

Enerqi Acupuncture & Wellness

315-308-0690

www.energiacuwellnesswellness.com

Welcome!

The following registration card, office policies forms and health questionnaire will take several minutes to complete. Please complete the questionnaire as completely as possible and let us know if there is anything else we can do to help you reach your health goals.

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Email

Address: _____

Occupation: _____

Primary Care Physician: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Would you like an appointment reminder phone call or email? YES NO

What is the best way to contact you? _____

Would you like us to add you to our email/ mailing list? Email: YES NO Mail: YES NO

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Acknowledgement of Notice of Privacy Practices

I have received, read and understood the Notice of Privacy Policies of our clinic. I understand how Enerqi Acupuncture & Wellness may use or disclose my health information. I understand when Enerqi Acupuncture & Wellness may not use or disclose my health information. I understand my health information rights and understand that Enerqi Acupuncture & Wellness reserves the right to change this Notice of Privacy Practices. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of Enerqi Acupuncture & Wellness.

Signature of Patient or Authorized Representative

Date

Late Cancellation/No Show & Payment Policies

We at Enerqi Acupuncture & Wellness value your health and your time. It is important that our patients keep to their prescribed treatment plan and come regularly to their appointments. Missed appointments decrease the effectiveness of treatment and lengthen the overall time required for patients to feel better.

In the event that you need to cancel or reschedule an appointment, kindly provide us with a minimum of 24 hours notice by phone or email so that we may offer your appointment time to other patients.

Unless otherwise agreed upon in advance or in the case of inclement weather, patients who cancel last minute or miss an appointment with no notice will be subject to a charge of \$40. Appointments that are rescheduled to a different time on the same day will not be subject to this charge.

Enerqi Acupuncture & Wellness gladly accepts cash, check and credit as forms of payment. A \$30 processing fee will be charged for any returned checks.

I have read and understand the Enerqi Acupuncture & Wellness Late Cancellation/No Show & Payment Policies.

Signature of Patient or Authorized Representative

Date

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Acupuncture 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 names below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist names 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) 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, 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. 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 major risks of treatment, other side effects and risks may occur. The 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 supplements may be inappropriate during pregnancy. Some possible side effects 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.

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

Signature of Patient or Authorized Representative

Date

Office Signature

Date

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Health History Form:

Name: _____ Date: _____

MAIN COMPLAINTS

Please list up to 3 main health concerns that you would like help with in order of importance to you.

#1 _____

How does this affect you? _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

Have you seen a doctor for this? _____

#2 _____

How does this affect you? _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

Have you seen a doctor for this? _____

#3 _____

How does this affect you? _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

Have you seen a doctor for this? _____

PAST PERSONAL MEDICAL HISTORY

Please check off any that apply to you

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Auto-immune Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> STD |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies: please list _____ |
| <input type="checkbox"/> Herpes | _____ |
| <input type="checkbox"/> Hepatitis/Liver Disease | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Other: please list _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Mental Illness | _____ |

CURRENT MEDICATIONS

Please list anything taken within the past 2 months including prescriptions, vitamins, supplements, etc.

HOSPITALIZATIONS, SURGERIES, INJURIES (please include dates)

LIFESTYLE

Do you follow any special diet (vegetarian, vegan, raw, macrobiotic, medically prescribed, etc.)? _____

How often do you eat every day? _____

Do you have a regular exercise program?

Yes ___ No ___ If yes, please describe: _____

How much of the following do you drink per day:

Alcoholic beverages _____

Caffeinated beverages _____

Water (8 oz cups) _____

Do you smoke? Yes ___ No ___

If so, how many cigarettes per day? _____

SLEEP

of hours of sleep per night _____

- Restless or light sleep
- Difficulty falling asleep
- Difficulty staying asleep
- Waking _____ x/night at _____ pm/am
- Wake to urinate _____ x/night
- Disturbing dreams
- Unrested upon waking

EMOTIONS

Have you been treated for emotional issues? YES NO

Have you ever considered suicide? YES NO

Which emotion(s) dominate your experience?

