Center for Acupuncture & Healing Arts
Our Clinic Protects Your Health Information and Privacy
Notice of Privacy Policies and Procedures

—You may keep this page for your records if you wish, or we will recycle it.—

This notice describes our office'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. Your Protected Health Information is used and disclosed for treatment, payment, and healthcare operations. You may authorize us to use or disclose Protected Health Information for any purpose, such as discussing your case with other healthcare providers.

Safeguards in place at our office 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 records are kept on permanent file.

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, 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 party administrators (*e.g*. requests for medical records, claim payment information).

Exceptions to confidentiality:

By law, we may be required, without your authorization, to provide state and federal agencies with information:

- About reasonable suspicion of child abuse or elder abuse.
- About reasonable suspicion that you may be a danger to yourself or others.
- About certain communicable diseases.
- If records are subpoenaed by a court of law.

Your right to your records:

Your records are the property of our clinic, but you have a right to obtain copies of your records, and we may charge a reasonable fee for providing them to you.

If you have questions about our privacy policy, please call (828) 526-0743, or ask us at your next appointment.

Center for Acupuncture & Healing Arts

Consent to use and disclose information for the purposes of treatment, payment, and health care operations

I give consent to Kim Bonsteel, LAc, and Center for Acupuncture and Healing Arts, together with their employees, contractors, and agents — hereinafter "CAHA" — to use and disclose my Individual Identifiable Health Information or Protected Health Information for the specific purposes:

1. Providing treatment and patient education to me.
2. Relating to payment for services rendered to me.
3. General administrative operations necessary to provide these services.

Protected Health Information is any information that includes:
1. Demographic information.
2. Information gathered by CAHA as it relates to my past, present, and future.
3. Information gathered by CAHA for past, present, or future payments for providing the services.

Heathcare operations purposes will include preparatory and treatment activities, quality assessment activities, business management, and other general operations procedures or activities.

I understand that my records, or duplicate records, may be securely kept by CAHA at any location where services are provided to me, or any location where administrative operations are carried out.

I have the right to revoke this consent, in writing, at any time, except to the extent that CAHA has acted in reliance on this consent.

I have read, reviewed, understand and agree to the Notice of Privacy Policies and Procedures for healthcare operations at CAHA.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

Informed Consent to Acupuncture & Adjunctive Treatments

Acupuncture is an ancient, widely-applied therapeutic method that supports the body's natural ability to be well. Very fine, sterile, disposable needles are inserted in specific locations on the body, then left for a period of time, during which the patient is requested to lie quietly and relax. During the treatment the practitioner asks that you report any sensations you experience. You have the right to refuse, request modification, or terminate the treatment at any time. You may ask for more information at any time.

During and after a treatment, many people report experiencing a feeling of relaxation, or increased energy and alertness.

As with any medical treatment, results are not guaranteed, and your best chance for a positive result may depend on your compliance with the treatment plan as recommended.

Occasionally, the healing process involves an initial worsening of symptoms before improvement.

Acupuncture has few side effects or contraindications. Side effects that may occur are rarely severe. You are encouraged to note any feelings or changes that occur during or after treatment. We request that you report to us any adverse responses you experience. Please call if you have any concerns after your treatment. ***Always seek standard medical care in any emergency.***

Side effects may include, but are not limited to, bruising or minor bleeding, discomfort that persists at an insertion site for some time after treatment, dizziness or fainting. Your practitioner is highly trained to avoid causing serious injury, but we are required to inform you that extremely rare risks could include, but are not limited to, bent, broken, or stuck needles, nerve damage, organ puncture, allergic reactions, and infection.

Adjunctive therapies and their risks include, but are not limited to, *moxibustion* (unintended burns, allergic reaction); *massage, acupressure, cupping, gua sha* (ecchymosis or bruising); *liniments, ointments, plasters* (skin irritation, rashes, allergic reaction); *herbs and supplements* (changes in bowel movements, abdominal pain or discomfort, aggravation of previously existing symptoms, allergic reaction); *dietary therapy* (problems with digestion, sleep, or energy, or allergic reaction to new foods); *therapeutic exercise* (dizziness, fainting — and if the health of your heart, arteries, or lungs is compromised, shortness of breath, chest pain, heart attack, or stroke. It is recommended to check with your doctor before beginning any new exercise regimen). ***Always seek standard medical care in any emergency.***

Declaration:

I have received and carefully read, or had read to me, the information included in this document concerning the possible effects of acupuncture & adjunctive therapies. Treatments and possible side effects were explained to my satisfaction. My questions were thoroughly and completely answered.

