Body Mind Revolution *for the Whole Being*

Patient Confidential Information

Name: _____
First Middle Last

Address: _____
Street City State Zip

Telephone: Home _____ Cell _____ Business _____

Email: _____ Gender: M F Marital Status: S M D W

Age: ___ Date of Birth: ___/___/_____ Place of Birth: _____ Drivers License #: _____
Month Day Year

Insurance & #: _____ Occupation: _____ Employer: _____

In case of emergency call:_____
Name Relation Phone(s) Email

Financial Agreement:
ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand that the service(s) listed above may or may not be covered by my insurance, and that I will be responsible for any and all charges related to the service(s) shown.

DATE:_____ NAME: _____ SIGNATURE:_____

Cancellation policy
Out of consideration for other patients, our cancellation policy requires a minimum 24 hours notice. Not providing 24 hours notice, not showing, or being more than 30 minutes late without informing us obligates us to charge your account at a standard fee for the cost of the treatment missed.
Compliance allows us to better serve you and other patients. Thank you for your understanding.

DATE:_____ NAME: _____ SIGNATURE:_____

Present Complaint:

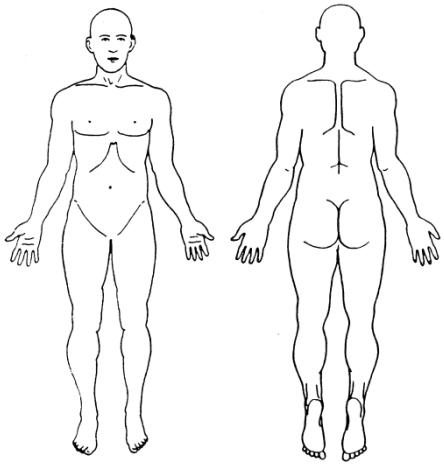
What is your #1 chief complaint?

When did this condition begin?

What treatment have you already received?

What exacerbates and what alleviates the condition?

MARK AREAS OF PAIN ON THE FIGURES BELOW
USING THESE CODES
+ + + BURNING
000 STABBING
--- SHARP
||| CONSTANT



Indicate condition's severity on a scale of 1 to 10 (*where 1 is symptom-free and 10 is severe):*
Strike a mark: **1** _____ **10**

Michele Lamarche, L.Ac. 310 422-1692
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Informed Consent to Acupuncture and Oriental Medicine

Print Patient's Name _____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxabustion, cupping, electro-acupuncture, herbology, nutrition, diagnosis, IASIS Neurofeedback, and various modes of physiotherapy, on me (or on the patient named above, for whom I am legally responsible), by the acupuncturist(s) named below.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture, moxabustion, cupping, electro-acupuncture, herbology, nutrition, physiotherapy and other procedures (including LENS neurofeedback). I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight bruising, tingling near the needling sites that last a few days, nausea, infection, and blisters. There have been reports of fainting and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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/ Representative	Print Name of Patient's Representative	Date

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1. Have you had any *surgeries*? If so, what were the surgeries and when did you have them?

2. Have you noticed any *long term effects* from the surgeries?

3. Have you had *serious injuries or illness*, if so when? Have you noticed longterm health changes?

4. Do you have *any allergies* (to medication or environment)? Please note which, and when they began:

5. When was the *date of your last physical*? _____ Were there abnormalities? Please explain.

6. Do you have a *history of antibiotic use*? Please explain.

7. What *medications* and what doses are you using?

8. What *supplements*, vitamins or herbs do you take?

Lifestyle:
How much *exercise* do you get weekly? What types and for how long? What intensity?

How much do you *sleep* daily? Is it restful? Do you have any difficulties falling or staying asleep?

Briefly, what is your diet like?

For Women Only:

Age of first period:_____
Length of cycle, day 1 to day 1: _____
Length of flow:_____
Date of last period: _____

Any vaginal discharge?_____
Date of last gynecological checkup:_____
Are you on the pill? ____

Do you have a history of any of the following?

☐ Menstrual cramps
☐ Breast pain
☐ Menstrual blood clots
☐ Breast cysts
☐ Excessive bleeding
☐ Ovarian cysts
☐ PMS
☐ Emotional changes w period
☐ Breast swelling/tenderness
☐ Irregular cycle
☐ Hot flashes
☐ Water gain
☐ Vaginal yeast infections
☐ Abnormal pap smear
☐ Endometriosis
☐ Infertility
☐ History of hormone therapy
☐ Problem getting pregnant
☐ Problems carrying to term
☐ Pregnancy
☐ Questions regarding fertility
☐ Menopause/Perimenopause

At what age did your mother enter menopause?

