Patient Medical History

EKB Acupuncture
Elisha Koota Bushell, AP
10189 W. Sample Rd.,
Coral Springs, FL 33065
954-464-8757

Name (last, first) _____ Date_____

Address_____

City / State / Zip _____

Home phone _____ **Work Phone** _____

Cell Phone _____ **Email** _____

Occupation _____**Birth Date** _____

Emergency contact _____
(Name & phone)

Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed
Children ____

Have you ever had acupuncture? _____ If yes, when? _____

For what condition? _____

Are you currently under the care of a physician? If so, who, and for what condition(s)?_____
_____

Main reason(s) for seeking acupuncture_____
How long have you experienced symptoms? _____

Your condition is improved by
_____
_____
_____

Your condition is aggravated by
_____
_____
_____

List all current medications, prescribed or over the counter
_____
_____
_____
_____

List all current vitamins, herbs and other supplements
_____

_____
_____

Significant illnesses (please check all that apply)
Cancer___ Diabetes___ Hepatitis___ Heart Disease___ Stroke___ Seizures___ HIV / AIDS___
Pneumonia___ Tuberculosis___ Multiple sclerosis___ Thyroid___ Asthma___ Stomach Ulcers___
Obesity___ Depression___ Shingles___ Chronic Fatigue___ Rheumatic Fever___ High Blood Pressure ___
STD's___ Other _____

Please list any surgeries you've had including dates

_____
_____
_____
_____

Please list any Allergies

_____
_____

Please list any major emotional or physical traumas you've experienced

_____
_____
_____

Lifestyle (please check all that apply, and note frequency of use)
___ Tobacco
___ Alcohol
___ Recreational drugs
___ Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency:

_____
_____

Dietary preferences
Vegetarian___ Raw foods diet___ Low fat diet___ High protein/low carb___ Dairy /milk /cheese___ Eggs___ Chicken___
Fish / seafood___ Red meat___ Artificial sweeteners___ Fast food/ burgers/fries___ Spicy / hot___
Sweet___Sour___Salty ___ Cold drinks___ Hot drinks___ Ice chewing ___ Extreme thirst ___
Thirst with no desire to drink___

General symptoms
Fatigue___ Sweat without exertion___ Night sweats___ Fever / chills___ Dizziness / vertigo___ Bleed / bruise easily___
Low immunity___ Other ___

Digestion
Extreme appetite___ No appetite___ Cravings___ Dieting___ Tired after eating___ Bloating___ Gas___
Acid regurgitation___ Heartburn/Ulcers___ GERD___ Nausea___ Vomiting___ Bulimia___ Anorexia___ Irritability or low energy between meals___ Other _____How many meals per day? _____ How many snacks per day?_____

Intestinal
Diarrhea___ Constipation___ Hemorrhoids___ Anal itching / burning___ Laxative use___ Bloody stool___ Mucous in stool___ Anal fissures___ Rectal prolapse__ Intestinal pain/cramping ___ Incomplete evacuation___ IBS___ Colitis___
Crohn's Disease___ Gout___ Celiac Disease___ Gallstones___ Other_____

Sleep
Falls asleep easily___ Lie in bed with eyes open___ Wake as specific times___ Wake repeatedly___ Wake frequently to urinate___ Vivid or Lucid Dreams___ Wake up not feeling rested___ Nightmares or Frightening dreams___
Need drugs or supplements to fall asleep___

Head, Eyes, Ears, Nose and Throat
Dry eyes___ Spots / flowery vision___ Blurred vision___ Poor vision___
Eye strain___ Night blindness___ Cataracts___ Macular degeneration___ Bleeding gums___ TMJ___ Sores on tongue or mouth___ Dry mouth___ Excess saliva___ Sinus problems___ Post-nasal drip___ Sore throat___ Headaches___
Swollen glands___ Difficulty swallowing___ Earaches___ Tinnitus / ringing___ Deafness___ Nosebleed___
Other_____

Cardiovascular / respiratory
Heart palpitations___ Chest pain___ Difficulty breathing___ High cholesterolVaricose veins___ Blood clots___ Swollen ankles___ Heart valve abnormality_____ Shortness of breath___ Cold hands / feet___
Dry cough___ Wheezing___ Chest tightness___ Difficult inhalation___ Difficult exhalation___ Productive cough(color of phlegm?)___Other _____

Skin / hair
Dry skin___ Rashes / hives___ Eczema___ Psoriasis___ Pimples / acne___ Fungal infections___ Brittle nails___ Ridged nails___ Hair loss___ Dandruff___ Other _____

