Welcome!
Welcome to Vitality Acupuncture LLC! At Vitality Acupuncture, we believe that healthcare should be about making the most of your vitality. Acupuncture and Chinese Medicine do just that by getting to the root of the problem and restoring health. This is healthcare that partners with your body to correct imbalances and maintain your vitality. This is healthcare that feels good! If there is anything we can do to make your experience more pleasant, or your healthcare more complete and balanced, please let us know!

What to expect
Your initial appointment with Vitality Acupuncture will take about an hour and a half and will involve an in-depth interview regarding your health. You may be prescribed an herbal formula as part of your treatment. Occasionally, Vitality Acupuncture uses a mail order herbal dispensary. This means that you will be expected to pay for your formula at the time of your visit and the granular formula will be delivered in the mail about 2 or 3 days later.

Financial Policies
Vitality Acupuncture LLC accepts cash, checks, or credit cards for payment. Checks may be made out to “Vitality Acupuncture”. If your insurance policy does not cover acupuncture care, you are required to pay in full at the time of your appointment. If you need to make other payment arrangements, please discuss this with Heather prior to your visit. There is a 24 hour cancellation policy. Vitality Acupuncture LLC will charge a $25.00 fee for missed appointments or for appointments that were cancelled without 24 hours notice.

Health Insurance
Some insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

We require that you pay at least $20 toward today’s charges and $20 on each visit. Your full portion of the bill is expected to be when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 1.5% applied per month.

By signing this form you are authorizing payment of medical benefits to be made directly to this office, and you agree to send or bring those payment to this office upon receipt. However, if you pay for your visits in full, the assignment will not be reported by this provider and any payment will be sent directly to you.

By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

I have read, understand, and agree with the financial and office policies of Vitality Acupuncture LLC, which are listed above.

Patient / Guardian’s Printed Name: ____________________________________________________________

Patient / Guardian’s Signature: ________________________________________________________________

Date: ____________________________________
Name: ___________________________________________________ Date: ______________________

Date of Birth: __________________________ Age: __________________ Sex: M / F

Address: ______________________________________________________________________________

City: ________________________________ State: ___________________ Zip: ____________________

Phone: (               ) ______________________ Alternate Phone: (               ) ______________________

Email Address: _________________________________________________________________________

Would you like to receive Vitality Acupuncture announcements and news via email? Y / N

Primary Care Physician: __________________________________________________________________

Emergency contact and phone: ___________________________________________________________________

How did you hear about Vitality Acupuncture LLC? _____________________________________________

Marital Status: _______________________ Do you have children? Y / N

Insurance Information
(if applicable)

Insurance company: _______________________________________________________________________

ID number: ____________________________ Group number: __________________________

Primary policy holder name and date of birth: _________________________________________________

Insurance phone number for providers: ______________________________________________________

Is this an accident claim? Yes / No If yes, what is the date of injury? _____________________________

Claim number: __________________________________________________________________________

Claim adjuster name and phone number: _____________________________________________________

Have you retained an attorney regarding this accident? Yes / No

If yes, please give the attorney’s name and phone number: ____________________________________
Patient Health History

Please identify your health concerns in order of importance below:
1. Concern: ____________________________________________________________________________
   How long have you had this problem? _____________________________________________________
   Past treatments for this problem: _______________________________________________________

2. Concern: ____________________________________________________________________________
   How long have you had this problem? _____________________________________________________
   Past treatments for this problem: _______________________________________________________

3. Concern: ____________________________________________________________________________
   How long have you had this problem? _____________________________________________________
   Past treatments for this problem: _______________________________________________________

Please circle areas of pain:

Are you in pain?
If yes, please mark your level of pain:

No Pain | Moderate Pain | Worst Pain
0  | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10

If you have pain is it:
☐ Sharp
☐ Dull
☐ Aching
☐ Stabbing
☐ Burning
☐ Cramping
☐ Moves around
☐ Fixed in one place

Do any of these make it feel better?
☐ Heat
☐ Cold
☐ Pressure
☐ Movement
☐ Rest

Do any of these make it worse?
☐ Heat
☐ Cold
☐ Pressure
☐ Movement
☐ Rest
### Temperature
- Cold hands or feet
- Usually feel hot
- Usually feel cold
- Alternating hot and cold
- Sensitive to temperature change
- Hot flashes
- Night sweats
- Spontaneous sweating
- Perspire easily

### Body pain
- Generalized muscle pain
- Joint pain
- Feeling of heaviness in the body
- Weakness or pain in the knees
- Weakness or pain in the low back

### Sleep & Mind
- Sleep 6 - 8 hours each night
- Difficulty falling asleep
- Difficulty staying asleep
- Frequent dreaming
- Restless sleep
- Waking unrested
- Mental foginess or sluggishness
- Anxiety
- Mental confusion
- Poor memory
- General restlessness

