ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

People & Pets Acupuncture provides each patient with a statement of **Privacy Policies.**

I, _____ have read, reviewed, understood, and agree to the statement of the Privacy Policies for healthcare services at People & Pets Acupuncture.

_____
Signature of Patient (or Legal Representative) Date

_____
Witnessed Date

Contact Information

We would like to keep in touch with you about our practices. Please complete the following information, which will allow us to contact you.

We may use various methods of contact, including phone, postal service, email or texting. If you prefer one method over another please let us know.

First Name:_____
LastName:_____

Date of Birth:_____

Address:_____

City:_____ **State**:_____
Zip:_____

Telephone-
Home:_____**Work**:_____**Cell**:_____

Email address:_____

How did you hear about us? (Please circle)

Friend/Family (name)_____ Yellow Pages Internet Website

Other_____

Signature:_____Date:_____

ACUPUNCTURE PATIENT MEDICAL FORM

Current overall health: (circle one) Excellent / Good / Fair / Poor / Explain:
_____

Chief complaint: (reason you are here) Use a separate sheet if need more explanation:
_____
_____
_____

Have you seen any other doctors for this condition? Yes_____ No_____

If so, who?_____

Type of treatment
received:_____

Results: _____ When did the condition begin?

_____

Has the condition occurred before? Yes_____ No_____

Check any of these conditions that either you or your relatives have had:

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Heart Problems	Hypothyroidism	Kidney/Urinary Problems	Mental/Emotional Concerns	Stomach/Intestinal Problems	Stroke	Mouth Problems	Skin Problems	Immune Disorders	Musculoskeletal Problems
You																
Father																
Mother																
Brother																
Sister																
Spouse																
Children																
Grand-parents													.			

Please check any other illnesses you have had:

☐ anemia	☐ hernia	☐ chicken pox	☐ venereal disease
☐ eye problems	☐ tuberculosis	☐ HIV	☐ emphysema
☐ gall/kidney stones	☐ bronchitis	☐ mumps	☐ pancreatitis
☐ thyroid disease	☐ hepatitis	☐ herpes/shingles	☐ mononucleosis
☐ hemorrhoids	☐ malaria	☐ rheumatic fever	☐ diverticulosis
☐ liver issues	☐ measles	☐ jaundice	☐ polio

Please check if you have any of these symptoms:

☐ abnormal weight gain	☐ fatigue	☐ overall sense of not feeling well
☐ abnormal weight loss	☐ fever/chills	

Please check any surgery you have had:

☐ appendectomy	☐ gall bladder	☐ back surgery
☐ tonsillectomy	☐ hernia	☐ ovariohysterectomy
☐ broken bones	☐ joint replacement	☐ heart surgery

Other:

Major accidents or falls:

Have you ever received:

☐ Chemotherapy	☐ Radiation therapy

Please list the 5 major health concerns you may have in order of importance:

_____

_____

_____

_____

_____

How do any of these concerns affect your daily functioning and your ability to live your life the way you want to on a daily basis:_____

_____

Using a scale of 1 – 10, how committed and willing are you to improving your state of health:

_____

Please list any medical tests you have had (i.e. Colonoscopy, Chest x-ray, ECG, Echocardiogram): _____

_____

Ever been hospitalized: □ Yes □ No Explain: _____

_____

Please list any vaccines you have had and when you had them: (i.e. to go overseas, small pox, tetanus, polio, typhoid, flu, pneumonia):_____

_____

Please list any allergies you may have: (i.e. foods, animals, drugs, herbs, supplements):

_____

Health of spouse: _____

Number of children, genders & ages: _____

_____

Childrens' health:_____

Household pets or other animals that you or your family is in close contact with:

_____

_____

Prescription drugs currently taking and for the past 3 months: _____

_____

Over the counter (OTC) medications, supplements or homeopathic medications currently taking and for the past 3 months: _____

_____

_____

_____

Have you ever taken: ☐ Birth control pills ☐ Thyroid pills ☐ Estrogen pills

☐ Progesterone ☐ Allergy shots ☐ Antibiotics ☐ Cortisone/prednisone ☐ Other hormones:_____