Musculoskeletal
Spinal pain___ Joint pain___ Tendonitis___ Swelling___ Arthritis___
Limited range of motion___ Disc degeneration___ Osteoporosis___ Numbness___ Carpal tunnel___
Other _____

Neuropsychological
Anxiety___ Irritability___ Insomnia___ Depression___ Easily stressed___ Poor memory___ Seasonal mood disorder___
Tics___ Tremors___ Death of someone close___ Job stress___ Recent divorce___
Currently in therapy___Financial setback___ Other _____

Emotional stress scale
1 2 3 4 5 6 7 8 9 10
no stress___ moderate___ extremely stressed___
Rate your stress level regarding
Work _____Health _____Love _____Money _____Family _____The future _____

Genito-urinary
Frequent urination___ Loss of urine when laughing or sneezing___ Incomplete urination / retention___ Dribbling___
Burning urination___Blood in urine___ Wake frequently to urinate___ Kidney stones___Bedwetting___
Bladder Prolapse___ Decreased libido / sexual desire___ Other _____

Men only
Enlarged prostate___ Prostate cancer___ Testicular cancer___ Testicular pain or swelling___ Erectile dysfunction___
Impotency___ STD's_____

Women only
Age menses began _____ Age menses ended (if applicable)_____
Date of last ob/gyn exam _____
Hysterectomy? ___ partial ___ full

Hormone replacement therapy___ Live births___ Miscarriage___ Abortions___ Infertility___ Birth control pills___ Breast cancer___ Ovarian cysts___ Fibroids___ Endometriosis___ Candida / yeast___ Vaginal discharge___ Vaginal odor___
Vaginal sores___ Herpes___ Human Papilloma Virus positive__Uterine prolapse___ STD history (chlamydia, PID, etc)___ Fibrocystic breast___

Period lasts _____ days Usual number of days in cycle _____
Headaches ___ before menstrual cycle ___ during cycle ___ after cycle___ Pain at ovulation___ Cramps / low back pain___ Acne associated with period___ Constipation associated with period___ Diarrhea associated with period___
Depression or irritability with period___ Bleeding outside of normal menstrual cycle___ No period / skipped cycles___
Irregular cycle___

Menstrual flow
Clotting___ Brownish___ Watery, thin and bright red___ Normal red___ Flooding and trickling___ Stop and start flow___

Patient Consent Form

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Acupuncture is NOT a substitute for conventional medical diagnosis and treatment.

Techniques commonly employed in the application of acupuncture:
Acupuncture needling – treatment will consist of the insertion of sterile disposable needles at specific sites on the body. Stimulation of said needles may be by manipulation, electrical stimulation or the application of warming substances (Moxa) on the needle itself.
Auxiliary / Associated therapies – massage, gua sha, cupping, assisted stretching, topical application of liniments

There is no guarantee that acupuncture will help any condition. Certain medications and social habits may decrease the beneficial effects of acupuncture. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, psycho pharmaceuticals and illegal drugs.

You need to be aware that:
Drowsiness may occur after treatment in a small number of patients, and if affected, you are advised not to drive.
Minor bleeding or bruising may occur in about 3% of treatments.
Fainting can occur in certain patients, particularly at the first treatment.
Pain during treatment occurs in about 1% of treatments.
Existing symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign.

I, (print name) _____, certify that I have read and understood the statements above. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep them updated on any changes.

Patient Signature: _____ Date: _____

Print Child's Name: _____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Acupuncture Injection Therapy Consent Form

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The benefits of acupuncture injection therapy have been explained to me. I understand that the products to be injected are safe and effective treatment for my condition.

I understand that the following side effects or local reactions may occur: local inflammation or swelling, bruising, bleeding under the skin at the injection site (hematoma), possible fainting or lightheadedness, possible localized pain/discomfort, allergic reaction, skin rash, redness, heat sensation and heaviness at the injection site, possible exacerbation of symptoms.

I stipulate that I am not currently taking anti-coagulant (blood thinning) therapy and that I voluntarily consent to acupuncture injection therapy as explained to me by my practitioner.

_____ _____

Print Name Date

_____

Signature

_____

Witness

HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

'This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) and for other purposed 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.

i. Uses and Disclosure of Protected Health Information

Users and Disclosure 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 that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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 a third part. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you_ For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: WE may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, qualify assessment business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

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You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights that respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

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 purpose of treatment, payment or healthcare 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.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an **alternative location. You have the right to obtain a paper copy of his notice from us,** upon request, even if you have agreed to accept this notice alternatively Le. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to have receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any charges. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. We will **not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14,** 2003.

Print Name:_____ _____

Signature_____Date_____