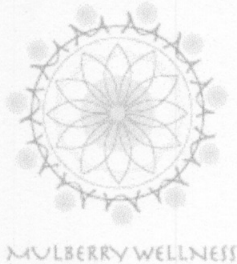


This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name____ Age________ Date ____________

Home Address____

City____________________________________ State____________________ Zip___________

Home Phone________________________ Mobile Phone______________________ Email_______________________

Birthdate___________________ If under 18, person responsible for your account_______________________________

Emergency Contact: Name____ Contact Phone:___________________

Whom should we thank for referring you to our office? ____

Have you had acupuncture therapy before? □ Yes □ No

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

Please indicate the use and frequency of the following:

Coffee _____________________ Soda pop _________________________ Water ______________________________

Alcohol________________________ Recreational drugs _______________________ Tobacco_____________________

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason

Health History

What are the health problems for which you are seeking treatment? ______________________

____

____

How long have you had this condition? ______________________

What other forms of treatment have you sought? ______________________

____

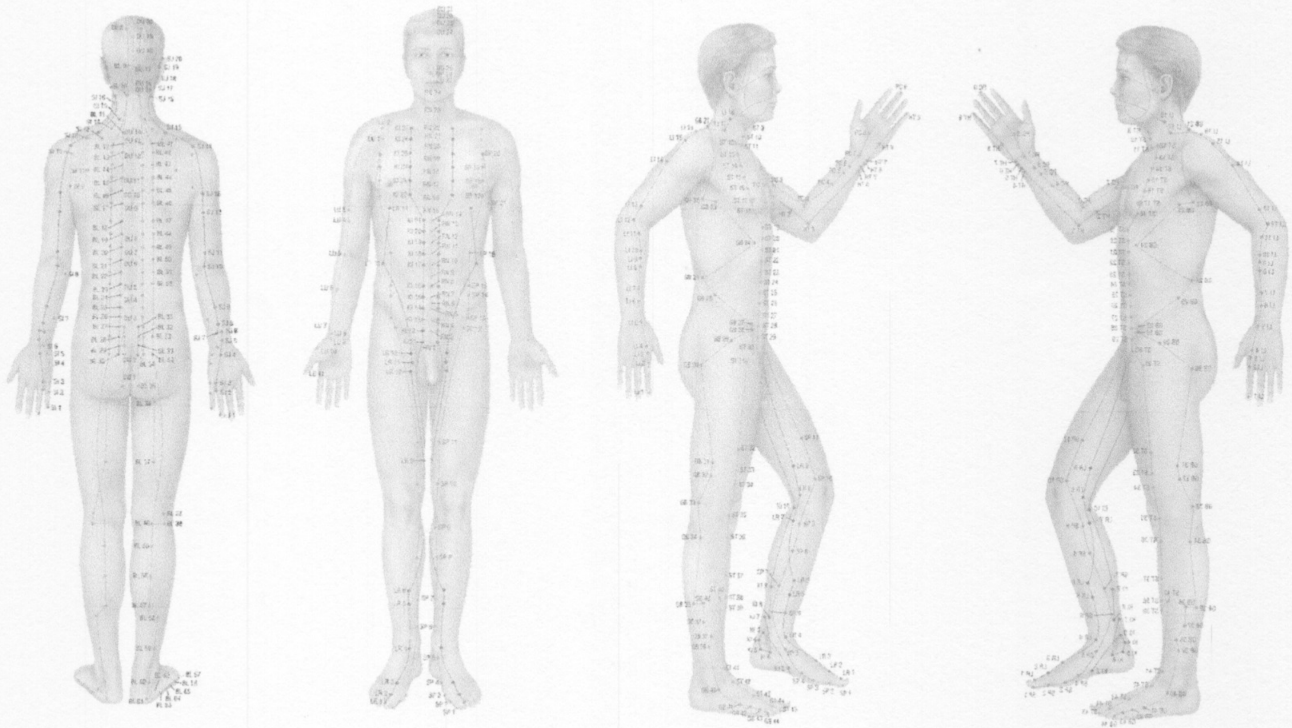
What helps your condition? ______________________