After careful consideration, I agree to receive acupuncture treatment. I understand that I have the right to refuse, request modification, or discontinue treatment at any time, and I am aware that exercising the right may affect the anticipated results.

_____
Printed name of Patient
(or legal guardian, if patient is under 18)

_____ _____
Signature of Patient Date
(or legal guardian, if patient is under 18)

_____ _____
Kim Bonsteel, L.Ac. Date

Center for Acupuncture & Healing Arts
Patient Confidential Contact Information

First_____MI ____ Last _____ _Preferred Name _____

Local Street Address_____

Local Mailing Address, if different_____

City_____State_____Zip_____

DOB: ___/___/_____ Gender: M ☐ F ☐ Marital status: ☐Single ☐Married ☐Widowed

Phone #s *(Which one is best to contact you during the day?)* ☐ Home ☐Work ☐Cell

Home_____Work_____Cell_____

E-mail (*we keep this private*) _____

Is your email secure for receiving confidential information about your case? ☐Yes ☐No

We may send you news, announcements, and coupons. You may opt out at any time.

Patient's Occupation_____Spouse's Occupation_____

If you are a seasonal resident, what is your other address and phone number?

Street Address or PO Box_____

City_____ State _____Zip_____Phone_____

Who is your Primary Care Physician? _____Where?_____

What kind of doc are they? ☐MD ☐DO ☐DC ☐ND ☐Other, please specify_____

Responsible party (if not patient):

Relationship_____Phone # (_____) _____

Name of Responsible Party _____

Address _____ City _____ State _____

In case of emergency, who should we contact?

Name_____Phone_____Alt.Phone_____

Physical Address_____

Work Address_____

How did you hear about us? _____

☐Internet ☐The Laurel magazine ☐Newspaper ☐Radio ☐Business Card ☐Word of mouth

☐Friend/Relative (Name? Optional, but we'd like to thank them)_____

Patient Name_____

Date of first visit___/___/_____ Male ☐ Female ☐ Age_____DOB___/___/_____

What is the reason for your visit today?_____

_____

What type of care do you desire? ***(You may check more than one.)***

_____1) Temporary relief of symptoms / pain control

_____2) Removing the tendencies causing my condition

_____3) Balanced optimum health care. Elimination of root/cause of problem, if possible

_____4) Wellness, prevention of disease, maintenance of health

How would you classify your condition?

_____1) Minor

_____2) Moderate

_____3) Intensifying, affecting daily activities

_____4) Fairly severe, progressively getting worse or more worrisome

_____5) Serious

Please state and describe the top three problems or conditions concerning you

 # 1 Problem (most troublesome)_____

When did it occur?_____ How? _____

Timing: Is it getting? better ☐ worse ☐ constant ☐ worsens at (time of day) _____

What makes it worse?_____ What makes it better? _____

What have you tried to help it?_____Results?_____

Describe related symptoms _____

 # 2 Problem _____

When did it occur?_____ How? _____

Timing: Is it getting? better ☐ worse ☐ constant ☐ worsens at (time of day) _____

What makes it worse?_____ What makes it better? _____

What have you tried to help it?_____Results?_____

Describe related symptoms _____

 # 3 Problem _____

When did it occur?_____ How? _____

Timing: Is it getting? better ☐ worse ☐ constant ☐ worsens at (time of day) _____

What have you tried to help it?_____Results?_____

Describe related symptoms _____

Patient Name_____

Please list any other current complaints or illnesses_____

Please list your current medications, and what they are for_____

Please list all past serious illnesses, hospitalizations, or surgeries, including childhood diseases_____

Please list any known allergies (food, environmental, chemicals or drugs)_____

Please list all of your current health care providers, including what kind (MD, osteopath, naturopath, chiropractor, herbalist, massage & bodywork therapist, etc) and any specialties (gynecologist, cardiologist, orthopedist, kinesiologist, cervical specialist, etc).

