ACUPUNCTURE
BEST HEALTH OPTION
WELLNESS

_____
(Patient Name)

Patient Form

Revision Sept. 2016

1

Today's date _____/_____/_____

Patient Name _____ Age _____ Date of Birth _____/_____/_____

Patient Address _____

Patient City, State, ZIP _____

Email Address _____

Height _____ Weight _____ Relationship Status _____ Occupation _____

Phone (H) (_____)_____-_____ (W) (_____)_____-_____ Employer _____

Partner's Name _____ DOB ____/____/_____ Phone (H) (____)_____-_____ (W) (____)_____-_____ ❒ This is my emergency contact.

Family Physician _____ Phone (_____)_____-_____

How did you hear about Best Health Option? ❒ Word of Mouth ❒ Internet ❒ Craigslist ❒ Flyer ❒ Ad ❒ Article

Emergency Contact Information:

The name of the person you would like to contact in emergency _____

Phone (H) (_____)_____-_____ Phone (W) (_____)_____-_____ Relationship _____

Have you eaten 2 hours prior to your treatment? ❒ Yes ❒ No ***You must eat within 2 hours prior to your treatment.***

Chief Complaint:

What is your main health complaint/concern for which you are seeking treatment?

_____

_____

When did this start?

_____

What other forms of treatment have you tried and did they help?

_____

_____

What makes it better or worse?

_____

Please mark on the scale below the severity of the condition (1 = no symptoms, 10 = worst ever)

1 ——————————————— 10

Additional Complaints

_____

_____

_____

_____

_____

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Health History

Check whether you or someone in your family have/had the condition. Note the year for conditions you have had.

	You	Year	Family
Cancer	❒	_____	❒
- Type(s) _____			
Diabetes	❒	_____	❒
Hepatitis (A, B, C)	❒	_____	❒
High Blood Pressure	❒	_____	❒
Heart Disease	❒	_____	❒
Stroke	❒	_____	❒
Seizure Disorder	❒	_____	❒
Thyroid Disease	❒	_____	❒
Asthma	❒	_____	❒
Pacemaker	❒	_____	❒
Osteoporosis	❒	_____	❒

	You	Year	Family
Herpes	❒	_____	❒
AIDS/HIV	❒	_____	❒
Other STD	❒	_____	❒
- Type(s) _____			
Rheumatic Fever	❒	_____	❒
Alcoholism	❒	_____	❒
Allergies	❒	_____	❒
- Type(s) _____			
Mental Illness	❒	_____	❒
- Type(s) _____			
Kidney Disease	❒	_____	❒
Anemia	❒	_____	❒
Drug Allergies	❒	_____	❒

_____

_____

_____

_____

Exercise

Do you exercise regularly?

Yes ❒ No ❒

If so, what and how often?

_____

_____

_____

_____

Habits

	Amt/Week	If quit, year
Coffee/Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____
Water	_____	_____

Medications & Supplements

Please list what medications, herbs, & supplements you take regularly and why

_____

_____

_____

_____

_____

_____

_____

_____

Surgeries

List any surgeries, what they were for & the date

_____

_____

_____

_____

_____

_____

_____

Childhood Traumas

_____

_____

_____

_____

_____

_____

_____

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Temperature

❒ Thirst for hot/cold drinks (circle)
❒ Thirst, but no desire to drink
❒ Night sweats
❒ Hot hands, feet, chest

Moisture

❒ Dry skin
❒ Edema/Swelling
❒ Dry lips
❒ Dry eyes
❒ Pimples
❒ Dry mouth
❒ Oily skin
❒ Rashes
❒ Itching

Digestion

BM: Freq? ____x/every ____ days
Stools keep shape? ❒ yes ❒ no
❒ Bitter taste in mouth
❒ Heartburn
❒ Gas
❒ Bloating
❒ Excessive hunger

Energy

❒ Sudden energy drop
❒ Dependence on caff/stimulants
❒ Heart palpitations
❒ Fatigue
❒ Hard to concentrate
❒ Headaches
❒ Dizziness/Lightheaded

