clasique
ACUPUNCTURE & PILATES STUDIO

Welcome to Clasique Acupuncture & Pilates Studio

Your Arrival :: We appreciate on-time arrival to all appointments. You are welcome to arrive early and enjoy our tea bar reception area prior to your treatment beginning. Please bring your new patient paperwork filled out, or allow 5-10 minutes prior to your scheduled appointment for completing the paperwork here. Upon entering, please quiet your cell phone.

Appointment Details :: Scheduling is available online, studio phone 828.333.5053, or email info@studioclasique.com. Appointment scheduling is required for all types of treatments, we cannot accommodate walk-ins. If you need to cancel or reschedule your treatment, we ask for 24 hours notice. Without **24 hours cancellation** notice, you are responsible for paying your scheduled treatment rate in full (exceptions due to weather or emergencies will be discussed on an individual basis between you and your practitioner). ***Please remember that Chinese Medicine can address all health issues, therefore we want you to come in for a treatment when you are sick, so please do not cancel because you are feeling sick, we want to see you!*** Payment is expected at the time of service in the form of cash, check, or any major credit card ($25 processing fee for all bounced checks).

Private Treatment Style :: Your treatment will begin by talking openly with your practitioner about your history and goals for the treatment, and will include pulse taking and tongue observation. In addition to acupuncture, any combination of therapies that your practitioner feels suit your specific treatment plan will be included. Please realize that you are an active participant in your health and treatment, and your feedback and involvement enhances your experience, recovery, progress and complete health picture. Initial private treatments may last from 75 to 90 minutes and follow up treatments range from 60 to 75 minutes. We recommend comfortable loose-fitting clothes.

Herbal Medicine & Essential Oils :: Chinese herbal medicine is available at Clasique in multiple forms. Your practitioner may recommend herbal therapies to enhance your acupuncture treatment, facilitate the reduction of symptoms, reiterate a balancing message to your body, treat a long-term pattern of deficiency or excess, or clear an acute situation. We have a complete apothecary of essential oils for making custom blends for use during treatments and for your take-home care.

After Your Treatment :: To get the most out of your acupuncture treatment we recommend a low-key window of about 12 hours after your treatment. The idea is to relax and allow the balancing treatment you just received to continue helping your body, mind and spirit to re-align and maintain this renewed place of harmony. Disruptions such as major exercise, alcohol consumption, heavy emotions and big stress are not necessarily damaging, but may prolong the healing process and disturb the smooth flow of qi and blood in your system. After your acupuncture treatment, it is wonderful to linger in that relaxed and clear state of mind for as long as you can.

Acupuncture & Pilates Studio :: Clasique Acupuncture is part of a shared business venture including a fully equipped Pilates exercise studio and Pilates Teacher Training program. At Clasique, we clearly believe that these two styles of health care are complementary. Your involvement in one, the other, or both is entirely your choice. Please know **privacy is of utmost importance at Clasique**, and should you at any point come to this business as both an acupuncture patient and Pilates client, your private information or previous treatment knowledge is honored and entirely confidential. Rest assured that all trained and licensed professionals you might work with at Clasique have a clear mind, an open heart, the utmost respect for your privacy and a focus on the present moment for your best, complete, unique care.

Complete Health :: Complete health is unique to the individual. Change is a constant. As change often comes with resistance, please be open minded and curious. We are here to help and we hope you contact your practitioner if you have further questions. This is our approach... honoring and aiding your unique whole health picture and encouraging the balance of body, mind and spirit.

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Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All your answers will be held absolutely confidential. If you have questions, please ask. Thank you for being here!

Date of Birth: _____/_____/_____ Age: _____ Height: _____ Weight: _____ Gender: M F

Marital status: S M D W

Mailing Address _____

Best Phone: _____Other Phone (specify): _____

Email Address: _____

Emergency Contact Person: _____Emergency Contact Phone: _____

Primary Care Physician: _____

1. When and where did you last receive health care? _____

For what reason?_____

Have you ever used Chinese medicine for your health care? _____

For what reason? _____

2. Please identify the health concerns that have brought you to Studio Clasique in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):_____

_____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

5. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

6. Do you have any infectious diseases? Y N If yes, please identify:_____

7. **Childhood Illness** (please circle any that you have had):