Name	Type of provider	Specialty	City & State

Patient Name_____

Please describe any current or past use of tobacco, alcohol, or recreational drugs, what kind, how much, how often, and when in your life you used them (confidential except with your permission or court order)

_____

_____

_____

Please list any implants, metal plates, artificial joints, pacemakers, insulin pumps, stents, biomechanical devices, etc_____

_____

_____

Check all that presently apply to you:

☐ very hungry	☐ pregnant or maybe	☐ very upset
☐ very full	☐ recently gave birth	☐ very anxious/nervous
☐ missed a meal	☐ menstruating	☐ very sad
☐ exhausted	☐ had alcohol today	☐ very angry
☐ bleeding disorder	☐ got high today	☐ down on myself
☐ bruise easily	☐ HIV/AIDS	☐ hepatitis ☐A ☐B ☐C
☐ faint easily	☐ high blood pressure	☐ heart problems
☐ sugar unstable	☐ epilepsy	☐ breathing problems
☐ sores, boils	☐ skin rash	☐ staph infection
☐ contagious disease	☐ fever	☐ _____infection

Is there anything else you would like to discuss?_____

_____

_____

_____

_____

I understand that the acupuncturist needs good information to help facilitate my healing. The above information is true, correct, and complete to the best of my knowledge and belief.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Kim Bonsteel, L.Ac., LMBT Date

Center for Acupuncture & Healing Arts

Acupuncture Health Questionnaire

Date_____ Patient Name _____

These questions are vitally important, so please answer carefully.

☐ **I have pain.**

1st location_____Is it new? _____Had it how long?_____How bad today? (0 to 10)____

2nd location_____Is it new? _____Had it how long?_____How bad today? (0 to 10)____

3rd location_____Is it new? _____Had it how long?_____How bad today? (0 to 10)____

My pain is:

- ☐ sharp, stabbing
- ☐ dull, aching
- ☐ burning
- ☐ shooting
- ☐ _____ *your description*
- ☐ fixed location or
- ☐ moves around
- ☐ better with rest or
- ☐ better with movement
- ☐ better with cold or
- ☐ better with heat
- ☐ pressure makes it better or
- ☐ pressure makes it worse

Food and Taste

- ☐ My appetite is big
- ☐ My appetite is small
- ☐ I crave or like sweet
- ☐ I crave or like sour
- ☐ I crave or like salty
- ☐ I crave or like spicy
- ☐ I crave or like bitter
- ☐ I have heartburn or take heartburn meds
- ☐ I am bloated, gassy
- ☐ I have nausea or vomiting
- ☐ I have a bitter taste in my mouth
- ☐ I have a sour taste in my mouth
- ☐ I have a metal taste in my mouth
- ☐ I have bad breath

Stools and Urine

- ☐ Stools daily
- ☐ Stools formed solid, torpedo shape
- ☐ Stools not daily, but 1 2 3 4 5 6 per week
- ☐ Stools dry and hard
- ☐ Stools difficult to pass
- ☐ Stools in bits like "Milk Duds"
- ☐ Multiple stools daily
- ☐ Stools soft, mushy, or loose
- ☐ Watery stools or diarrhea
- ☐ Undigested food in stools
- ☐ Very stinky stools
- ☐ Gassy stools
- ☐ Explosive stools
- ☐ Hot stools (anus burns)
- ☐ Blood in stools
- ☐ Mucus in stools
- ☐ Oily, greasy stools
- ☐ Incomplete evacuation
- ☐ Frequent urination
- ☐ Need to go when only small amount
- ☐ Scanty urine
- ☐ Dark urine
- ☐ Colorless urine
- ☐ Cloudy urine
- ☐ Blood in urine
- ☐ Burning urine
- ☐ Painful urination
- ☐ Trouble starting
- ☐ Trouble stopping
- ☐ Forceful stream or
- ☐ Small, weak stream or
- ☐ Moderate stream

Thirst and Drink

- ☐ I drink ____ glasses of water daily
- ☐ I like to drink large amounts
- ☐ I like to drink small amounts
- ☐ I am thirsty often
- ☐ I don't thirst
- ☐ I like cold beverages
- ☐ I like warm or hot beverages

Alcohol

One "drink" means one beer, one glass of wine, or one ounce of liquor. How many drinks do you average?

