Carol L. Reed, L.Ac., MSOM
Acupuncturist, Herbalist, & Tui Na Practitioner

T 208.351.0952 **www.ElementsOfTao.com**
carol@elementsoftao.com

Personal Information (please print clearly)

Gender ID: ❑ Male ❑ Female

Name: _____ Date of Birth: _____ ❑ Other: _____

Address: _____

Phone # Cell: _____ Home: _____ Work: _____

Email: _____ Referred by: _____

Preferred Method of Communication? ❑ Cell ❑ Home ❑ Email

Emergency Contact & Phone Numbers: _____

Occupation: _____ Height: _____ Weight: _____

Primary Treating Physician: _____ Physician's Phone #: _____

Health History Questionnaire (Please take the time to fill this out thoroughly)

Chief Complaint

What health issues are you looking to have treated?

_____

_____

_____

When did the problem begin? _____

Have you been given a diagnosis for this problem? If so, what? _____

_____

Have you received acupuncture before? When and for what reason? _____

_____

What sort of therapies are you currently using? _____

_____

Are you using any medications, herbs, or supplements? If so, give names and dosages? _____

_____

_____

_____

_____

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Name: _____ Date of Birth: _____

Medical History - Do you have or have you had any of these western medical conditions?

❑ Arthritis	❑ Diabetes	❑ Heart Disease	❑ Kidney Disease	❑ Seizures
❑ Asthma	❑ Drug/Alcohol Abuse	❑ Hepatitis	❑ Liver Disease	❑ Surgeries
❑ Blood Disorder	❑ Fibroids (Uterine)	❑ HIV/AIDS	❑ Lung Disease	❑ Thyroid Disorder
❑ Cancer	❑ Gall Bladder Disease	❑ Hypertension	❑ Stroke	❑ Other

Please elaborate for any of the above checked conditions: _____

_____

Personal Habits - Please indicate if you have used any of the following substances? Circle "day" or "week"

❑ Tobacco	_____ times per day / week	Age started: _____	Age quit: _____
❑ Alcohol	_____ times per day / week	Age started: _____	Age quit: _____
❑ Coffee	_____ times per day / week	Age started: _____	Age quit: _____
❑ Marijuana	_____ times per day / week	Age started: _____	Age quit: _____
❑ Other: _____	times per day / week	Age started: _____	Age quit: _____

Do you exercise regularly? ❑ Yes ❑ No If yes, what kinds? _____

Are you pregnant? ❑ Yes ❑ No If no, when was last period? _____

Do you have or have you had any of the following conditions? Please check all that apply:

❑ Catch cold easily	❑ Dry skin/scalp/hair	❑ Vision problems	❑ Asthma/wheezing	❑ Frequent urination
❑ Night or day sweats	❑ Itching	❑ Facial pain	❑ Pneumonia	❑ Incontinence
❑ Fatigue/Low energy	❑ Eczema	❑ Nosebleeds	❑ High blood pressure	❑ Wake to urinate
❑ Difficulty fall asleep	❑ Acne	❑ TMJ	❑ Low blood pressure	❑ Urinary tract infection
❑ Wake easily at night	❑ Headaches	❑ Teeth/gum problems	❑ Heart palpitations	❑ Yeast infections
❑ Wake too early	❑ Dizziness/vertigo	❑ Breathing difficulty	❑ Cold hands or feet	❑ Kidney stones
❑ Nightmares	❑ Ringing in ears	❑ Phlegm production	❑ Fainting	❑ Painful menstruation
❑ Sleep Apnea	❑ Eye pain or itching	❑ Chronic cough	❑ Pain urinating	❑ Changes in sex drive

Are there any other conditions you would like to discuss not mentioned on this questionnaire? If so, please elaborate:

_____

Disclosure of Information

Please Read the Following Carefully

How to Prepare for Your First Visit: Plan on showing up a few minutes early to your appointment and please wear, or bring with you loose comfortable clothing so that I may access just above the knees if needed. Allow for time to find parking and try to have a light meal before your treatment if you are hungry.

Your Privacy: Your right to privacy in this medical practice is paramount and I will never disclose any of your personal information without your express consent, unless required to do so by law.