Sleep

❒ Difficulty falling asleep
❒ Disturbing/vivid dreams
❒ Wake ____x/night @ _____am/pm
❒ Restless sleep
❒ Not rested upon waking

Emotions

❒ Anger
❒ Irritability
❒ Anxiety
❒ Worry
❒ Obsessive thinking
❒ Sadness/Grief
❒ Indecision
❒ Depression
❒ Joy
❒ Fear
❒ Timid/Shy
❒ Other:

Eyes, Ears, Nose, Throat

❒ Blurry Vision
❒ Spots in front of eyes
❒ Frequent colds
❒ Sinus congestion
❒ Phlegm (color _____)
❒ Ringing in ears
❒ High or ❒ Low Pitch

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(Patient Name)

Patient Form

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Female:

Menses

Light Pink — Red — Dark Purple

Are you pregnant? ❒ yes ❒ no
Age at first menses: _____
Length of full cycle: _____ days
Length of menses: _____ days
Last menses start date: _____
# of pregnancies _____
# of births _____ premie _____
# of abortions _____

# of miscarriages _____
❒ Heavy periods
❒ Light periods
❒ Painful periods
❒ Irregular periods
❒ Mid-cycle spotting
❒ Mood changes
❒ Fatigue w/menses

❒ Changes in body/psyche prior to menstruation (PMS)
❒ Cramps
  ❒ Before bleeding
  ❒ First day
  ❒ During period
❒ Clots
❒ Breast tenderness

❒ Digestive changes w/mns
❒ Endometriosis
❒ Cysts/Fibroids
❒ Vaginal discharge
❒ Genital sores
❒ Yeast infections
Birth control? ❒ yes ❒ no
  type _____

Menopause

Age at last menses _____
Year menopause began _____
❒ Vaginal dryness

❒ Hot flashes _____x/day
❒ Night sweats _____x/week
❒ Loss of sex drive

Urinary

Clear — Yellow — Dark Yellow

Fluid in = fluid out? ❒ yes ❒ no
❒ Urgency to urinate
❒ Painful urination
❒ Incontinence
❒ Kidney stones

❒ Frequent urination
❒ Burning urination
❒ Cloudy urine
❒ Blood in urine

Male:

Urinary

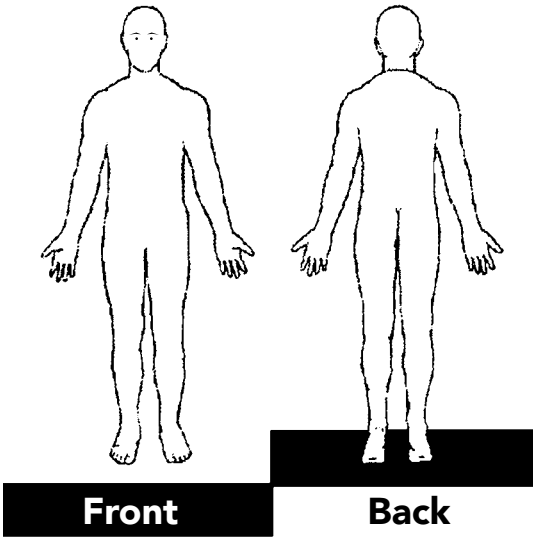
Fluid in = fluid out? ❒ yes ❒ no
❒ Decrease in flow
❒ Dribbling
❒ Difficulty starting/stopping
❒ Incontinence
❒ Kidney stones

❒ Urgency to urinate
❒ Frequent urination
❒ Painful urination
❒ Burning sensation
❒ Cloudy urine
❒ Blood in urine

Reproductive

❒ Change in sex drive
❒ Erectile dysfunction
❒ Premature ejaculation
❒ Sores on genitals
❒ Discharge
❒ Prostate disease

❒ Genital pain
❒ Jock itch
❒ Vasectomy
❒ Hernia
❒ Hemorrhoids



Pain & Injuries

Mark the location of any pain &/or injuries on the picture at left

Pain is (check all that apply):

❒ Dull
❒ Achy
❒ Sharp
❒ Stabbing
❒ Burning
❒ Fixed
❒ Moves around
❒ Radiating
❒ Other

Practitioner use only.

