Harmony Acupuncture

4616 Potter Road Matthews, NC 28104 704-233-3544

General Information

GENERAL PATIENT INFORMATION Date:

Last Name_____ First Name_____

Marital Status: _____ DOB: _____

Preferred Phone_____ (H / C / W) Secondary Phone_____ (H / C / W)

Address_____

(street) (city) (state) (zip)

Email address: _____ ☐ *Check here to receive our newsletter.*

Emergency Contact: _____

(Name) (Relationship) (Phone Number)

Your Primary Care Physician_____

Who can we thank for referring you? _____

Present Health Concerns

Please list most important health Concerns in order of significance	Prior diagnosis of this problem? If so, what?
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

FOR OFFICE USE ONLY: *ICD-9 Codes:* 1st Treatment Date:

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HEALTH HISTORY QUESTIONNAIRE

Name:	**DOB:**	**Age:**	**Ht/Wt:**
Occupation:	**Marital status:**		
Emergency Contact Name:	**Phone:**		

Who may we thank for referring you?

Recent Health Care Providers: Name, Date, Service Provided:

MAIN CONCERN:

How does this problem affect your daily activities?

When did you first notice symptoms?

If you have been diagnosed, what is diagnosis? What

kinds of treatment or therapies have you tried?

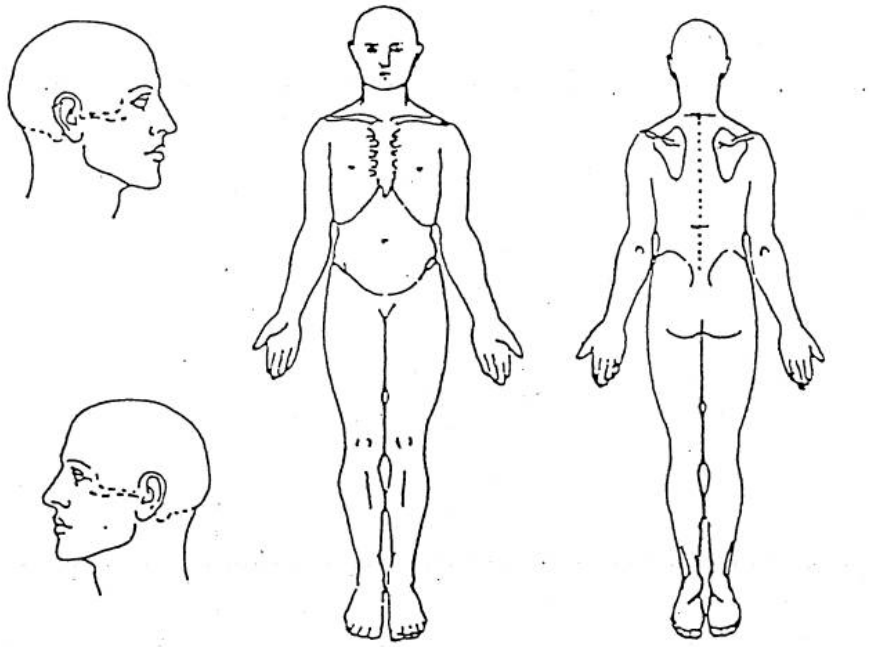
Hospitalizations/Surgeries/Accidents:

Allergies:

Family Health History

Family Member	*Age*	*Important Diseases/Illnesses*	*Deceased Y/N*

Please mark painful or distressed areas on the charts below



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

LIFESTYLE

Exercise

- ■ Sedentary (No exercise)
- ■ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ■ Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)
- ■ Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)

Diet

Are you dieting? ■ Yes ■ No

If yes, are you on a physician prescribed medical diet? ■ Yes ■ No

# of meals you eat in an average day? _____

Describe daily diet:

_____

_____

Caffeine/ Alcohol/ Drugs Tobacco

Indicate # of cups/cans per day ■ Coffee _____ ■ Tea_____ ■ Cola _____

■ Tobacco_____packs per day Type? # of years

Do you drink alcohol? ■ Yes ■ No

If so, how many drinks per week?