After Your Visit: Plan ahead to allow some time for rest. Keep rigorous exercise and alcohol use to a minimum during the few hours after your treatment.

Financial Policies

Cancellation Policy: If you need to reschedule or cancel your appointment, please give me at least 24 hours notice, otherwise I reserve the right to charge for missed appointments.

Payment Methods: Cash, check, and credit cards are all acceptable forms of payment. If you pay with a credit card, know that you may only receive an electronic receipt via email that you may print at a later time.

Returned Checks: If your check is returned by the bank, Carol L. Reed will notify and bill you for non-payment. You must pay in cash or credit card the original fees plus a $30 dishonored check fee.

I understand that I am responsible for the cost of all care provided to me.

Informed Consent to Treatment

By signing below, I (the Patient) do hereby voluntarily consent to be treated with the procedures mentioned below by Carol L. Reed, Licensed Acupuncturist. I understand that receiving regular primary care by a licensed physician is an important choice that is strongly recommended by Carol L. Reed.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin and moxibustion is performed by the application of heat to the skin at certain points on or near the surface of the body, in an attempt to treat bodily dysfunction or diseases, to modify pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising or redness, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. 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. Carol L. Reed has informed me that this clinic uses sterile disposable needles and maintains a clean and safe environment.

Cupping: I understand that the use of cupping commonly produces *temporary* bruising or redness that may last several days. I understand that I may refuse this therapy if it is recommended to me.

Chinese Herbs: I understand that herbal substances may be prescribed to me to treat bodily dysfunction or disease, to modify pain perception, and to normalize the body's physiological functions. 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 effect may result from taking these substances. These could include, but are not limited to: changes

in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and contact Carol L. Reed as soon as possible.*

Tui-Na Massage/Acupressure: I understand that I may also be offered tui-na massage/acupressure as part of my treatment to modify pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment at any time, if I choose to do so.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment and will notify Carol L. Reed if I have, or receive an electronic device implantation such as a pacemaker, while under her care.

I will notify Carol L. Reed, should I become pregnant, or if I am in the process of trying to get pregnant while under her care so she may avoid acupuncture points and herbal formulas that could induce miscarriage. Otherwise, Carol L. Reed has informed me that Chinese Medicine can be very beneficial in the pregnancy and birthing process.

I understand that when necessary, Carol L. Reed, will only share my health information according to the stipulations detailed in the "HIPAA Notice of Privacy Practices" document that has been provided to me, and of which I acknowledge receipt.

I hereby release Carol L. Reed from all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

I have carefully read, or had read to me, all of the above information and am fully aware of what I am signing. I have had the opportunity to ask for a more detailed explanation and don't expect Carol L. Reed to anticipate and explain all possible risks and complications of treatment. I fully understand that there is no implied or stated guarantee of success for the above mentioned treatments. I give my permission and consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: *X*_____ Date: _____

Printed Name: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

******If not signed by patient, please indicate relationship:*

___ Parent or guardian of minor patient

Personal representative of person with disabilities

X_____
Carol L. Reed, L.Ac., MSOM

HIPAA NOTICE OF PRIVACY PRACTICES

Your right to privacy in this medical practice is paramount and I will never disclose any of your personal information without your express consent, unless required to do so by law.

This notice describes my 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. Please read it carefully.

Carol L. Reed, L.Ac., MSOM will acquire private information about her patients. This is confidential and will not be discussed outside the office, except that Carol may discuss patients with other health care professionals in terms that do not allow identification of the individual.

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.

Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts, or contact by alternative means.

Additionally, we may be required to disclose your health information in the following circumstances: In the event of an emergency; if required by law; if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care; if ordered by the courts, government authorities, public health, law enforcement, coroners, or funeral directors; in the event of organ donations, research, military activity, or for national security.

Patients have the right to receive an accounting of any such disclosures made by my office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

If you would like copies of records, you must submit a written request for copies of medical records at least 5 business days in advance. The charge for copying records is 30 cents per page, with a $15.00 minimum charge.

Any complaints about these policies or requests for further information may be directed to Carol L. Reed at 208.351.0952.