☐ Diet pills (prescription or OTC)

Other (please explain):_____

DIET & LIFESTYLE

Please check the following that apply to you and the frequency/amounts used:

☐ coffee (caffeinated/decaf) ☐ wine/beer/alcohol ☐ tea (herbal/caff) ☐ soft drinks

☐ chocolate ☐ artificial sweetener ☐ antacids ☐ laxatives ☐ ice cream

☐ candy ☐ cigarettes ☐ other tobacco products ☐ marijuana ☐ other recreational drugs

_____

_____

_____

What kind of exercise program do you do:_____

How often?_____

Other types of exercise/hobbies?_____

How many times do you eat out per week?_____

Junk food eaten per week and what types: _____

Healthiest foods per week that you eat: _____

From 1-10, what is your average stress level per week: _____

Do you travel outside the U.S. ☐ Yes ☐ No If so, how often and where: _____
_____

Please check any relevant symptoms:

Stomach:

- ☐ Excess burping/bloating after eating
- ☐ Diarrhea immediately following a meal
- ☐ Bad breath
- ☐ Sense of fullness during or after meals
- ☐ Undigested food found in stools
- ☐ Excess gas
- ☐ Frequent urination
- ☐ Difficulty digesting certain foods
- ☐ Feeling hunger directly after eating
- ☐ Heartburn when lying down or leaning forward
- ☐ Increase thirst/appetite
- ☐ Hard to lose weight
- ☐ Feeling of indigestion/burning immediately following a meal or 1 to 4 hours later or from certain foods(spicy, chocolate, citrus, peppers, alcohol or caffeine).

Gall Bladder:

- ☐ Itchy skin
- ☐ Gall bladder stones
- ☐ Gall bladder surgery
- ☐ Fatty foods cause diarrhea
- ☐ Changes in stool color

Colon:

- ☐ Feeling that bowels don't empty completely
- ☐ Abdominal pain relieved by passing gas/stool
- ☐ Alternating diarrhea/constipation
- ☐ More than 3 bowel movements/day
- ☐ Stools once every 3 days
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hard/dry/small stool
- ☐ Foul smelling gas
- ☐ Difficult passing stool

Hormonal:

- ☐ Hands/feet cold
- ☐ Feel cold all over
- ☐ Thin eye brows
- ☐ Night sweats
- ☐ Insomnia
- ☐ Trouble urinating
- ☐ Pain/burning legs
- ☐ Restless legs at night
- ☐ Seasonal depression
- ☐ Ever consider suicide
- ☐ Migraine headaches
- ☐ Hair thinning of head/face/legs or falling out
- ☐ Muzzy headed
- ☐ Nervousness/anxiety
- ☐ Decreased/Increased sex drive
- ☐ Menstrual irregularity: less/more bleeding
- ☐ Depression, not motivated
- ☐ Morning headaches that get better as the day progresses
- ☐ Heart palpitations

Blood Glucose Sensitivity:

- ☐ Need to eat frequently throughout the day
- ☐ Eating relieves tiredness
- ☐ Tired after eating certain foods
- ☐ Easily upset, nervous, anxious
- ☐ Irritable/shaky/sweaty/muzzy headed if meals are missed
- ☐ Waist equal or bigger than hip girth

Adrenal Fatigue:

- ☐ Tired in afternoon
- ☐ Likes salty foods
- ☐ Afternoon headaches
- ☐ Hard to fall asleep
- ☐ Hard to stay asleep at night
- ☐ Headaches when stressed
- ☐ Feel stressed a lot
- ☐ Wake up not feeling rested
- ☐ Gain weight when stressed
- ☐ Excess sweating even with little or no exertion

Head:

☐ Jaw/TMJ problems	☐ Tinnitus(ringing in ears)	
☐ Head injury	☐ Impaired hearing	☐ Frontal/Vertex/Whole head
☐ Sinus problems	☐ Glaucoma	headaches
☐ Earaches	☐ Cataracts	☐ Dizziness

