tingling**
□**Superficial** □**Deep**

I have (Check all that apply):
□ **Swollen Joints** □**Arthritis** □**Tendonitis** □**Bone pain**
□**Muscle pain** □**Cramping**

□**Fractured Bone(s)-Where? _____**

Additional Personal Medical History

__Abuse Survivor __AIDS/HIV __Addictions __Blood Clots __Cancer __Cardiovascular Disease
__Concussions __Considered Suicide __COPD __Diabetes __Thyroid issues
__Fungal infections __Gout __Hepatitis __Herpes __High Blood Pressure
__Kidney Stones __Neurological Disease __Seizures __STD's __Stroke
__Tuberculosis __Ulcer __Valley fever

Women's Health: Duration between menses _____
Duration of flow_____ Pregnancies_____
Miscarriages_____ Abortions_____
__Irregular cycles __Painful menses
__Hormonal headaches __Trouble Conceiving
___Menopause

Men's Health

__Erectile Dysfunction __Premature Ejaculation
__Inability to ejaculate __Pain or discomfort
__Pain with urination __Frequent urination
__Incontinence

-

Body-Feedback™ Assessment

Please Rate 0=Never, 1=Sometimes, 2=Most of the time, 3= All of the time

Lung Meridian

Discomfort in Shoulder, chest, upper back	0 1 2 3
Concerns with respiratory or skin health	0 1 2 3
Feelings of grief or sadness	0 1 2 3

Bladder Meridian

Discomfort of entire back, head, ankle	0 1 2 3
Concerns with nerves	0 1 2 3
Physically or emotionally inflexible	0 1 2 3

Large Intestine Meridian

Discomfort in low back, hip or shoulder	0 1 2 3
Concerns with digestion	0 1 2 3
Feelings of being stuck or blocked	0 1 2 3

Kidney Meridian

Discomfort in the low back and inner thigh	0 1 2 3
Concerns with horemones and Detoxing	0 1 2 3
Feeling self destructive	0 1 2 3

Stomach Meridian

Discomfort in Sinuses, esophagus, or neck	0 1 2 3
Concerns with digestion or tyroid	0 1 2 3
Feeling spacey, distratced or scattered	0 1 2 3

Pericardium Meridian

Discomfort in ribcage or posterior hip	0 1 2 3
Concerns with metabolism and horemones	0 1 2 3
Feeling manic at times	0 1 2 3

Spleen Meridian

Discomfort in upper back or Left side only	0 1 2 3
Concerns with energy level and muscle tone	0 1 2 3
Feeling worried or over-thinking	0 1 2 3

Triple Burner Meridian

Discomfort in joints in general or hairline	0 1 2 3
Concerns with fluid retention or lymph	0 1 2 3
Feeling regid or tied to rules	0 1 2 3

Heart Meridian

Discomfort in jaw, left shoulder, or sacrum	0 1 2 3
Concerns with sleep cycle or heart function	0 1 2 3
Feeling of melancholy or sadness	0 1 2 3

Gallbladder Meridian

Discomfort in tendons, shoulders or temples	0 1 2 3
Concerns with muscles or digestion	0 1 2 3
Feeling aloof or detached	0 1 2 3

HIPPA NOTICE
PRIVACY DISCLOSURE AND POLICIES

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

· Limited access to facilities where information is stored.
· Policies and procedures for handling information.
· Requirements for third parties to contractually comply with privacy laws.
· All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information:

· From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
· From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Invigorate Acupuncture, PLLC maintain my records confidentially in accordance with the law. I agree to inform Invigorate Acupuncture, PLLC if I need any special arrangements pertaining to this issue.

Signature:	**Date:**
Printed name:	

Informed Consent to Receive Treatment

By Signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist, Kate Campos or other licensed acupuncturists who are now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist.
I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, tui-na (chinese massage), chinese herbal medicine, nutritional counseling and lifestyle coaching.

Acupuncture: This is a safe treatment involving the insertion of fine, sterile, single-use needles through the skin. Treatments can occasionally produce a mild, temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a bruise at the acupuncture site. Other possible risks include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report any dizziness or lightheadedness to the licensed acupuncturist that occurs during or after a treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience and discomforts related to the use of any herbs I am prescribed, I understand that I should stop taking the herbs and inform my licensed acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage of administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking a medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or TDP lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by a heated glass cup or a pumped cup. There is the possibility of local non-painful bruising from this suction. Vary rarely a slight burn or blister may appear due to heat.

Gua-Sha: Gua Sha is a light scraping on the skin in a area using a smooth edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS unit may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during the treatment. Occasionally a mild achiness or soreness will be felt in the areas treated. I understand that I must inform my practitioner if am am using a pacemaker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or discomfort, as well as any area where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment, during or after the massage.

I understand that the clinical and administrative staff may review my patient records and lab records, 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 conditions and for future conditions for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Invigorate Acupuncture, PLLC is not a primary care physician.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my consent and permission for treatment.

Patient name:	Date:
Patient Signature:	Guardian Signature:

Notice and Authorization for Insurance Billing

I _____ (print name) do hereby give full permission and authorize Invigorate Acupuncture, PLLC, to bill my insurance for services rendered by Kate Campos, LAc. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Kate Campos LAc
6053 E. Grant Road, Suite A
Tucson, AZ 85712

As a courtesy, my insurance will be billed directly by Invigorate Acupuncture, PLLC. When possible, Invigorate Acupuncture, PLLC will call my insurance to verify my benefits, although benefits quoted by my insurance company are not a guarantee of payment. I am responsible for knowing the benefits my insurance policy covers. Payments will be due at the time of service for any non-covered services, deductibles or co-pays.

I understand if I do not have insurance coverage, I will receive a time of service discount. If I do have insurance that covers acupuncture treatment or other modalities, Invigorate Acupuncture, PLLC will bill my insurance for me at the full insurance fee rate. **I understand a full fee rate for services rendered is available upon request. I will be required to pay my insurance policies stated copay or coinsurance fee if required by my insurance, and/or the difference of the full insurance reimbursement and cash based fees**.

I understand the aforementioned office fees, insurance and billing policy. If my insurance is billed by this office, my billing statement will show “signature on file.”

Please check one of the following:

____ I authorize Invigorate Acupuncture, PLLC to bill my insurance.

____ I choose not to have my insurance billed for me and will pay cash or credit card for my treatments at the time of service.

*Please note Invigorate Acupuncture, PLLC has a 24-hour appointment cancellation policy. Unless due to an emergency, any cancellations made with less than 24 hours notice prior to their scheduled appointment time will be charged a $30.00 fee.

_____ _____
Signature Date