- | | | |
|----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> anger | <input type="checkbox"/> irritability | <input type="checkbox"/> depression |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> worry | <input type="checkbox"/> sadness/grief |
| <input type="checkbox"/> joy | <input type="checkbox"/> indecision | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> fear | <input type="checkbox"/> happiness | <input type="checkbox"/> obsessive thoughts |

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING, PARTICULARLY IN THE PAST 3 MONTHS

HEAD, EYES, EARS, NOSE & THROAT:

Eye strain/pain	Poor/blurry vision	Glaucoma/cataracts	Tearing/Dryness	Spots in vision
Red/itchy eyes	Ringling in ears	Ear aches	Poor hearing	Headaches
Migraines	Sinus problems	Nose bleeds	TMJ/jaw problems	Grinding teeth
Frequent sore throats	Facial pain	Lip or mouth sores	Tooth/Gum problems	Dizziness
Concussion	Other _____			

SKIN:

Dry skin/hair	Rashes	Eczema	Acne	Hives	Itchy skin	Recent moles
Psoriasis	Dermatitis	Dandruff	Oily skin	Recent changes in skin or hair texture		
Hair loss	Dry/brittle nails		Other _____			

RESPIRATORY:

Cough	Pneumonia	Coughing blood	Asthma /Bronchitis	Pain with deep breath
Shortness of breath		Chest tightness	Wheezing	Difficulty breathing while laying down
Frequent colds		Phlegm (what color) _____		Other _____

CARDIOVASCULAR:

Chest pain	Irregular heartbeat	High/Low blood pressure	Cold hands/feet	
Swelling/Edema	Blood clots	Fainting	Varicose veins	Blocked arteries
Heart disease	Palpitations	Stroke	Heart murmur	Other _____

GASTROINTESTINAL:

How frequently do you have a bowel movement? _____x/day?

Ulcers	Nausea /Vomiting	Acid reflux	Heartburn	Excessive gas	Abdominal pain
Belching	Bloating	Colitis	Hernia	Indigestion	Bleeding gums
Diarrhea	Constipation	Rectal pain	Hemorrhoids	Blood in stool	IBS/Crohn's disease
Bad breath	Chronic laxative use	Slow digestion	Other _____		

URINARY:

Frequent urination	Urgent urination	Pain with urination	Blood in urine	Unable to hold urine
Kidney stones	Burning sensation	Cloudy urine	Decreased/interrupted flow	
Waking to urinate	Urination frequency _____x/day?		Urinary/Kidney infections	
Scanty urination	Excessive amount of urine		Other _____	

GENERAL:

Weight gain/loss	Poor or excessive appetite	Cravings for _____	Peculiar tastes/smells
Fevers/Chills	Night sweats	Bleeding or bruising easily	Fatigue
Sudden energy drop at _____time of day		Unusual sweating	Hot flashes
Strong thirst for: hot or cold drinks		Thirst but no desire to drink	Cold hands/feet

FEMALE REPRODUCTIVE:

Are you currently sexually active? YES NO

Are you or could you be pregnant right now? YES NO

Age of first period _____ Date of last period _____

Heavy/scanty periods Painful periods

Mid-cycle bleeding Endometriosis

Difficulty getting pregnant Western infertility treatment

of pregnancies _____ # of live births _____

Breast lumps Vaginal dryness

Hysterectomy Menopause

Are you using birth control? YES NO

Period duration _____ days Days between periods _____

Irregular periods Menstrual clots PMS

Ovarian cysts Uterine fibroids

Genital sores Yeast infections

of miscarriages _____ # of abortions _____

Vaginal discharge Polycystic ovarian disease

Low libido Other _____

MALE REPRODUCTIVE:

Are you sexually active? YES NO

Do you practice birth control? YES NO

Prostate problems Testicular problems Erectile difficulties Penile discharge Premature ejaculation

Low libido Vasectomy Low sperm count/motility Other _____

MUSCULOSKELETAL:

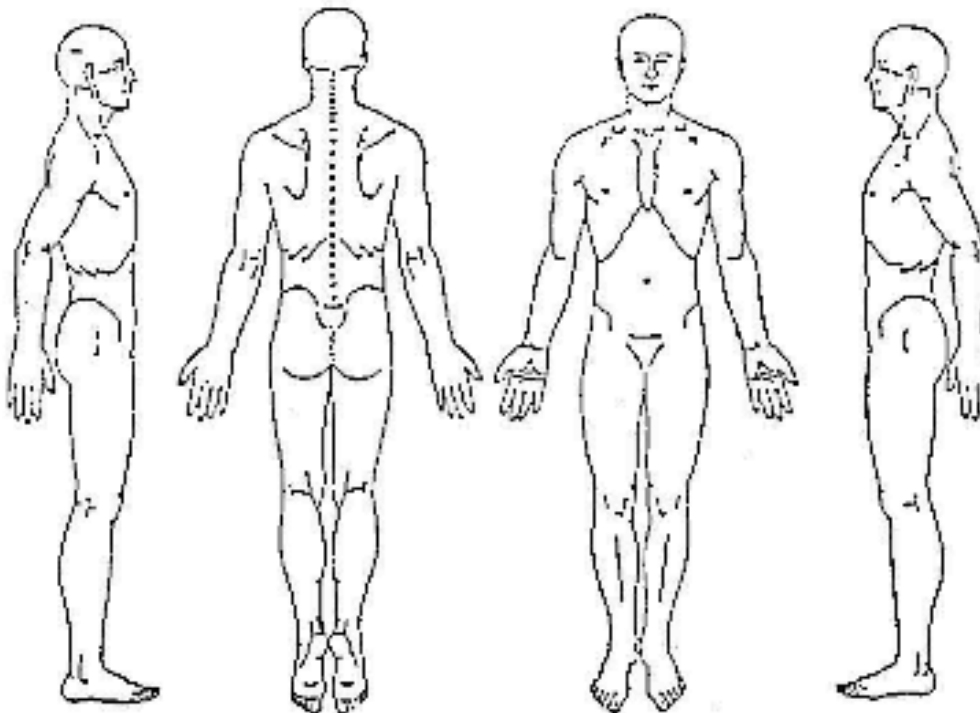
Neck pain Shoulder pain Hand/wrist pain Hip pain Knee pain Foot/ankle pain

Muscle pain Bursitis Muscle weakness Sciatica Muscle spasm Tendonitis

Sprains Strains Carpal tunnel Arthritis Osteoporosis Fibromyalgia

Back Pain: Low _____ Middle _____ Upper _____ Numbness Other _____

Please indicate any painful or distressed areas by circling the affected areas on the picture below.



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HIPPA Notice of Privacy Policies

This notice describes how your medical information may be used and disclosed and how your privacy is being protected at our clinic. The privacy of your medical information is important to us and we are committed to protecting your medical records. We create a record of the care and services you receive at our organization to provide you with quality care and to comply with certain legal requirements. In order to maintain the level of service that you expect from our clinic, we may need to share limited personal medical and financial information. This notice will also describe your rights and certain duties we have regarding the use and disclosure of medical information.

How Enerqi Acupuncture & Wellness May Use or Disclose Your Health Information

Enerqi Acupuncture & Wellness collects health information about you and stores in chart form. Your medical records are the property of Enerqi Acupuncture & Wellness, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians, health care providers or other health care facilities that will provide services that we do not provide. We may disclose medical information to family or others who can help you when you are sick or injured.

Health Care Operations & Payment: We use and disclose medical information about you to obtain payment for the services we provide and perform daily operations at Our Clinic. For example, we may use and disclose this information to review and improve quality of care, or the competence and qualifications of our professional staff.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Notification & Communication with Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Required by Law: We will limit our use and disclosure of your health information to relevant requirements of the law. When the law requires us to report abuse, neglect, domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Public Safety: We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

When Enerqi Acupuncture & Wellness May Not Use or Disclose Your Health Information

Enerqi Acupuncture & Wellness will not use or disclose health information that identifies you without your written authorization except as described in this Notice of Privacy Policies. If you do authorize our clinic to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your health information with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect or copy the record. We will charge a reasonable fee, as allowed by New York law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

Questions and Complaints

Questions and complaints about this Notice of Privacy Practices or how our clinic handles your health information should be directed to our Privacy Officer during regular business hours. If you are not satisfied with the manner in which our clinic handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.