Mumps Measles German Measles (Rubella) Diphtheria Chicken Pox Rheumatic Fever

8. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Diphtheria Pertussis

Hepatitis B Hib

Others: _____

9. **Family History**:

Please circle any health conditions that apply to your immediate family's medical history (parents, siblings, children, spouse). Indicate who in your family was or is afflicted by the following conditions:

Cancer Heart Disease High Blood Pressure Stroke Diabetes

Mental Illness Emotional Disorders Asthma/Allergies Kidney disease

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

11. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	

13. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Irritability Nervousness Constant Anxiety

Panic Attacks Depression Obsessive Behavior Irrational Fears

14. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Slow Wound Healing Chronic Fatigue Frequent Dips in Energy Chronic Infections

15. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Floaters in Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches/Migraines Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

16. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Chest Tightness/Pressure

Persistent Cough Shortness of Breath Asthma Tuberculosis

Pleurisy Emphysema Other Respiratory Problems: _____

17. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure L/R Shoulder Pain

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

18. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain Gas

Heartburn Epigastric Pain Bladder Disease Liver Disease Hepatitis B or C

Hemorrhoids Sudden Weight Loss Constipation Loose Stools Incontinence

19. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Painful Urination Blood in Urine Heavy Flow Frequent UTI

Kidney Disease Kidney Stones Impaired Urination Frequent Urination (at Night)

20. **Female Reproductive** (please circle any that you experience now & underline any that you have experienced in the past):

Irregular Cycles Painful Periods Heavy Flow Light Flow Clotting

Nipple Discharge Vaginal Discharge Premenstrual Problems Bleeding Between Cycles STDs

Breast Tenderness Breast Lumps Pain at Ovulation Ovarian Cysts Hot Flashes

21. **Menstrual/Birthing History:**

Age of First Menses: _____ Birth Control Type: _____ # of Abortions: _____

# of Days of Menses: _____ # of Pregnancies: _____ # of Live Births: _____

Length of Cycle: _____ # of Miscarriages: _____

22. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

23. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

24. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Loss of Balance Seizures/Epilepsy Numbness/Tingling Paralysis

Tremor/Shakes Bi-Polar/Personality Disorder Other: _____

25. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus Night

Sweats Feeling Hot or Cold Hormone Therapy or Issues: _____

26. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Severe Cold Hands/Feet

Difficulty Falling/Staying Asleep Is there anything else we should know? _____

27. **Lifestyle:**

How many meals do you typically eat per day? _____ Describe a typical dinner: _____

_____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

How would you describe the *quality* of your sleep? _____

Occupation: _____ Most of your day is spent: sitting / standing / very active

Do you enjoy work? Y / N Why/Why not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y / N Explain: _____

_____

Television & Internet habits: _____

Reading habits: _____

What do you most enjoy doing? _____

Favorite time of year and why? _____

28. **Additional concerns or goals regarding your treatment** (if any)**:**

_____

_____

_____

_____

_____

_____

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Notice of Privacy Policy

Dear Valued Patient,

This notice describes our studio's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our practice, we may need to share limited personal medical and financial information with your insurance company with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our studio include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.
- Online booking program is confidential.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. Your visits and treatments will remain confidential and will not be discussed with other patients or visitors to the business. Be aware that in an emergency situation we will contact the "Emergency Contact Person" you indicated on your initial Health History form. If you would like us not to contact this person in case of an emergency, please submit a written request to our office.

If you have questions about our privacy guidelines, please call 828.333.5053, or visit our website to send an email; www.studioclasique.com.

Yours truly,

Brooke Tyler, Studio Owner, Licensed Acupuncturist
Clasique Acupuncture & Pilates Studio

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Consent for Acupuncture Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture, adjunct techniques, and herbal substances from the Oriental Materia Medica by a licensed acupuncturist at Clasique Acupuncture & Pilates Studio.

I am aware that certain adverse side effects may result from acupuncture, herbal medicine and the adjunct therapies. Listed below are possible therapies, but only a select few may be part of your treatment plan.

Acupuncture :: Acupuncture involves the insertion of solid, sterile, disposable needles through the skin at certain points of the body to treat bodily dysfunction or imbalance. Side effects could include discomfort, local bruising, minor bleeding and the possible aggravation of symptoms existing prior to acupuncture treatment.