Skin:

☐ Rashes	☐ Eczema	☐ Itching
☐ Psoriasis	☐ Hives	
☐ Oily/Damp	☐ Dry	

Respiratory:

☐ Cough	☐ Pneumonia
☐ Pain on breathing	☐ Shortness of breath
☐ Bronchitis	☐ Spitting/coughing up blood
	If phlegm, describe color:

Cardiovascular:

☐ Heart attack	☐ Blood clot (DVT)	☐ High blood pressure
☐ Angina	☐ Chest pain	☐ Low blood pressure
☐ Angioplasty	☐ Bypass surgery	☐ Irregular heartbeat

Immune:

☐ Frequent colds	☐ Chronically swollen glands
☐ Chronic infections	☐ Allergies/hay fever
☐ Fibromyalgia	☐ Autoimmune disease
☐ Multiple Sclerosis	☐ Chronic fatigue disease
☐ Lupus	☐ Lou Gehrig's (ALS)

Hormonal:

- ☐ Hands/feet cold
- ☐ Feel cold all over
- ☐ Thin eye brows
- ☐ Night sweats
- ☐ Insomnia
- ☐ Trouble urinating
- ☐ Pain/burning legs
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- ☐ Muzzy headed
- ☐ Nervousness/anxiety
- ☐ Decreased/Increased sex drive
- ☐ Menstrual irregularity: less/more bleeding
- ☐ Depression, not motivated
- ☐ Morning headaches that get better as the day progresses
- ☐ Heart palpitations

Men:

- ☐ Decreased libido
- ☐ Muscle soreness
- ☐ Premature ejaculation
- ☐ Testicular pain
- ☐ Hernia
- ☐ Weight gain
- ☐ More emotional
- ☐ Decrease in morning erections/ED
- ☐ Inability to concentrate
- ☐ Decrease in physical strength & stamina
- ☐ Fat deposition around chest and hips
- ☐ Benign hyperplastic prostate (BHP)
- ☐ Urinary/fecal incontinence
- ☐ Perspire more easily

Other: _____

Women:

- ☐ Extended periods
- ☐ Shortened periods
- ☐ Abnormal PAP test
- ☐ Scant blood flow
- ☐ Heavy blood flow
- ☐ Irregular periods
- ☐ Hair thinning/loss
- ☐ Nipple discharge
- ☐ Clots during periods
- ☐ Bleeding between cycles
- ☐ Pain/cramping during periods
- ☐ Breast pain/swelling during periods
- ☐ Lower abdominal pain during periods
- ☐ Fibrocystic breasts/uterus
- ☐ Urinary/fecal incontinence
- ☐ Peri-menopausal symptoms
- ☐ Facial acne during periods
- ☐ Self breast exam regularly
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Abortion
- ☐ PMS

Are your periods of regular duration of around 28 days?

pregnancies− # miscarriage− # live births−

Other:_____

Menopause:

- ☐ Night sweats
- ☐ Acne
- ☐ Depression
- ☐ Low libido
- ☐ Moodiness
- ☐ Tender breasts
- ☐ Painful intercourse
- ☐ Muzzy headedness
- ☐ Facial hair growth
- ☐ Hot flashes with exertion
- ☐ Spontaneous sweating during day not associated with exertion
- ☐ Vaginal pain, dryness/itching

Uterine bleeding post-menopause:

- ☐ Scanty
- ☐ Heavy

Frequency of post-menopausal bleeding:

Other: _____

Musculoskeletal:

□ Neck/shoulder pain □ Upper/Lower back pain □ Joint pain □ Muscle soreness

□ Reduced range of motion: Where? _____

□ Fractures: _____ When? _____

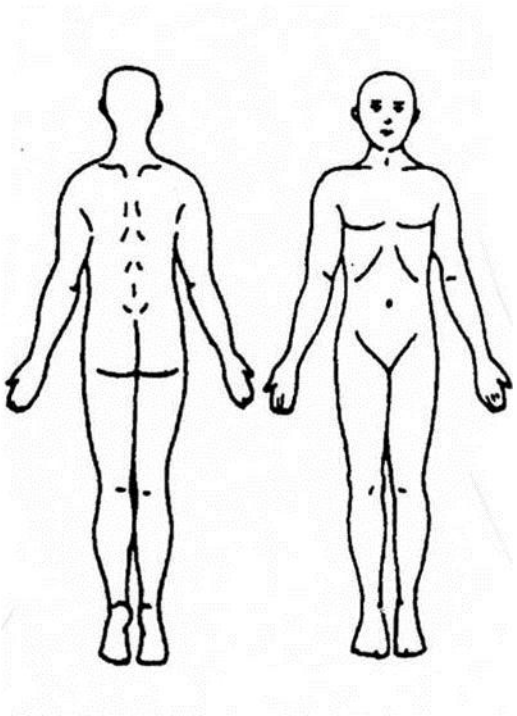
□ Joint replacement surgery: Which joint?_____

When?

_____

Other:_____

Please mark any areas of discomfort with an 'X' :



Is the pain dull, achy, sharp or burning? _____

_____

NOTICE OF PRIVACY POLICIES (HIPPA)
(INFORMATION FOR YOUR FILES)

People & Pets Acupuncture is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

-Information we receive from you.
-Information we receive from other healthcare providers.
-Information we receive from third party payers.

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship with you we will likely use and disclose protected health information (PHI) about you for treatment, payment, and healthcare operations. PHI is information about you that may identify you and relates to your past, present, and future physical or mental health condition, and is related to health care services.

You may specifically authorize us to use your protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose for your protected health information.

Marketing
People & Pets Acupuncture will not use your health information for marketing communications without your written authorization. We may at times send newsletters, appointment reminders or other information and communications to you via phone call, postal service, email, or text messages.

Disclosure
People & Pets Acupuncture may use or disclose your Protected Health Information when required by law.

Patient Rights

-Upon authorization from you in writing, you have the right to access, review, or receive copies of your healthcare records. (Copying may incur a reasonable fee).

-Upon written request, you have the right to receive a list of items this office has disclosed about your health care information.

-You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

-You have the right to request that we amend your Protected Health Information: the request must be made in writing.

-You have a right to receive all notices in writing.

If you have questions, complaints, or want more information, please contact the office or contact: **Dr. Andrea L. Fochios. Telephone: 828-254-2773**

To send a written complaint to the U.S. Department of Health and Human Services:
DHHS (Office of Civil Rights)
200 Independence Avenue, SW Room 509 F HHH Building
Washington,DC 20201

PATIENT CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I understand that as part of my healthcare, People and Pets Acupuncture maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I, _____ give consent to this office to use and disclose my Individual Health Information of Protected Health Information for the following purposes:

-As a basis for planning my care and treatment.
-As a means of communication among the many healthcare professionals who contribute to my care.
-As a source of information for applying my diagnosis and surgical information to my bill.
-As a means by which a third party payer can verify that services billed were actually provided.
-As a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

-To object to the use of my health information for directory purposes.
-To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations-and that the organization is not required to agree to the restrictions requested.
-To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____

Witness Date

People & Pets Acupuncture

Patient Contact Information (please print legibly & complete in full)

Today's Date_____

Patient's First Name_____Last_____Middle_____

Address_____City_____

State_____ Zip Code_____

Patient's Driver's License No_____SS#_____

Gender (M/F)_____ Date of Birth_____Age_____

Home Phone_____Cell_____Work_____

Email_____

Spouse's/Partner's Name_____Phone_____

Patient's Occupation_____

Employer's Name_____

Employer's Address_____

Employer's Phone_____

Primary Care Physician_____

Primary Care Physician's Address_____

Primary Care Physician's Phone_____

Emergency Contact_____Phone_____

Relationship_____

Signature of Patient (or Guardian if patient is a minor)_____

Date_____

PEOPLE & PETS ACUPUNCTURE
CONSENT TO TREATMENT FORM

By signing this consent form, I do hereby voluntarily give permission to be treated with acupuncture and/or substances from the Oriental or Western Materia Medica by a licensed acupuncturist at People & Pets Acupuncture. I understand that acupuncturists practicing in the State of North Carolina are NOT primary care providers and that regular primary care by a licensed physician or equivalent health care provider is an important choice that is strongly recommended by this facility's practitioners.