Do you use recreational drugs? Type_____ ■ Yes ■ No

MENTAL HEALTH

Is stress a major problem for you? ■ Yes ■ No

Do you feel depressed? ■ Yes ■ No

Do you panic when stressed? ■ Yes ■ No

Do you have problems with eating or your appetite? ■ Yes ■ No

Do you cry frequently? ■ Yes ■ No

Have you ever attempted suicide? ■ Yes ■ No

Have you ever seriously thought about hurting yourself? ■ Yes ■ No

Do you have trouble sleeping? ■ Yes ■ No

Have you ever been to a counselor? ■ Yes ■ No

PERSONAL HISTORY			
General	■ Poor Appetite	■ Weight Gain	■ Night Sweats
	■ Insomnia	■ Weight loss	■ Fever
	■ Disturbed Sleep	■ Sweating easily	■ Chills
	■ Localized Weakness	■ Bleeding/bruising	■ Sudden energy drop
	■ Cravings	■ Tremors	■ Poor Balance
	■ Strong Thirst		
Skin and Hair	■ Rashes	■ Eczema	■ Recent moles
	■ Ulcerations	■ Pimples	■ Changes in hair texture
	■ Hives	■ Dandruff	■ Hair loss
	■ Itching		
Head, Eyes, Ears, Nose, Throat	■ Dizziness	■ Color blindness	■ Recurrent sore throats
	■ Concussions	■ Cataracts	■ Nose bleeds
	■ Migraines	■ Blurry vision	■ Grinding teeth
	■ Glasses	■ Earaches	■ Sores on lips or tongue
	■ Spots in front of eyes	■ Ringing in the ears	■ Facial pain
	■ Eye pain	■ Poor hearing	■ Teeth problems
	■ Poor vision	■ Eye strain	■ Headaches
	■ Night blindness	■ Sinus problems	■ Jaw clicks
	■ Photophobia	■ TMJ	■ Gum/teeth problems
Cardiovascular	■ Dizziness	■ High B.P.	■ Swelling of feet
	■ Low blood pressure	■ Fainting	■ Blood clots
	■ Chest pain	■ Cold hands or feet	■ Difficulty in breathing
	■ Irregular heartbeat	■ Swelling of hands	■ Phlebitis
	■ Tightening in chest	■ Palpitations	■ Stroke
Respiratory	■ Cough	■ Bronchitis	■ Frequent colds or flu
	■ Asthma	■ Shortness of breath	■ Excessive phlegm
Gastrointestinal	■ Nausea	■ Belching	■ Rectal pain
	■ Vomiting	■ Black stools	■ Hemorrhoids
	■ Diarrhea	■ Blood in stools	■ Abdominal pain/cramps
	■ Constipation	■ Indigestion	■ Chronic laxative use
	■ Gas/ Bloating	■ Bad breath	■ Chrohn's
	■ Parasites	■ Diverticulitis	■ Colitis
Genitourinary	■ Pain on urination	■ Incontinence	■ Sores on genitals
	■ Low to no sex drive	■ Decrease in flow	■ Impotence/frigidity
	■ Blood in urine	■ Kidney stones	
Musculoskeletal	■ Neck pain	■ Back pain	■ Hand/wrist pain
	■ Muscle pain	■ Muscle weakness	■ Shoulder pain
	■ Knee pain	■ Foot/ankle pains	■ Hip pain
	■ Sciatica	■ Tendonitis	■ Arthritis
	■ Migraines	■ Varicose veins	

Neuropsychological	■ Seizures	■ Poor memory	■ Anxiety
	■ Dizziness	■ Depression	■ Bad temper
	■ Loss of balance	■ Concussion	■ Frequent mood swings
Other Illness	■ HIV positive	■ Rheumatic fever	■ Eating disorder
	■ AIDS	■ Hypoglycemia	■ Jaundice
	■ Epstein-Barr	■ Diabetes	■ Hepatitis
	■ Mononucleosis	■ Underweight	■ Overweight

WOMEN ONLY	
Age at onset of menstruation: Date of last menstruation:	
Period occurs every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	
Number of pregnancies Number of live births	
Are you pregnant or breastfeeding?	
Have you had a D&C, hysterectomy, or Cesarean?	■ Yes ■ No
Any urinary tract, bladder, or kidney infections within the last year?	■ Yes ■ No
Any hot flashes or sweating at night?	■ Yes ■ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	■ Yes ■ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	■ Yes ■ No
MEN ONLY	
Do you usually get up to urinate during the night?	■ Yes ■ No
Do you feel burning discharge from penis?	■ Yes ■ No
Has the force of your urination decreased?	■ Yes ■ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	■ Yes ■ No
Do you have any problems emptying your bladder completely?	■ Yes ■ No
Any difficulty with erection or ejaculation?	■ Yes ■ No
Any testicle pain or swelling?	■ Yes ■ No

Please list drugs, herbs and supplements you currently take:

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to 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 Licensed Acupuncturist at Harmony Acupuncture.

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 have been informed that acupuncture and the adjunct modalities are generally a safe method of treatment, but may have some side effects, including bruising, numbness or tingling near the treatment sites that may last a few days. Dizziness or fainting is a rare reaction that may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that I have been prescribed are purchased from suppliers that meet current Good Manufacturing Practice (GMP) enforced by the United Stated Food and Drug Administration (USFDA). The most common side effects of herbal medicine are gas, indigestion, or loose stools. If I have any questions about my herbal prescription, those questions will be answered by a Licensed Acupuncturist at the Harmony Acupuncture.

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.

I will notify a Harmony Acupuncture acupuncturist who is caring for me if I am or

become pregnant. I understand that no promises have been made to me as to the

results of treatment.

By signing below, I show that I have read, or have had read to me, the above Consent to Treat, 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.