Pregnancy history:
Live birth(s) ____ Miscarriage(s) ____ Terminated pregnancy(ies) ____
Method of Birthing used: ☐ hospital, ☐ birthing center, ☐ at home, ☐ vaginal delivery, ☐ cesaerian
What was/were your birthing experience(s): how long did you labor_____,
Did you use epidural/other sedation, or not?_____
Do you believe you are pregnant or that there is any possibility? _____

For Men Only: Urological History ☐ Premature ejaculation ☐ Questions re-virility
☐ Impotence/Erectile Issue ☐ Viagra Use ☐ Prostate problems ☐ Slow urination stream

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Past Medical History

Illness	Timing	*Specifics* plus what happened, did it *resolve*?
Chicken Pox	☐ Current ☐ Past	
German Measles	☐ Current ☐ Past	
Measles	☐ Current ☐ Past	
Mumps	☐ Current ☐ Past	
Polio	☐ Current ☐ Past	
Anemia	☐ Current ☐ Past	
Diabetes/Insulin Resistance	☐ Current ☐ Past	
Hypoglycemia	☐ Current ☐ Past	
Gallstones	☐ Current ☐ Past	
Arthritis	☐ Current ☐ Past	
Gout	☐ Current ☐ Past	
Hepatitis	☐ Current ☐ Past	
High blood pressure	☐ Current ☐ Past	
Liver disease	☐ Current ☐ Past	
Kidney stones/disease	☐ Current ☐ Past	
Jaundice	☐ Current ☐ Past	
Gallbladder removal	☐ Current ☐ Past	
Hernia	☐ Current ☐ Past	
Hemorrhoids	☐ Current ☐ Past	
Sinusitis	☐ Current ☐ Past	
Sleep apnea	☐ Current ☐ Past	
Thyroid disease	☐ Current ☐ Past	
Loss of voice or hoarseness	☐ Current ☐ Past	
Epilepsy, convulsions	☐ Current ☐ Past	
Head Injury	☐ Current ☐ Past	
Neck Injury	☐ Current ☐ Past	
Back Injury	☐ Current ☐ Past	
Fracture	☐ Current ☐ Past	
History of tobacco use	☐ Current ☐ Past	
History of alcohol use	☐ Current ☐ Past	
History of recreational drug use	☐ Current ☐ Past	
Frequent colds	☐ Current ☐ Past	
Nausea/vomiting	☐ Current ☐ Past	
HIV/ AIDS	☐ Current ☐ Past	
STDs	☐ Current ☐ Past	
Cold Sores	☐ Current ☐ Past	
Genital Herpes	☐ Current ☐ Past	
Epstein Barr/Mononucleosis	☐ Current ☐ Past	
Chronic Fatigue	☐ Current ☐ Past	

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Past Medical History

Illness	Timing		*Specifics* plus what happened, did it *resolve*?
Fibromylagia	☐ Current	☐ Past	
Asthma	☐ Current	☐ Past	
Pneumonia	☐ Current	☐ Past	
Bronchitis	☐ Current	☐ Past	
Whooping cough	☐ Current	☐ Past	
Emphysema	☐ Current	☐ Past	
Tuberculosis	☐ Current	☐ Past	
Bloating after meals	☐ Current	☐ Past	
Indigestion	☐ Current	☐ Past	
Acid Reflux	☐ Current	☐ Past	
Crohn's/Colitis/ Diverticulitis/IBS	☐ Current	☐ Past	
H-Pylori/GI Infection/Parasite	☐ Current	☐ Past	
Peptic Ulcer	☐ Current	☐ Past	
Cancer	☐ Current	☐ Past	
Insomnia	☐ Current	☐ Past	
Change in appetite or thirst	☐ Current	☐ Past	
Abnormal weight loss or gain	☐ Current	☐ Past	
Abnormal sweating	☐ Current	☐ Past	
Heart disease	☐ Current	☐ Past	
Heart attack/Angina	☐ Current	☐ Past	
Heart failure	☐ Current	☐ Past	
Rheumatic fever	☐ Current	☐ Past	
Stroke	☐ Current	☐ Past	
Other (describe)	☐ Current	☐ Past	
	☐ Current	☐ Past	
	☐ Current	☐ Past	
	☐ Current	☐ Past	

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Notice of Privacy Practices For Patients (HIPPA)

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the information to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
415-437-8310 (VOICE); 415-437-8311 (TDD); 415-437-8329 (FAX)

Contact Person
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I, _____ Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____