Scope of Practice in North Carolina includes but is not limited to: Using Oriental Medical theory to assess, diagnose from an Oriental or Chinese Medical perspective and develop a treatment plan in an attempt to improve overall body function and/or relieve pain.

Treatment techniques may include: Acupuncture uses very thin, sterilized needles inserted into specific points through the skin; stimulation of those needles possibly by electric stimulation (e-stim) when appropriate, application of heat in the form of moxibustion or heat lamps, cupping, dermal friction (Tui Na massage), acupressure, herbal therapies, essential oils, flower essences or homeopathics, dietary counseling based on traditional Chinese medical principles, breathing techniques or exercises (such as Qi Gong) according to Chinese Medical principles. Therapy Laser or 'cold laser' may be utilized as well.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of sterile needles through the skin or by application of heat to the skin (or both needles & moxa) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent 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: minor pain, soreness, transient bruising in the treatment area, infection, needle 'sickness' (dizziness, nausea, fainting), broken needles, sensations of heat, cold, tingling, numbness, skin irritation or slight bleeding at the needle site, generalized fatigue that may last 24 to 48 hours or pneumothorax. Direct moxibustion may include a risk of burning or scarring. I do understand that I may refuse this form of therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or disease patterns, to modify or prevent 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 effects may result from taking them. These could include but are not limited to: changes in bowel movements, abdominal pain or discomfort, and possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems that I associate with these substances, I should stop taking them and contact this office and/or the practitioner as soon as possible.*

Acupressure/Tui Na Massage: I understand that I may also be given acupressure or tui na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that certain adverse side effects may result from this treatment. These could include bruising, sore muscles or aches, and possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture (e-stim): 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: electric shock, pain or discomfort, and possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. *Please let the clinician know if you have any pacemakers or metal in your body*.

Western Biomedical Diagnoses: I understand that it is not within the scope of practice for acupuncturists to offer Western medical (biomedical) diagnoses and that it is my responsibility to seek such medical work-ups, diagnoses and possible treatments from an M.D., or equivalent if I have not already done so.

I have have not (*please circle one*) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the acupuncturist of this diagnosis.

I do do not (*please circle one and any that apply*) have a pacemaker, metal in my body, a bleeding disorder, neuropathy (decreased and/or no sensation) or malignant tumors.

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time. ***If I become pregnant, I will notify the acupuncturist immediately.***

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record and request a copy by paying a prescribed fee.

I understand that the practitioner will answer any questions that I have to the best of his/her ability. I understand that results are not guaranteed. I do not expect the clinician to anticipate and explain every possible risk and its complications. With this knowledge, I voluntarily consent to Chinese Medical diagnostic and therapeutic procedures as mentioned above.

I understand that charges for treatment and/or prescribed and dispensed substances are to be paid for at the time of the visit. This office receives payment with cash, check or credit card: (Visa or Mastercard). If payment at that time is not possible, arrangements must be made prior to the scheduled appointment.

I have carefully read (or have had read to me) the above consent for Chinese Medical Treatment and my questions have been answered regarding its content. **By signing below, I agree to receive the above named procedures when appropriate and any other Chinese Medical techniques. I intend this consent form to cover the entire course of treatment for my present condition as well as any future condition for which I seek treatment by the practitioners in this office.**

Signature:_____ **Date:** _____

Printed Name: _____ **Email:** _____

Address: _____

City: _____ **State:**_____ **Zip Code:**_____

Home Phone: _____**Work Phone:**_____ **Cell Phone:**_____

Witnessed:_____ **Date:**_____