PATIENT SIGNATURE **X** _____ DATE _____
(Or Patient Representative, Indicate relationship if signing for patient)

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Notice of Privacy Policies

Harmony Acupuncture is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. Outlined here are policies we follow and rights to which you are entitled, according to state and federal law.

We gather personal 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

Please be aware that during the course of our relationship we will likely use and disclose protected health information (PHI) about you for treatment, payment, and healthcare operations. PHI is identifying information about your past and present physical or mental health condition.

You may specifically authorize us to use PHI for any purpose or to disclose the health information we have about you by submitting the authorization in writing.

Marketing

Harmony Acupuncture will not use your health information for marketing communications without your written authorization. We may send newsletters and appointment reminders, by calls, e-mails, post cards or letters, unless otherwise advised by you. You have the right to opt out of fundraising and marketing communications; please initial as indicated on the HIPAA Acknowledgement & Consent form.

Disclosure

Harmony Acupuncture may use or disclose your Protected Health Information without your express authorization only 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 about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information, including restricting information released to your health insurance company regarding any services/products for which you pay in full at the time of service.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

Harmony Acupuncture maintains patient sign-in sheets that are visible and accessible to patients, staff and others who may enter the office. You have the right to use your first name only at sign-in.

If you have questions, complaints or want more information, please contact Joshua Herr, Practice Manager, at our clinic in Asheville. If you wish to make a formal complaint, send it to:

U.S. Department of Health and Human Services
DHHS (Office of Civil Rights)
200 Independence Avenue SW
Room 509F HHH Building
Washington DC 20201

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Patient's HIPAA Acknowledgement & Consent

I_____give consent to Harmony Acupuncture for the use and disclosure of my Protected Health Information (PHI) for these specific purposes:

1. Providing treatment to me.
2. Collecting and processing payment for the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The purpose of this consent:
Protected Health Information (PHI) is any information that includes individually identifiable demographic information, including information gathered by this practice as it relates to my past, present, and future healthcare services and financial transactions. This practice may use my PHI for healthcare operations purposes, including quality assessment activities, credentialing, business management, marketing, and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment of healthcare operations of the Acupuncture practice, but the practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to restrict certain disclosures to my health insurance provider (if applicable) regarding products or services for which I pay out of pocket and in full at the time of service.

I understand my authorization is required for uses or disclosures of my PHI for marketing purposes, for any disclosures that constitute a sale of PHI, and for any other uses/disclosures not described in our Notice of Privacy Policies.

I understand that I have the right to opt out of fundraising and marketing communications from Harmony Acupuncture. (Harmony Acupuncture does not sell or share your information with outside parties.) I will notify Harmony Acupuncture front desk staff if I choose to opt out of receiving these communications.

I understand that I have the right to be notified of any breach of my unsecured PHI.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this acupuncture practice before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I understand that I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

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Office Policies

Welcome to our clinic! For your convenience, we will explain our office policies so that we can serve you more efficiently. Please read the following carefully and keep for your files.

1. Please refrain from wearing perfume oils, as some of our patients are sensitive to these fragrances.

2. Please provide your practitioner with a list of any and all medications and/or supplements you are currently taking.

3. Acupuncture is a very safe medical procedure and well known for its efficacy and lack of side effects. Occasionally, bruising may occur. Do not be alarmed, but if you have questions or concerns, we encourage you to call the office.

4. We recommend relaxation and/or sleep after treatment.

5. There is a $40 charge for cancellation of your appointment with less than 24 hours notice. At Harmony Acupuncture, we schedule a specific amount of time for each patient to be with their practitioner. We do this because we are committed to providing the very best service. An advance cancellation notice allows an opportunity to extend services to the people on our waiting list.

6. Please be on time for your appointments. If you find that you cannot be on time please notify our office. If you are late for your appointment, the doctor may not be able to see you.

7. All herbs are paid for at the time of receipt. We can also mail them to you when payment is received in advance.

8. There is a $20 charge for returned checks.

9. We accept cash, personal check and Visa/MasterCard/American Express/Discover and Health Savings/Flexible Spending Account debit cards.

10. Please advise us of any change in your address or phone number(s).

11. As a courtesy to others, please turn your cell phone off while at the clinic, unless there is an emergency.

12. Please do not leave your children unattended.

Thank you.

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Acknowledgement of Receipt Of Notice of Privacy Policies

The following acknowledges that Harmony Acupuncture has provided you with a *Statement of Privacy Policies.*

I, _____, have read, reviewed, understood and agree to the *Statement of Privacy Policies* for healthcare services at Harmony Acupuncture.

Signed: _____

Date: _____

Acknowledgement of Receipt Of Office Policies

The following acknowledges that Harmony Acupuncture has provided you with a *Statement of Office Policies.*

I, _____, have read, reviewed, understood and agree to the *Statement of Office Policies* for healthcare services at Harmony Acupuncture.

I agree to provide at least 24 hours notice of cancellation and otherwise understand I will incur a charge of $40 for the missed appointment.

Signed: _____

Date: _____