- ☐ On average, I have ____ drinks per day, ____days per week.

Center for Acupuncture & Healing Arts

Energy

- ☐ My energy is good most of the time
- ☐ I have too much energy
- ☐ My energy is up and down a lot
- ☐ My energy is often low
- ☐ I wake up tired
- ☐ I'm slow getting started in the morning
- ☐ I feel tired or sleepy after meals
- ☐ My energy gets low at the same time each day, ____ AM PM
- ☐ I have trouble concentrating or focusing
- ☐ I get distracted easily
- ☐ I have problems with memory
- ☐ Everything seems too hard

Exercise

- ☐ I exercise ____ times per week, an average of _____minutes each time.
- ☐ I spend an average of _____ hours per week sitting down.

Head, Face, and Neck

- ☐ Hair brittle or falling out
- ☐ I don't often get headaches, but I have one today
- ☐ I get headaches often
- ☐ Headache in my forehead or cheeks
- ☐ Headache in my temples or sides of the head
- ☐ Headache behind the eyes
- ☐ Headache on top of my head
- ☐ Headache in the back of my head
- ☐ I use pain relievers for headache ____ times per week
- ☐ Headaches are throbbing
- ☐ Headaches are stabbing
- ☐ Headaches are _____
- ☐ My neck is stiff
- ☐ My neck is painful or uncomfortable
- ☐ The tops of my shoulders have big knots and tension
- ☐ I have pain in my face
- ☐ My face feels hot now
- ☐ My face feels hot often
- ☐ I have spells of dizziness or vertigo
- ☐ My face twitches or spasms

Eyes, Ears, Nose, Mouth, and Throat

- ☐ Recent vision changes
- ☐ Blurred vision
- ☐ I see floaters inside my eyes
- ☐ Tired eyes
- ☐ Dry eyes
- ☐ Sore or painful eyes
- ☐ Cataracts
- ☐ Other eye problem_____
- ☐ Hearing loss
- ☐ Ears feel stuffy
- ☐ Ringing in the ears
- ☐ Heartbeat in the ears
- ☐ Ear pain
- ☐ Trouble clearing the ears when pressure changes
- ☐ Other ear problem_____
- ☐ Dry nose
- ☐ Nasal polyps
- ☐ Nosebleed
- ☐ Clogged sinuses
- ☐ Sinus pressure or pain
- ☐ Respiratory allergies
- ☐ Sneezing
- ☐ Stuffy nose
- ☐ Runny nose
- ☐ Drainage from nose to throat
- ☐ Other nose or sinus problem _____
- ☐ Clear mucus or phlegm, nose or throat
- ☐ White mucus or phlegm, nose or throat
- ☐ Yellow mucus or phlegm, nose or throat

- ☐ Green mucus or phlegm, nose or throat
- ☐ Blood spots in mucus or phlegm, nose or throat
- ☐ Cough
- ☐ Cough brings up sputum
- ☐ Cough without sputum
- ☐ Dry cough
- ☐ Barking cough
- ☐ Throat itches or tickles
- ☐ Dry throat
- ☐ Difficulty swallowing
- ☐ Choke easily
- ☐ Hoarse voice or loss of voice
- ☐ Other throat problem_____
- ☐ Lips dry, chapped or cracked
- ☐ Dry mouth
- ☐ Too much saliva
- ☐ Cold sores around mouth
- ☐ Sores inside the mouth
- ☐ Sores on the tongue
- ☐ Gums bleed when I floss or brush
- ☐ Gums bleed in general
- ☐ Bad teeth
- ☐ Jaw clenching
- ☐ Jaw pain
- ☐ Jaw popping
- ☐ Grind my teeth
- ☐ Other mouth or jaw problem _____