What aggravates your condition? ______________________

Please list any surgeries or major health incidents (accidents, etc.) in your life: ______________________

____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

What would you like to achieve with acupuncture treatment? ______________________

Symptom Survey

Please "check" the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
__ excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__ jaundice
__ digestive problems, indigestion	__ cold hands and feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__ light-colored stool
__ heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__ soft or brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work, relationships, etc.	__ poor memory	__ constipation	__ urinary problems	__ difficulty in making decisions
__ lack of appetite	__ sadness	__ blood in stool	__easily bruised	
		__ hemorrhoids	__ dental problems	__ high cholesterol
		__ recent use of antibiotics		__ bitter taste

__ fatigue __edema __asthma __allergies __dizziness __ get sick easily __headaches

__ I usually feel warm __ I usually feel chilled

♀For Women

Age of first period ______________ Date of last period _______________ Number of children (live births) ________________

Number of days between periods (your cycle) _______________________Number of days of flow_________________________

Color of flow:	Amount of flow:	# of pads you use per day:	Pain and cramping:
□ pale/light red	□ spotting	1st day ___	□ No
□ red	□ light	2ND day ___	□ Yes
□ bright red	□ even throughout	3RD day ___	□ before flow □ mild
□ dark red	□ heavy	4th day ___	□ during flow □ moderate
□ dark red/brown □ clots		+days ___	□ after flow □ severe

Other symptoms related to menses: □ Discharge □ PMS □ Headache □ Nausea

□ Constipation □ Diarrhea □ Swollen Breasts □ Mood Swings □ Increased Appetite

□ Decreased Appetite □ Insomnia

Have you ever been diagnosed with: □ fibroids □ fibrocystic breasts □ endometriosis □ ovarian cysts □ PID

□ polycystic ovary syndrome □ STD _________________________

Please indicate if the following pertain to you:

Kidney Yin

- ☐ Do you have lower back weakness, soreness or pain?
- ☐ Do you have ringing in your ears?
- ☐ Is your hair prematurely gray?
- ☐ Do you have dark circles under your eyes?
- ☐ Do you have night sweats?
- ☐ Are you prone to hot flashes?
- ☐ Would you describe yourself as "afraid" frequently?
- ☐ Do you have dizziness?
- ☐ Do you have knee problems?

Kidney Yang

- ☐ Is your back sore or weak?
- ☐ Are your feet cold, especially at night?
- ☐ Are you typically colder than those around you?
- ☐ Is your libido low?
- ☐ Are you often fearful?
- ☐ Do you wake up at night or early in the morning because you have to urinate?
- ☐ Do you urinate frequently, and is the urine diluted and/or profuse?
- ☐ Do you have early morning loose, urgent stools?

Spleen

- ☐ Are you often fatigued?
- ☐ Do you have poor appetite?
- ☐ Is your energy low after a meal?
- ☐ Do you feel bloated after eating?
- ☐ Do you crave sweets?
- ☐ Do you have loose stools, abdominal pain, or digestive problems?
- ☐ Are your hands and feet cold?
- ☐ Are you prone to feeling sluggish?
- ☐ Are you prone to heaviness or grogginess in the head?

- ☐ Do you have varicose veins?
- ☐ Are you prone to worry?
- ☐ Have you been diagnosed with low blood pressure?
- ☐ Do you sweat a lot without exerting yourself?
- ☐ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- ☐ Are you often sick, or do you have allergies?
- ☐ Have you ever been diagnosed with hypothyroid or anemia?
- ☐ Do you have hemorrhoids or polyps?

