Nourishing
Energy Acupuncture

Thank you for taking the time to complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date ___ / ___ / ____ Name _____ Date of Birth _____ / _____ / _____ Age _____

Address_____ City_____ State_____ Zip_____

Phone _____ Email _____

Phone Numbers of Emergency Contact and relationship_____Occupation _____

How did you hear about us? Doctor: _____Advertisement: _____ Friend: _____Other: _____

Chief Health Concern: _____

_____

What is your goal for us?_____

i**Health Concern #2**: _____

_____

What is your goal for us? _____ _____

Other Concerns: 3) _____ 4) _____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____

Have you had acupuncture before? _____

If yes, where/who _____

Any concerns or fears about the needles? _____

If yes, what? _____

What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.

_____

_____

_____

_____

ALLERGIES Medications, Seasonal, Environmental, Food.

_____

_____

_____

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	Dose

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SYMPTOMS: Please mark anything that is applicable to you. Check if it is a current problem or mark with a P for past.

LIVER/GALBADDER
_____Irritability / Anger
_____Depression / Stress
_____Headaches / Migraines
_____Visual Problems
_____Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness Blurred Vision
_____Feeling of Lump in Throat
_____Clenching of Teeth at Night
_____Muscle Cramping / Twitching
_____Tension
_____Joints/Neck/Shoulder Pain/Tight
_____Poor Circulation
_____Soft / Brittle Nails
_____Emotional Eater

KIDNEY/URINARY BLADDER
_____Urinary Problems
_____Bladder Infection
_____Lack of Bladder Control
_____Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____Feel Cold Easily
_____Low Sex Drive
_____Excess Sexual Desire
_____Poor Memory
_____Loss of Hair
_____Hearing Problems
_____Cavities
_____Craving / Avoiding Salty Foods
_____Fear
_____Hot Flush
_____Night Sweating

HEART/SMALL INTESTINE
_____ Heart Palpitations
_____Chest Pain Insomnia
_____Sleep Problems
_____Easily Startled
_____Restlessness/Agitation
_____Vivid Dreams
_____Lack of Joy in Life

LUNG/LARGE INTESTINE
_____Dry Cough
_____Cough with Sputum
_____Nasal Discharge
_____Post-Nasal Drip
_____Sinus Infection
_____Congestion
_____Itchy, Red or Painful Throat
_____Dry Mouth /Throat / Nose
_____Skin Rashes
_____Hives
_____Snoring
_____Grief / Sadness
_____Shortness of Breath
_____Allergies
_____Asthma
_____Low Resistance to Colds or Flu
_____Sneezing
_____Mild Fever Comes & Goes

SPLEEN/STOMACH
_____Heaviness Anywhere in Body
_____Fatigue
_____Worse After Eating
_____Hard to Get Up in the Morning
_____Edema (Swelling) Muscles
_____Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____Decreased / Increased Appetite
_____Crave Sweets
_____Hypoglycemia
_____Difficulty Digesting Oily Foods
_____Nausea / Vomiting
_____Gas / Belching
_____Insulin Sensitivity
_____Hemorrhoids
_____Constipation
_____Diarrhea
_____Abdominal Pain
_____Indigestion / Heartburn
_____Over-Thinking
_____Tendency to Gain Weight
_____Brain Foggy

OTHER:_____
_____
_____
_____

2845 Wyandot St Apt B, Denver CO 80211 t: 720-295-4594 nourishingenergyacu.com

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Please indicate those that are current health problems for yourself with a "C" under the appropriate person's column. "P" should be used to indicate a past problem. Leave blank those that do not apply.

PERSONAL MEDICAL HISTORY

AIDS /HIV _____
Alcohol _____
Anxiety _____
Arthritis _____
Asthma / Hay Fever / Allergy _____
Back Trouble_____
Bursitis _____
Cancer_____
Constipation_____
Depression _____
Diabetes _____
Digestive Trouble_____
Headaches _____
Heart Trouble _____
Hepatitis _____
High Blood Pressure _____
Immune Disorder_____
Insomnia _____
Kidney Trouble _____
Liver Trouble _____
Migraine _____
Neck Pain _____
Thyroid Disorder _____
Tobacco _____
Weight Problem _____
Other Emotional Problems:_____
Other:_____

FAMILY MEDICAL HISTORY

AIDS /HIV _____
Alcohol _____
Anxiety _____
Arthritis _____
Asthma / Hay Fever / Allergy _____
Back Trouble_____
Bursitis _____
Cancer_____
Constipation_____
Depression _____
Diabetes _____
Digestive Trouble_____
Headaches _____
Heart Trouble _____
Hepatitis _____
High Blood Pressure _____
Immune Disorder_____
Insomnia _____
Kidney Trouble _____
Liver Trouble _____
Migraine _____
Thyroid Disorder _____
Tobacco _____
Weight Problem _____
Other Emotional Problems:_____
Other:_____

MUSCULOSKELETAL

Do you have any pain anywhere? _____

☐ Muscle Cramps – Where?
☐ Joint Swelling – Where?
☐ Muscle Pain / Rheumatism – Where?
☐ Arthritis – Where?
☐ Tendonitis – Where?
☐ Bursitis – Where?