Moxibustion/Heat Therapy :: Moxibustion is the burning of the Chinese herb Ai Ye (Mugwort leaf) indirectly or directly on the surface of the skin intending to warm and stimulate qi and blood via activating certain acupuncture points. You and the licensed practitioner will communicate on temperature sensitivity during treatment, however there is a mild risk of burning or scarring from the use of moxa. The same risk applies for the use of a TDP lamp, a far infrared heating device used to increase circulation and deeply warm and nourish the body.

Chinese Herbs :: Substances from the Oriental Materia Medica may be recommended as part of your treatment plan. Herbs come in various forms; tea pills, raw herbs, tinctures, granules and topical plasters or liniments. All are GMP certified, meaning the production and packaging methods adhere to strict quality control guidelines. You are not required to take herbs, but agree to follow directions for dosage and administration if you do decide to take them. Adverse side effects could include changes in bowel movement, abdominal discomfort, and the possible aggravation of symptoms existing prior to herbal treatment.

Tui Na Massage/Cupping/Gua Sha :: Tui na is a form of Chinese manipulative therapy similar to massage involving hands-on stimulation of acupuncture meridians or points. Cupping, or "fire cupping" involves placing cups containing suction on the skin. Cupping is used to treat pain, relieve stagnation, stimulate the respiratory system, and release heat from the body. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge, most often a ceramic Chinese soupspoon or honed animal horn. Adverse side effects of all these body treatments could include skin irritation and discoloration, discomfort, sore muscles and mild bruising.

Electro-Acupuncture :: Electro-Acupuncture involves attaching a device to at least 2 acupuncture needles in the body and sending a mild current/electrical pulse between them. This treatment is stimulating, and not painful or shocking. You may refuse this extra stimulation at anytime. Adverse side effects could include pain or discomfort, electrical shock, and possible aggravation of pre-existing symptoms.

Dietary & Exercise Advice :: In conjunction with your treatment you may be given advice and suggestions concerning changes in your diet or exercise routine. Food therapy is an extremely effective means of self-healing, disease prevention and resolution of chronic and acute conditions. Changing eating habits is difficult and you may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. Communicate with your practitioner about any difficulties you may have with specific dietary recommendations. Suggestions concerning physical activity and exercises may be included in your treatment. Specific exercise guidelines are intended to improve your condition and enhance the efficacy of your acupuncture treatment. If you experience extreme discomfort, pain, dizziness, chest tightness, loss of breath, or severe aggravation of symptoms you will stop all exercises and consult your practitioner for further advice.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I do not hold Clasique responsible for any pain or discomfort, or aggravation of symptoms as a result of any of these treatment therapies. **I give my permission and consent to treatment.**

Signature :: _____ Date :: _____

Printed Name :: _____

I also understand that Clasique Acupuncture & Pilates Studio has a **24-hr cancellation policy**. Without 24-hr notice for rescheduling your treatment, you are responsible for full payment of your session value. Thank you for understanding.

24-hr cancellation policy, initial here :: _____

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Acknowledgement of Privacy Policy & Consent for Health Care Treatment

I, _____ consent to the use or disclosure of my identifiable health information by Clasique for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis and treatment at Clasique may be conditioned upon my consent as evidenced by my signature on this document.

My ***identifiable health information*** means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Clasique's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment and describes my rights and the duties of my practitioners with respect to my identifiable health information.

The Notice of Privacy Practices is provided on the website at www.studioclasique.com. Clasique reserves the right to change information contained in the Notice of Privacy Practices at any time.

Consent to the use and disclosure of health information for treatment, payment and healthcare.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as; a basis for applying my diagnosis and planning my treatment, a means by which a third-party payer can verify that services billed were actually provided, a means of communication among the healthcare professionals who contribute to my care, and a tool for assessing care quality of healthcare professionals.

I understand that I have the right to; object to the use of my health information for directory purposes, request restrictions as to how my health information may be used or disclosed to carry out treatment/payment/healthcare operations (and that the organization is not required to agree to the restrictions requested), and revoke this consent in writing (except to the extent that the organization has already taken action in reliance thereupon).

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Office Signature Date