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_____
(Patient Name)

Initial/Recurrent Treatment: General

CC:_____
_____

Goal Statement:_____
_____

General TCM Assessment:_____
_____
_____

❒ Neck is supple, no masses.

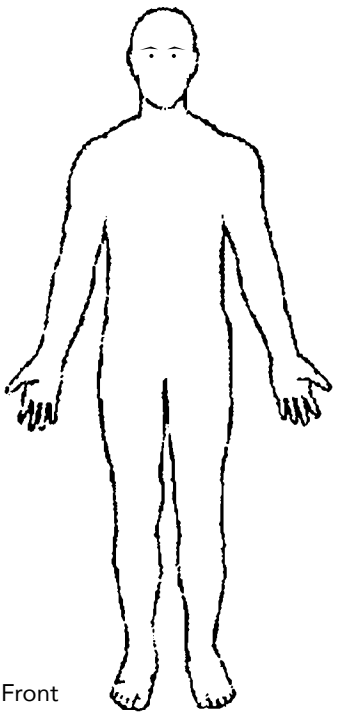
❒ Back is normal, no curvature.

❒ Extremities exhibit AROM without obvious deformities, edema or erythema.

❒ Baseline strength, bulk and tone of musculature.
No palpable masses or foreign bodies appreciated.

❒ Skin integrity intact without rashes, lesions or lacerations.

❒ Temperature unremarkable to touch.



Front

❒ GuaSha ❒ Moxa ❒ AcuStim
❒ TuiNa ❒ Kinesio Taping
❒ Cupping _____

Tongue:_____
Pulse:_____
Root Dx:_____
Branch Dx:_____
Treatment plan:_____
Essential oils/AAT pre/peri needle:_____
_____

Needles in:_____ # _____ **Needles out**:_____ # _____
Needles in:_____ # _____ **Needles out**:_____ # _____
Treatment:_____
Essential oils/AAT post needle:_____
_____

Post treatment response:_____VAS:___/10

❒ Education ❒ Formula ❒ Supplement ❒ Essential oil ❒ Post treatment care

❒ Herbal supplement education: verbal explanation re action, written guidelines presented with formula including possible drug interactions with Western meds. Instructed to call with adverse side effects.

❒ Prescription of formula/supplement _____

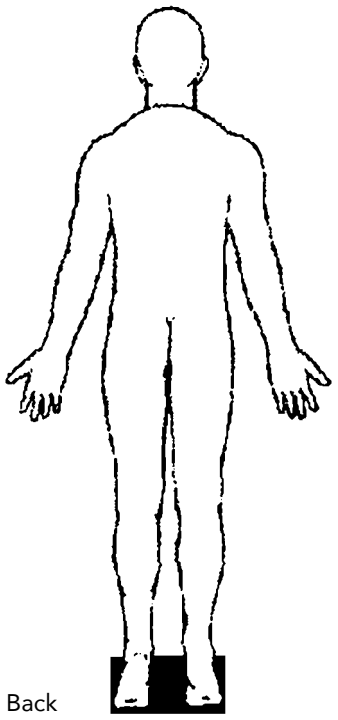
❒ Post treatment instructions given to patient.

❒ Essential oil education: verbal explanation re action inhalation, topical or ingestion guidelines. Written directions provided to patient. Instructed to call with adverse side effects.

POC: ❒ Recommend weekly treatments for 4-6 weeks with evaluation at that time. Primary goal maintenance treatment. Nutritional guidelines, recommended supplements and aromatherapy/ essential oil suggestions discussed with patient.

POC: ❒ Patient determines frequency of treatment based on symptoms and need.

POC: ❒ Instructions give to patient.