Blood

- ☐ Do you have dry, flaky skin?
- ☐ Are you prone to getting chapped lips?
- ☐ Are your fingernails or toenails brittle?
- ☐ Are you losing hair on your head?
- ☐ Is your hair brittle or dry?
- ☐ Do you have diminished nighttime vision?
- ☐ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

Blood stasis

- ☐ Do you experience periodic numbness of your hands and feet, especially at night?
- ☐ Do you have varicose or spider veins?
- ☐ Do you have red cherry spots (hemangiomas) on your skin?
- ☐ Do you have chronic hemorrhoids?
- ☐ Do you have dark spots in your eyes?
- ☐ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

Liver Stagnation

- ☐ Are you prone to emotional depression?
- ☐ Are you prone to anger and/or rage?
- ☐ Are your pupils usually dilated and large?
- ☐ Do you have difficulty falling asleep at night?
- ☐ Do you experience heartburn or wake up with a bitter taste in your mouth

Heart-

- ☐ Do you wake up early in the morning and have trouble getting back to sleep?
- ☐ Do you have heart palpitations, especially when anxious?
- ☐ Do you have nightmares?
- ☐ Do you seem low in spirit or lacking vitality?
- ☐ Are you prone to agitation or extreme restlessness?
- ☐ Do you fidget?
- ☐ Do you sweat excessively, especially on your chest?

Excess Heat

- ☐ Are your mouth and throat usually dry?
- ☐ Are you often thirsty for cold drinks?
- ☐ Do you often feel warmer than those around you?
- ☐ Do you wake up sweating or have hot flashes?

Dampness

- ☐ Do you feel tired and sluggish after a meal?
- ☐ Do you have cystic or pustular acne?
- ☐ Do you have urgent, bright, or foul-smelling stools?
- ☐ Are you prone to yeast infections?
- ☐ Are you overweight?
- ☐ Do you have a wet, slimy tongue?
- ☐ Does your body feel like a barometer? Can you sense when it will rain?

Fertility Information

# of IVF procedures______________________________ # of IUI procedures____

Has a physician diagnosed a difficulty with fertility due to: ☐ Female Factor ☐ Male Factor ☐ Unexplained

☐ Other ____

Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.
I understand that methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine , and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace-maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature:____ Date:________

Print Name:____

HIPAA Notice
Privacy Disclosure and Policies

As a patient with Mulberry Wellness, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes the 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.

Safeguards in place 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 files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing.
In administering your health care, we may gather and maintain information that may include these examples of non-public personal information
· From your medical history, treatment notes, all 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)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Angela Rosen, L.Ac. maintain my records confidentially in accordance with the law. I agree to inform Angela Rosen, L.Ac. if I need any special arrangements pertaining to this issue.

Print name: ____

Signature: ____ Date: ________________

FINANCIAL POLICIES

Mulberry Wellness requests payment for your treatment at the time of service. Cash, check or major credit card are all acceptable forms of payment. Angela Rosen, LAc works with an insurance biller and will submit claims for patients who have provided their insurance information. If your visit will not be covered by an insurance plan, or if you fail to provide proof of insurance, payment in full is expected at each visit. We will verify your insurance coverage as a courtesy, but knowing your insurance benefits is your responsibility, so please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. In the event we bill your insurance carrier and the claim is returned to us because the deductible has not been satisfied, we will bill you for those services. Please understand that it could take several months between the time of service and the issuing of our billing statement once we receive notification from your insurance carrier regarding your deductible balance.

Supplements, herbal medicine and some lab tests are not covered by your insurance plan. Payment for these items is due at time of service.

Insurance Claim Submission. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Payment for Out of Network Services. Some insurance companies may send payment for acupuncture services that are performed by an out of network practitioner directly to you, the patient. These checks are the payments for your acupuncture services that are owed to our office. They are to be signed over to Angela Rosen, LAc within 30 days of receipt. If you would prefer to have your credit card on file charged for the amount paid directly to you, please let us know.

Returned Checks. If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Recovery of funds is automated through our bank's FARS /ECR service, which collects promised monies on our behalf.

Nonpayment. If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment.

Missed Appointments. If you miss your appointment or cancel with less than 24 hours notice, you will be charged $85 for the appointment after the second occurrence.

I have read and understand the policies and agree to abide by the guidelines.

Print name: ____

Signature: ____ Date: ________________

Thank you for understanding our policies. Please let us know if you have any questions.