Acupuncture of West Michigan
2815 Michigan St. N.E.,Suite A
Grand Rapids, MI 49506
P: 616-855-7718 F:616-855-2977

Personal Information

First Name:_____ Last Name: _____

Nickname: _____ Date:_____

Home Address:_____ City:_____

State:_____ Zip:_____ Home Phone: (_____)-_____-_____

Cell Phone: (_____) - _____-_____ Work Phone: (_____) - _____-_____ Ext___

Email Address:_____

Appointment Reminders: ___ Email ___ Text Message (Carrier _____) ____ Text and Email

Date of Birth:____/____/_____ Gender: M F

Marital Status: Single Married Partnered Divorced Widowed

Height:_____ Weight:_____ Occupation:_____

Have You Received Acupuncture Before: Yes No When:_____

How Did You Hear About Us:_____

In Case of Emergency Contact: Name:_____

Phone: (_____)-_____-_____ Relationship_____

Reason for Visit

Please list the reason or reasons you are seeking acupuncture today in order of importance. Please note that it is not always possible to address all conditions in one visit.

Condition	**Past Treatment (Medications, Surgery, Etc.)**
1._____	1._____
2._____	2._____
3._____	3._____

Please list all of the medical providers involved in your care for the above condition.

1._____

2._____

3._____

Lifestyle

Please indicate the use and frequency of the following:

	Yes	No	How Often		Yes	No	How Often
Coffee/Black Tea	____	____	_____	Soda Pop	____	____	_____
Recreational Drugs	____	____	_____	Exercise	____	____	_____
Tobacco	____	____	_____	Antacids	____	____	_____
Alcohol	____	____	_____	Laxatives	____	____	_____

Do You Typically Eat Three Meals A Day: Yes No If No How Many:_____

How Many Hours Per Night Do You Sleep:_____ Is It Easy For You To Fall Asleep: Yes No

Do You Wake Up During The Night: Yes No Do You Wake Feeling Rested: Yes No

How Many Hours Per Week Do You Work:_____ Do You Enjoy Work: Yes No

Medical History

Please note if you or an immediate family member are currently or have ever experienced any of the below diseases.

Illness	You	Relative
Cancer	_____	_____
High Blood Pressure	_____	_____
Emotional Disorders	_____	_____
Seizures	_____	_____

Illness	You	Relative
Diabetes	_____	_____
Heart Disease	_____	_____
Stroke	_____	_____

Do You Currently Have Any Infectious Diseases: Yes No If Yes, What Disease:_____

Do You Have Any Known Allergies: Yes No If Yes, To What:_____

Are You Taking Coumadin or Warfarin: Yes No Do You Have A Pacemaker: Yes No

Please list any medications (prescribed or over the counter), vitamins, supplements, or herbs you are currently taking or have taken in the last year.

Medication	Dosage	Reason	How Long	Prescribed By

Blood Pressure:_____/_____ Month And Year Blood Pressure Was Last Checked:_____/_____

Men Only

Date Of Last Prostate Check Up:_____/_____

Please Circle Any Symptoms That You Experience:

Erectile Dysfunction (ED)

Delayed Urinary Stream

Changes in Libido or Sexual Function

Decreased Force Of Stream

Genital Discharge

Genital or Groin Pain

Urinary Problems

BPH/Enlarged Prostate

Women Only

Are You Or Could You Be Pregnant: Yes No If Yes, How Far Along Are You:_____

Of Pregnancies:_____ # Of Live Births:_____

Age Of Last Period (Menopause):_____ Number Of Days Between Periods:_____

Number of Days Of Flow:_____ Color Of Blood:_____

Do You Have Clots In Your Flow: Yes No If Yes, What Is The Size Of The Clots:_____

Do You Have Heavy Flow: Yes No Do You Have Light Flow: Yes No

Have You Been Diagnosed With Any Of The Following (Please Circle If Yes):

Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts Pelvic Inflammatory Disease

Please Circle Any Symptoms That You Experience:

Vaginal Discharge

Premenstrual Nausea

Premenstrual Swollen Breasts

Poor Appetite Before Period

Poor Appetite During Period

Changes in Libido

Premenstrual Mood Swings

Ravenous Hunger Around Period Time

Headache Around Period Time

Changes in Bowel Frequency Around Periods

Hot Flashes

Vaginal Dryness

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 have 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.

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.

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: _____

Patient Signature **X** _____

(Date)

NOTICE OF PRIVACY POLICIES – August 21, 2014

Protecting your privacy and healthcare information is fundamental to our relationship with you. this notice will remain in effect until it is replaced or amended by changes in the law.

This office gathers 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

Protected health Information includes demographic information; information related to your physical or mental health; and payments for healthcare services.

During the course of your treatment we will likely use and disclose health information about you when it is required for treatment, payment, and when necessary during the course of normal business. Without your consent or authorization, this office may disclose information about you only to the following groups for the specified purposes:
- to a public health agency, for a purpose such as controlling disease.
- in case of suspected child abuse, to the appropriate governmental authority
- in other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if it appears necessary to prevent serious harm to you or others.
- to health oversight authorities, for regulatory, licensing, and other legal purposes
- in litigation, subject to certain requirements controlling the terms of the disclosure
- to law enforcement agencies, subject to applicable legal requirements and limitations.
- for medical research purposes, subject to your authorization or approval by an institutional review board
- if you are in the United States military, national security, or intelligence for Foreign Service, to your authorized superiors or other authorized federal officials.

We may not use or disclose information about you for any other purpose without your written authorization, provided separately from your written consent. You may submit written authorization to disclose Protected Health Information to a person or group specified by you.

Marketing

Marketing communications to yo may include mailings, newsletters, and appointment reminders by phone, postcard, letters, email, or text messaging. You have to the right to be taken off any or all of these lists.

Disclosure

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

Group Visits

If I choose to participate in a group visit, it is possible that some of my individually identifiable health information will be disclosed. I understand the following statements about my rights:
- I realize that I have the option to speak with my medical provider individually.
- I understand that I have the option to be treated individually if I so choose.
- I understand that discussions may occur regarding individually identifiable health information during a group visit.
- It is my responsibility to keep private names and information about other participants, as they are expected to do for me.

- It is possible that information that is used or disclosed in a group visit may be re-disclosed by other participants in the group visit.

Patient Rights

Upon written request, you have the right to access, review, or receive copies of your healthcare records.

Upon written request, unless prohibited by law, you have the right to receive a list of items this office disclosed about your healthcare information.

You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

You have the right to request restrictions on the use and disclosure of your Protected Health Information for the purposes of treatment or payment for healthcare operations, but this office is not required to agree to these restrictions.

You have the right to request that we amend your Protected Health Information. This request must be in writing.

You have the right to receive all notices in writing.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be brought to our attention by calling our office or directing a letter to the above address.

If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DDHS (Office of Civil Rights)
200 Independence Ave, SW
Room 509F HHH Building
Washington, DC 20201

I have received a copy of, read, reviewed, understand, and agree to the "Notice of Privacy Policies" for healthcare services at Acupuncture of West Michigan.

Patient Signature:_____

Date:_____

Acupuncture of West Michigan Cancellation Policy.

Scheduling an appointment involves the reservation of time specifically for you. Consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, a fee equal to the cost of the scheduled visit will be charged for sessions missed without such notice.

Patient Signature:_____

Date:_____