Back

❒ GuaSha ❒ Moxa ❒ AcuStim
❒ TuiNa ❒ Kinesio Taping
❒ Cupping _____

Practitioner signature _____ **Date** _____ **Time**_____

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CHINESE MEDICINE / ACUPUNCTURE INFORMATION & INFORMED CONSENT

I have been informed of the risks & benefits of the procedures & products listed below that apply to my treatment:

-Chinese Medicine: distinct system of health care regulating the flow and balance of energy to restore and maintain health.

-Acupuncture: the insertion of sterile needles through the skin with or without the application of electric current and/or heat or laser stimulation of acupuncture points.

-TuiNa/Chinese Body Work: is a method of Chinese Bodywork that utilizes soft tissue manipulation, acupoints, and therapeutic bodywork methods to treat a wide variety of musculoskeletal and internal organ disorders.

-Ashiatsu: gentle but deep massage the practitioner performs applying constant pressure with bare feet.

-GuaSha: "scraping" an area of skin with a smooth non metal instrument.

-Cupping: utilizes a partial vacuum created in a glass dome or cup that is then applied to a particular area of the body.

-Moxibustion: means the thermal stimulation of acupuncture points or specific body areas by utilizing the burning of the dried form of the herb, Artemisia Vulgaris; the heat may be applied on or above specific points or areas or on the acupuncture needle itself.

-Aroma Acupoint Therapy: chosen essential oils on acupoints in a specific sequence to elicit a response.

-Kinesio Taping: cotton fiber tape with acrylic heat activated adhesive applied for mechanical and space correction, inhibition or facilitation of muscle groups and myofacial or epidemal pain relief.

-Ear Seeds/Tacks/ASP Needles: placed in the ear to provide mediated or continuous stimulation for post treatment effect.

-Chinese Oils or Patches: facilitate muscular pain relief.

-Chinese Herbal Formulas or Wester Supplements: patent formulas prescribed for identified Chinese pattern diagnosis. Supplements to support physiological response to treatment.

The benefits and risks of receiving treatments described above have been explained to me. Although rare, certain side effects may result from acupuncture and Chinese Medicinal treatment, I understand that each procedure or treatment has specific risk and benefits.

Minor bruising; Minor burning or blistering; Some pain at the site of the treatment.
Needle sickness; Broken Needles; Infection and the risks from needling in the vicinity of an infection.
Herbal allergies; Herbal sickness.

I understand I am responsible for my bill and
*insurance copay/reimbursement will be made directly to BHO
*a service fee may be charged if appointment cancellation is less than 24 hours of treatment scheduled
* I permit a copy of this authorization to be used in place of the original
I have read the NOTICE OF PRIVACY PRACTICES and authorize Best Health Option to disclose my health information within the structure of those privacy practices

Patient signature: _____ **Date** _____ **Time** _____

Practitioner/witness signature: _____ **Date** _____ **Time** _____

Consent to treat a minor child or disabled dependent:

I authorize _____ and whomever he/she designates as assistants to administer acupuncture care as deemed necessary to my _____ (relationship)

Patient's name_____ Adult's/Guardian's signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices when you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information Based upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, Best Health Option will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by our employees and others that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to seek payment of your health care bills and to support the operation of Best Health Option. Following are examples of the types of uses and disclosures of your protected health care information that Best Health Option are permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Best Health Option once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other Physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the Doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment to our Practitioners.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of Best Health Option. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name; we may also call you by name in the waiting room when your clinician is ready to see you; we may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment; we will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Best Health Option has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or

object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Best Health Option Doctors may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your prote0orized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, the Doctor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we have attempted to obtain your consent but are unable to obtain your consent, we may still use or disclose your protected health information to treat you.

C**ommunication Barriers:** We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and the Doctor determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on Best Health Option premises, and (6) medical emergency and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and Best Health Option created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.Seg.

2. Your Rights:
The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that Best Health Option use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Office if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Best Health Option are not required to agree to a restriction that you may request. If our Practitioners believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If our Practitioners agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Practitioners.

You may have the right to have the Practitioners amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice by reading it where it is posted or by receiving it electronically.

3. Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying us. We will not retaliate against you for filing a complaint.