Back, Chest, and Abdomen

- ☐ Numbness
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Chest pain
- ☐ Side-of-body pain or rib pain
- ☐ Upper abdomen pain
- ☐ Pain in the area of the navel
- ☐ Lower abdomen pain

Limbs

- ☐ Cold hands
- ☐ Hot hands
- ☐ Cold feet
- ☐ Hot feet
- ☐ Numbness/tingling, arms or hands
- ☐ Numbness/tingling, legs or feet
- ☐ Weakness of the arms or hands
- ☐ Weakness of the legs or feet
- ☐ Arms or legs feel heavy
- ☐ Weak knees
- ☐ Muscle aches
- ☐ Difficulty walking
- ☐ Tremors or twitches
- ☐ Spasms or cramps
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Toe pain
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Finger pain
- ☐ Swelling of joints
- ☐ Hot joints
- ☐ Other limb problem _____
- ☐ Nails are brittle, thin, or weak

Sleep

- ☐ I sleep too much
- ☐ I don't like to get up
- ☐ My sleep is good and refreshing without any sleep aids
- ☐ I take sleep aids ____ times per week
- ☐ My usual bedtime is ____ PM AM
- ☐ I usually rise at ____ AM PM
- ☐ I have trouble falling asleep
- ☐ I have trouble staying asleep
- ☐ I watch TV or use electronics at night
- ☐ I eat late or snack in the evening
- ☐ I drink alcohol less than 3 hours before bed
- ☐ I wake in the night more than twice to urinate
- ☐ I wake in the night thinking about business or personal problems
- ☐ I wake in the night around __ AM PM

- ☐ I remember dreams
- ☐ My dreams are vivid
- ☐ My dreams are disturbing
- ☐ I have nightmares
- ☐ I snore
- ☐ I get leg cramps in bed
- ☐ My arms go numb in bed
- ☐ I have restless legs or kick in my sleep
- ☐ I snore
- ☐ Diagnosis of sleep apnea
- ☐ I use CPAP to breathe in bed
- ☐ Other sleep problem _____

Sweating

- ☐ I'm sweating now because of a fever
- ☐ I sweat a lot
- ☐ I sweat about the same as others
- ☐ I don't sweat much
- ☐ I almost never sweat
- ☐ I have night sweats
- ☐ I sweat at odd times
- ☐ My sweat is cold and clammy
- ☐ My sweat stings my skin
- ☐ When I exercise or get hot, my whole body sweats
- ☐ Only certain parts of my body sweat:
  - ☐ Top of head
  - ☐ Forehead
  - ☐ Face
  - ☐ Neck
  - ☐ Upper chest
  - ☐ Upper back
  - ☐ Armpits
  - ☐ Upper arms
  - ☐ Forearms
  - ☐ Hands
  - ☐ Belly
  - ☐ Low back
  - ☐ Crotch
  - ☐ Hips
  - ☐ Thighs
  - ☐ Legs
  - ☐ Feet

Feelings of Heat or Cold

These questions are about what you feel, not what a thermometer says.

- ☐ I feel hot today
- ☐ I have chills today
- ☐ I feel chills and heat at the same time
- ☐ Chills and heat alternate
- ☐ I want to avoid heat
- ☐ I want to avoid cold
- ☐ I want to avoid wind
- ☐ I am "cold-natured" and feel cold often
- ☐ I am "hot-natured" and feel hot often
- ☐ I have trouble getting warm in winter
- ☐ The heat of summer beats me down
- ☐ Trouble adjusting to the change of the seasons
- ☐ My hands are cold
- ☐ My feet are cold
- ☐ My hips and butt are cold
- ☐ My _____feels cold
- ☐ I feel hot in the palms of my hands
- ☐ I feel hot in the soles of my feet
- ☐ My _____feels hot