Describe Pain

☐ Sharp ☐ Fixed ☐ Sharp ☐ Fixed ☐ Sharp ☐ Fixed ☐ Burning ☐ Aching
☐ Other:_____

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Women Only

Hysterectomy – Ovaries Removed? _____Yes _____No

Could You be Pregnant Now? ____Yes ____No

Number Of: ___ Pregnancies ___ Births___Abortions___Miscarriages

Post-menopausal Bleeding? ____Yes ____No

When did your last period start? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow: ☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow: ☐Dark ☐Bright red ☐Dark red

Birth control: ☐None ☐IUD ☐Birth control pills ☐Spermicide ☐Barriers

Do You Suffer From:

☐ Cramping (Mark as appropriate) ☐ Severe ☐ Mild ☐ During Period ☐ Before Period ☐ After Period

☐ Clotting (Mark as appropriate) ☐ Large ☐ Medium ☐ Small Are they dark colored? Yes_____

☐ Bleeding Between Periods

☐ Pelvic Inflam. Disease

☐ Endometriosis

☐ Mastitis

☐ Infertility

☐ Ovarian Cysts

☐ Hot Flashes

Men Only

☐ Impotence ☐ Discharge from Penis ☐ Testicular Pain or Lump ☐ Premature Ejaculation ☐ Weak Erection ☐ Prostate Problems ☐ Infertility ☐ Low Sex Drive

Is there anything else you would like me to know?

_____

_____

_____

_____

_____

_____

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

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Is there anything else you would like me to know?

_____

_____

_____

_____

_____

_____

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Mandatory Disclosure

Education and Experience

Serena Shaw received her Master's of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in April of 2015. This was a three-year program with 2,850 hours of course work and clinical work. She was certified as a Diplomat in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This included a certification in Clean Needle Technique as well. She is also a licensed Massage Therapist, receiving her certification from the Denver School of Massage Therapy and had been a practicing massage therapist for over nine years.

Serena has been trained in multiple adjunct therapies including herbal medicine, cupping, moxibustion, Tui Na, massage therapy, auricular acupuncture, Gua sha, and dietary and lifestyle recommendations.

Nourishing Energy Acupuncture complies with rules and regulations of the Colorado Department of Public Health and Environment, including proper sanitization practices and the use of sterile, single-use disposable needles.

Fee Schedule (subject to review each January and July):

Initial visit with exam.....$95.00 + cost of herbs
Follow-up visit.....$75.00 + cost of herbs
Cupping only.....$40.00 for 30min session
Massage Therapy.....30min $40.00.....60min $75.00.....90min $95.00
Missed appointments (less than 24-hour notice).....$50 (cost of missed appointment)

Patient Rights

- Patients may seek a second opinion and may terminate therapy at any time.
- Patient has the right to be informed about any technique or method of therapy used and the duration of those therapies if known.
- Professional relationship. Sexual intimacy is never appropriate and should be reported to the Director of Registration in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to: Director of the Division of Registration in the Department of Regulatory Agencies, 1560 Broadway, Suite 1545, Denver, Colorado 80202, phone (303) 894-2464.

I have carefully read and understand the above and agree to the terms of this Client Disclosure Form.

Signature:_____ Date_____

Nourishing
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Consent to Treat

By signing below, I do hereby authorize Serena Shaw, Licensed Acupuncturist and massage therapist, at Nourishing Energy Acupuncture, to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: Acupuncture, Chinese Herbs, Moxibustion, Cupping, Tui-Na (Chinese Massage) and Western Massage Therapy.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases. I am aware that certain adverse side effects may result. These could include but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that Chinese Herbal formulas may be recommended to me to treat bodily dysfunction or diseases. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort. Should I experience any problems that I associate with these substances, I should suspend taking them and call Nourishing Energy Acupuncture as soon as possible.

Cupping: I understand that cupping may be used to promote circulation of qi through the meridians. Cups may produce a red/purple color on the area treated lasting for 1–5 days. **Moxibustion:** I understand that heat treatments using Artemesia vulgaris ("moxa") involves putting moxa on the head of a needle while inserted in the skin, or directly on the skin. The heat generated from moxa treatments may involve a slight discomfort or leave a blister or scar on the skin. I understand that I may refuse this therapy.

Tui Na and Massage: I understand that based on my condition that a variety of massage techniques may be employed to reduce muscle tension, release myofascial restriction, promote circulation, reduce pain and increase range of motion. These techniques may include traditional Chinese Tui Na techniques, myofascial release, deep tissue massage and Swedish massage.

Most conditions require an average of 6-12 treatments, although some will respond within 4-6 treatments and others may require more. This depends on the severity and the chronic nature of the chief complaint.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved in the treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

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 give my permission and consent to treatment.

