

New Patient Health Information

First Name: _____ Last Name: _____ Gender: F / M BirthDay: _____

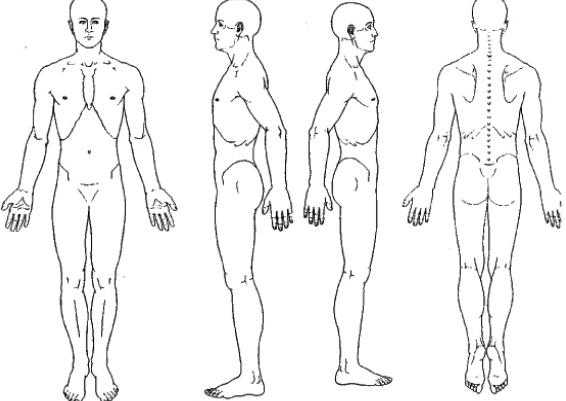
Address: _____ City: _____ Zip: _____

Email: _____ Tel: (____) _____ Occupation: _____

Marital Status: Single Married Divorced Widowed Height: _____ Weight: _____

What trouble bothers you most today and How long it has been _____

Please check any of the following as you feel are significant to you:

<input type="checkbox"/> Pain: <u>Yes/No</u> Level: <u>/10</u> Location 	<input type="checkbox"/> Migraine headache <input type="checkbox"/> Tension Headache <input type="checkbox"/> Cold / Flu / Bronchitis/ Pneumonia <input type="checkbox"/> Sore Throat / Cough <input type="checkbox"/> Hay fever / Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Sinusitis <input type="checkbox"/> Nose bleed frequently <input type="checkbox"/> Tongue Sores
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<input type="checkbox"/> Lack of thirst/forget to drink	<input type="checkbox"/> Easy thirst / Dry Mouth / Dry Throat	<input type="checkbox"/> Nausea
<input type="checkbox"/> Poor or No appetite	<input type="checkbox"/> Good appetite	<input type="checkbox"/> Bad Breath
<input type="checkbox"/> Bloating / Indigestion	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Abdominal Pain /Cramp/ ulcer
<input type="checkbox"/> Bowel Movement ____ times/____ day	<input type="checkbox"/> hard/ <input type="checkbox"/> soft / <input type="checkbox"/> Normal / <input type="checkbox"/> loose	<input type="checkbox"/> Hemorrhoid
<input type="checkbox"/> Incontinence of Urine	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Cloudy / Bubbling Urine	<input type="checkbox"/> Painful Burning Urination	<input type="checkbox"/> Night Urine ____ times

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness / Vertigo / Ringing Ear	<input type="checkbox"/> Drinking or Drug
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> Palpitation/ irregular heartbeat	<input type="checkbox"/> Edema / Water retention	

Color Blind Motion Sickness / Car Sick / Seasick Dry Eyes
 Eczema / Acne /Skin Eruptions Skin Tag on neck Hair Loss
 Brittle Nails Fatty Modules under skin
 Difficult to gaining Weight Difficult to lose weight
Energy Level: _____ /10 Body feel always hot /get chills easily Cold hand and feet
My body accepts more on Winter season Summer Season

- Insomnia
- Sleeping too much
- Night Sweats
- Anxiety /Depression/ Worry
- ADD / ADHD

Men

Potency Issue Prostatitis Fertility Issues

Female

Birth History: Pregnancies _____ Births: _____ Miscarriages: _____ Abortions: _____

Menopause:	Menopause: No
<input type="checkbox"/> Yes	Age when period begin _____ Duration of flow /days _____
Is your cycle regular? <input type="checkbox"/> Yes/ <input type="checkbox"/> No	
Date of last Period: _____ Do you think you are pregnant right now? No _____	
Difficulties during period : <input type="checkbox"/> Excessive flow <input type="checkbox"/> Less flow <input type="checkbox"/> Cramps <input type="checkbox"/> Clots <input type="checkbox"/> Breast Distension <input type="checkbox"/> Emotional Change	

Any other than above, please describe: _____

Family History: _____

Please list medicine you are taking: _____

Have you have any surgery & Date: _____

How do you know about this clinic? _____

If you know us from Groupon, please write down the groupon number: _____

New Patient Intake Form

File No: _____

Patient's Name: _____

Date: _____ / _____ / _____

Chief Complaint: _____

Physical Exam: Heart Rate: _____ BPM Heart Rhythm: Normal/Abnormal BP: _____ / _____ mmHg

Tongue Body: Pale/ Pink/ Red/ dark Red/ Purple/ Blue

Coating: White/ Yellow/ Gray/ Black/ Half in Center or Side /Thin/ Thick/ Dry/ Slippery/ Greasy/ Scanty/ Graphic

Shape: Stiff / Cracked/ Swollen in Side Center Half /Tooth-marked/ Ulcerate/ Flabby/ Thin/ Narrow

Pulse: Lt: _____ Rt: _____

Superficial	Deep	Slow	Rapid	Deficient	Excess	Surging	Thready	Abrupt
Hesitant	Tense	Soft	Weak	Moderate	Knotted	Intermittent	Rolling	String-taut

TCM Diagnosis: _____

Treatment Principles: _____

Acupuncture Treatment: _____

(Technique: Tonify: - Sedating: Moxa: Electro: E TuiNai: T Cupping: C)

Herbal Treatment: _____

Recommendations: _____

Abundant Blessing Acupuncture & Herbs

299 W Hillcrest Dr, Ste 206, Thousand Oaks, CA, 91360 Tel: (805) 432-4936

Cash Patient Service Fees:

Acupuncture Treatments Initial \$120 Follow Up \$90 5 Treatments \$350
MicroNeedling /Facial Acupuncture \$120 Cupping/Moxa Only \$40. Herb \$15 -- 50/week
Cancellation fee \$30 if fail to notice at least 2 hours before appointment

Patient Name:

Abundant Blessing Acupuncture & Herbs

4165 Thousand Oaks Blvd, Ste 150, Westlake Village, CA, 91362

Tel: (805) 432-4936

Cash Patient Service Fees:

Acupuncture Initial Consultation \$30 Treatment \$90 5 Treatments \$400

NeuroFeedback 120/ Session \$1000 for 10 Sessions

8 Treatments \$560
Herb \$15 -- 50/week

Cancelation fee \$30 if fail to notice at least 2 hours before appointment

Patient Name:

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.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who 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 pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 another provider. 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.

Health Care Operations: We may use or disclose, as needed, your protected health information for our physician's practice. For example, but are not limited to,

- quality assessment activities,
- employee review activities,
- training of medical students, licensing
- billing or transcription services

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.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. 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, if 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. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

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.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

2. YOUR RIGHTS

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 for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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 health care 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.

3. COMPLAINTS

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

You may contact our Office at (805)432-4936 for further information about the complaint process.

4. Acupuncture SAFETY

Acupuncture is performed by insertion needles through the skin, or by the application of heat to the body in an attempt to treat bodily dysfunctions or diseases, to body's physiological functions. Side effects include but not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possibly temporary aggravation of symptoms existing prior to acupuncture treatment.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity.

Cash Patient Fees:

Acupuncture Treatments	Initial	\$120	Follow Up	\$90	5 Treatments	\$350
MicroNeedling /Facial Acupuncture	\$120		Cupping/Moxa Only	\$40.	Herb	\$15 -- 50/week
Cancellation fee \$30 if fail to notice at least 2 hours before appointment						

This notice was published and becomes effective on **June 1, 2011.**

Patient Name: _____ Signature: _____ Date: _____