Mental and Emotional

- ☐ I have a lot of anger
- ☐ I anger easily
- ☐ I get irritable
- ☐ I want control all the time
- ☐ I plan everything in detail
- ☐ I have trouble making decisions
- ☐ I make hasty decisions
- ☐ I'm creative
- ☐ I'm on an emotional roller-coaster, up and down
- ☐ I get anxious or nervous
- ☐ When I'm anxious, I sometimes feel my heartbeat
- ☐ I often feel elated
- ☐ I worry
- ☐ I over-think things
- ☐ I go round and round with problems
- ☐ I'm obsessive
- ☐ I'm compulsive
- ☐ I live in my head a lot
- ☐ I have poor self-esteem

- ☐ I think too highly of myself
- ☐ I don't know my purpose
- ☐ I don't know how I fit in the world
- ☐ I am sad a lot
- ☐ I am depressed
- ☐ I carry grief
- ☐ I am sensitive
- ☐ I am not sensitive at all
- ☐ I don't notice things
- ☐ I don't have much motivation
- ☐ I don't have much willpower
- ☐ I have big fears
- ☐ I have little fears
- ☐ I have unexplained dread
- ☐ I have a feeling of doom
- ☐ I think, "Why bother?"
- ☐ I put things off
- ☐ I don't finish things
- ☐ I make decisions and don't carry them out

Immune System

- ☐ I never get sick
- ☐ I catch every bug that comes along
- ☐ Cuts and scrapes are slow to heal
- ☐ I have toenail fungus
- ☐ I get candida outbreaks
- ☐ I get herpes outbreaks
- ☐ I get shingles outbreaks
- ☐ Autoimmune disease

Skin

- ☐ My skin is dry
- ☐ I get acne
- ☐ I get cysts
- ☐ I get boils or carbuncles
- ☐ I get lipomas
- ☐ I've had skin cancers removed
- ☐ I get rashes
- ☐ I get dry eczema
- ☐ I get weeping eczema
- ☐ I get dry psoriasis
- ☐ I get weeping psoriasis
- ☐ Other skin issue _____
- ☐ Other skin issue _____

For Men

Monthly testicular self-exam is recommended

- ☐ My sex drive is low
- ☐ I don't have good erections
- ☐ I ejaculate too soon
- ☐ Ejaculation is painful
- ☐ After ejaculation, I feel tired or dizzy
- ☐ I've had prostate procedures
- ☐ Other issues _____

Men, if there is anything you want to add, use the last page

For Women

Monthly breast self-exam is recommended

- ☐ My sex drive is low
- ☐ Headache after orgasm
- ☐ Difficult to have orgasm
- ☐ Intercourse is painful
- ☐ Vaginal discharge, recent
- ☐ White discharge
- ☐ Yellow discharge
- ☐ Vaginal dryness
- ☐ Hysterectomy, year _____, reason _____
- ☐ One ovary removed
- ☐ Two ovaries removed
- ☐ Red discharge
- ☐ Smelly discharge
- ☐ Itchy vulva or vagina
- ☐ History of fibroids
- ☐ History of endometriosis
- ☐ History of ovarian cysts
- ☐ History of polycystic ovaries
- ☐ I use birth control pills
- ☐ I don't have periods

- ☐ I have not reached menopause
- ☐ I cycle every 28-29 days
- ☐ My cycles are shorter
- ☐ My cycles are longer
- ☐ My periods last ___ days
- ☐ Bleeding is heavy for ___ days
- ☐ Much cramping
- ☐ Little or no cramping
- ☐ Much irritability
- ☐ Little or no irritability
- ☐ Spotting between periods
- ☐ I am peri-menopausal and my cycles are far apart
- ☐ Bright red blood, few or no clots
- ☐ Thin, pink blood
- ☐ Dark, clotty blood
- ☐ I am post-menopausal
- ☐ I have hot flashes
- ☐ I have hot flashes that start in the chest
- ☐ I have hot flashes that start in the low back
- ☐ I have hot flashes in the whole body at once
- ☐ I have dramatic mood swings
- ☐ My bone density is decreasing
- ☐ How many children? _____
- ☐ How many caesareans? _____
- ☐ Other women's health issues, or history, list below

<u>Women and Men</u>, you may list any other health conditions or issues below

_____

SIGNATURE affirming these statements are true, correct, and complete