Signature:_____Date:_____

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Office Policies

Cancellations & missed appointments. Please provide 24 hour notice of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within less than 24 hours you will be charged a $50 fee.

Reasons for being dismissed/denied treatment: Patients who show inappropriate conduct, non or late payment of fees, or safety concerns may be denied treatment.

Acknowledgment of Notice of Privacy Practices and Consent to Treat
With my consent, Nourishing Energy Acupuncture may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nourishing Energy Acupuncture's Notice of PRivacy Practices for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, Nourishing Energy Acupuncture may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Nourishing Energy Acupuncture may mail to my home or any other designated location any items that assist practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, Nourishing Energy Acupuncture may email me appointment reminders and patient statements. I have the right to request that Nourishing Energy Acupuncture restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to Nourishing Energy Acupuncture use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Nourishing Energy Acupuncture may decline to provide treatment to me.

I, _____, hereby acknowledge that I read and reviewed a copy of Nourishing Energy Acupuncture's Notice of Privacy Practices and fully understand this consent form. I am consenting to use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated.
Signature of patient or Parent/Legal Guardian _____Date_____

Nourishing
Energy Acupuncture

HIPAA Notice

Dear Patients:

Below is a copy of Nourishing Energy Acupuncture's Notice of Privacy Practices and other pertinent information that we are required by law to provide to you.

HIPAA (Health Insurance Portability and Accountability Act) was established by Congress to develop national safeguards to protect the confidentiality of patient medical information. The Privacy Section of this law was put into effect on April 14, 2003. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice at your visit.

Please sign the acknowledgment of receipt to indicate that you have received the notices for you and other minor family members and/or dependents who receive care from Nourishing Energy Acupuncture, Serena Shaw L.Ac

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED \AND DISCLOSED BY Nourishing Energy Acupuncture, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

What is this Notice and Why is it Important?
This notice is required by law to inform you of how your health information will be protected, how Nourishing Energy Acupuncture may use or disclose your health information, and about your rights regarding your health information. If you have any questions about this notice, please contact Nourishing Energy Acupuncture.

Understanding Your Health Information
Each time you visit Nourishing Energy Acupuncture, a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnosis, treatments, and a plan for future care. This information, referred to as your medical record, serves as a:

- Data source for medical research and public health
- Source of data for planning facilities, marketing healthcare services and fundraising
- Tool for education health professionals
- Tool with which we can assess and work to improve the care we provide
- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal documents of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed

Nourishing
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HIPAA Notice

YOUR HEALTH INFORMATION RIGHTS

You have the following rights related to your medical and billing records kept by Nourishing Energy Acupuncture:

Obtain a copy of this notice. You will view a copy of this notice at your first visit after its publication. Thereafter you may request a copy of this notice or any revisions from Nourishing Energy Acupuncture.

Authorization to use your health information. Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

Access to your health information. You may request a copy of your health information that Nourishing Energy Acupuncture keeps in your medical or billing record. Your request must be submitted in writing. We may charge for the costs of providing you access and for your copies.

Amend your health information. If you believe that the information we have about you is incorrect or incomplete, you may request that we correct or add information. Your request must be in writing and you may request a form for this purpose by contacting Nourishing Energy Acupuncture.

Request confidential communications. You may request that when we communicate with you about your health information, we do so in a specific way (e.g., at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

Limit our use or disclosure of your health information. You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, health care operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services.

Our Responsibilities

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our practice and business associates, provide this notice about our privacy practices, and abide by the terms of this notice. We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice. The new notice will be carried by us and will be available at your request.

Except for the purpose related to your treatment, to collect payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time. We are unable to take back any disclosure we have already made with your permission.

Patient or Parent/Legal Guardian Signature _____Date_____

Nourishing
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New Patient Interview

Patient Name_____**Date**_____
Chief complaint_____
_____
_____
_____
What is your diet like?
Do you get three meals a day?
Any dietary restrictions?
Do you get exercise? _____How much?_____

What is your digestion like? Gas_____bloating_____indigestion_____cramping_____
What are your bowels like? Constipation_____loose_____undigested food_____Hard_____
What is your energy level Like?
What is your stress level like?
How do you sleep at night?
Vivid dreams_____Difficult to fall_____Difficult to stay_____Wake often to pee_____
Do you have trouble waking get going in the morning?
Do you startle easily?
Do you sigh a lot?
Do you have a common emotion?

Menstrual History
Preganancy_____Miscarrage_____
Regular?_____Irregular_____
Cycle Length_____Flow: Light_____Heavy_____Normail Color: dark/brown_____bright_____pale_____
Clots_____large_____small_____
PMS_____
Endomentriosis/fibroids/ovarian cycts/UTI/KD infection
Male
Weak stream_____prostate trouble_____erectile dysfunction_____low libido

Pain_____
_____
_____
_____

Tongue_____
Pulse: Left_____Right_____
Assesment:
Treatment:
Plan