### Digestion
- Poor appetite
- Always hungry
- Heartburn
- Acid reflux
- Abdominal pain
- Belching
- Hiccoughs
- Nausea
- Vomiting
- Frequent gas
- Bloating
- Fatigue after eating
- Abrupt weight loss or weight gain
- Constipation
- Diarrhea
- Loose stool
- Blood in stool
- Mucus in stool
- Undigested food in stool
- Dry, hard stool
- Hemorrhoids

### Emotions
- Frequently frustrated or angry
- Frequently worried or pensive
- Frequently sad
- Frequently happy or content
- Frequently scared or anxious
- Frequently lonely

### Male Reproductive:
- Hemia
- Prostate problems
- Testicular pain or swelling
- Penile discharge
- Sexual difficulties
- Nipple discharge

### Female Reproductive:
- Breast lumps
- Breast tenderness
- Nipple discharge
- Abnormal vaginal discharge, color: __________
- Vaginal dryness
- History of irregular menstrual cycle
- PMS
- Painful periods
- Heavy periods
- Light periods
- Frequent blood clots
- Hysterectomy
- Ovarian cysts or fibroids
- Endometriosis
- Post-menopausal bleeding

### Hair & Skin
- Hair loss
- Dry hair
- Dry skin
- Dry, brittle fingernails

### Thirst
- Thirsty for cold drink
- Thirsty for warm drink
- More thirsty at night
- No thirst
- Always thirsty

### Urination
- Frequent urination
- Nighttime urination
- Burning urination
- Painful urination
- Hesitant urination
- Dribbling urination
- Loss of bladder control
- Blood in urine
- Cloudy urine
- Strong odor in urine
- Large amount of urine
- Very small amount of urine

### Energy
- Low energy
- Sleepy in the afternoon
- Feel worse with exercise
- Feel better with exercise
- Too much energy

### Chest
- Palpitations
- Irregular heartbeat
- Chest pain with exercise
- Chest pain traveling to shoulder
- Chest tightness
- Difficulty breathing
- Shortness of breath

### Ears, Eyes, Nose, Throat
- Ear congestion
- Hearing loss
- Ringing in the ears
- Dry, red, or irritated eyes
- Floating spots in vision
- Blurry vision
- Poor night vision
- Seasonal allergies
- Frequently catch colds
- Runny nose
- Stuffy nose
- Sinus congestion
- Frequent sneezing
- Nose bleeds
- Nasal discharge, color: __________
- Cough with phlegm, color: __________
- Dry cough
- Cough with blood
- Wheezing
- Dry mouth or throat
- Sore throat
- Sensation of needing to clear throat or swallow something
- Mouth sores
- Painful, swollen, or bleeding gums
Previous or Current Surgeries / Accidents / Diseases (diabetes, cancer, HTN, etc):
<table>
<thead>
<tr>
<th>When:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

If applicable, please list any allergies or hypersensitivities you may have:
___________________________________________________________________________________________

Current Medications and dosage (include prescription, non-prescription, vitamins, herbs, supplements):
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Do you have any infectious diseases? Yes / No
If yes, please identify:_________________________________________________________________________

1. Do you typically eat at least three meals per day? Y / N
2. What kinds of foods do you most commonly eat? ___________________________________________________
_____________________________________________________________________________________________

3. What do you do to stay active? _________________________________________________________________
_____________________________________________________________________________________________

4. Do you have a spiritual practice? Y / N
5. What level of education did you complete? ________________________________________________________
6. What is your occupation, or if you are retired, what was your occupation? ________________________________
7. Do you smoke, and if so, how often?
8. Do you use chewing tobacco, and if so, how often?_______________________________________________
9. Do you drink alcohol, and if so, how often and what kind? ____________________________________________
_____________________________________________________________________________________________

10. Do you drink caffeinated drinks, and if so, how often and what kind? ________________________________
11. How many glasses of non-caffeinated, non-carbonated beverages (water) do you drink per day? _______________
12. How many hours of television do you watch each day? _______________
13. How many hours do you sleep per night? _______________
14. Have you experienced any major traumas in your life? Y / N Please explain. __________________________
_____________________________________________________________________________________________

15. Is there anything else you would like to share that will help me to serve your needs? ____________________
_____________________________________________________________________________________________

Family Medical History:
Please list any family members with a history of illness or disease, and list that disease.
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
Consent for Treatment

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 for whom I am legally responsible) by the acupuncturist practicing on behalf of Vitality Acupuncture LLC. I understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal therapy, Qi Gong, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, slight bleeding at the needling site upon removal of the needle, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 acupuncturist uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

As part of treatment, the acupuncturist may recommend herbal or nutritional therapy. 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 the herbs that have been recommended may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand some herbs may be inappropriate during pregnancy. I will notify the acupuncturist if I am or become pregnant.

I do not expect the acupuncturist to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgement during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand that the acupuncturist 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.

Patient Signature  Date
(Or signature of Patient Representative and relationship to patient)
Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of patient or representative __________________________ Date ____________

Print patient name __________________________ Patient Birth Date __________________________