nourishing energy

ACUPUNCTURE

Thank you for taking the time to complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date ___ / ___ / ____ Name _____ Date of Birth _____ / _____ / _____ Age _____

Address_____ City_____ State_____ Zip_____

Phone _____ Email _____

Phone Numbers of Emergency Contact and relationship_____Occupation _____

How did you hear about us? Web: _____ Friend: _____Class Pass:_____Other: _____

Chief Health Concern: _____

_____

What is your goal for us?_____

Health Concern #2: _____

_____

What is your goal for us? _____ _____

Other Concerns: 3) _____ 4) _____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____

Have you had acupuncture before? _____

If yes, where/who _____

Any concerns or fears about the needles? _____

If yes, what? _____

What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.

_____

_____

_____

_____

ALLERGIES Medications, Seasonal, Environmental, Food.

_____

_____

_____

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, and nose sprays. NOTE: If need more space, use page 4.

| Prescription Name | Purpose | Dose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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SYMPTOMS: Please mark anything that is applicable to you. Check if it is a current problem or mark with a P for past.

LIVER/GALBADDER
_____Irritability / Anger
_____Depression / Stress
_____Headaches / Migraines
_____Visual Problems
_____Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness Blurred Vision
_____Feeling of Lump in Throat
_____Clenching of Teeth at Night
_____Muscle Cramping / Twitching
_____Tension
_____Joints/Neck/Shoulder Pain/Tight
_____Poor Circulation
_____Soft / Brittle Nails
_____Emotional Eater

KIDNEY/URINARY BLADDER
_____Urinary Problems
_____Bladder Infection
_____Lack of Bladder Control
_____Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____Feel Cold Easily
_____Low Sex Drive
_____Excess Sexual Desire
_____Poor Memory
_____Loss of Hair
_____Hearing Problems
_____Cavities
_____Craving / Avoiding Salty Foods
_____ Fear
_____Hot Flush
_____Night Sweating

HEART/SMALL INTESTINE
_____ Heart Palpitations
_____Chest Pain Insomnia
_____Sleep Problems
_____Easily Startled
_____Restlessness/Agitation
_____Vivid Dreams
_____Lack of Joy in Life

LUNG/LARGE INTESTINE
_____Dry Cough
_____Cough with Sputum
_____Nasal Discharge
_____Post-Nasal Drip
_____Sinus Infection
_____Congestion
_____Itchy, Red or Painful Throat
_____Dry Mouth /Throat / Nose
_____Skin Rashes
_____Hives
_____Snoring
_____Grief / Sadness
_____Shortness of Breath
_____Allergies
_____Asthma
_____Low Resistance to Colds or Flu _____Sneezing
_____Mild Fever Comes & Goes

SPLEEN/STOMACH
_____Heaviness Anywhere in Body
_____Fatigue
_____Worse After Eating
_____Hard to Get Up in the Morning
_____Edema (Swelling) Muscles
_____Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____Decreased / Increased Appetite
_____Crave Sweets
_____Hypoglycemia
_____Difficulty Digesting Oily Foods
_____Nausea / Vomiting
_____Gas / Belching
_____Insulin Sensitivity
_____Hemorrhoids
_____Constipation
_____Diarrhea
_____Abdominal Pain
_____Indigestion / Heartburn
_____Over-Thinking
_____Tendency to Gain Weight
_____Brain Foggy

OTHER:_____
_____
_____
_____

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ACUPUNCTURE

Please indicate those that are current health problems for yourself with a "C" under the appropriate person's column. "P" should be used to indicate a past problem. Leave blank those that do not apply.

| PERSONAL MEDICAL HISTORY | FAMILY MEDICAL HISTORY |
|---|---|
| AIDS /HIV _____ | AIDS /HIV _____ |
| Alcohol _____ | Alcohol _____ |
| Anxiety _____ | Anxiety _____ |
| Arthritis _____ | Arthritis _____ |
| Asthma / Hay Fever / Allergy _____ | Asthma / Hay Fever / Allergy _____ |
| Back Trouble_____ | Back Trouble_____ |
| Bursitis _____ | Bursitis _____ |
| Cancer_____ | Cancer_____ |
| Constipation_____ | Constipation_____ |
| Depression _____ | Depression _____ |
| Diabetes _____ | Diabetes _____ |
| Digestive Trouble_____ | Digestive Trouble_____ |
| Headaches _____ | Headaches _____ |
| Heart Trouble _____ | Heart Trouble _____ |
| Hepatitis _____ | Hepatitis _____ |
| High Blood Pressure _____ | High Blood Pressure _____ |
| Immune Disorder_____ | Immune Disorder_____ |
| Insomnia _____ | Insomnia _____ |
| Kidney Trouble _____ | Kidney Trouble _____ |
| Liver Trouble _____ | Liver Trouble _____ |
| Migraine _____ | Migraine _____ |
| Neck Pain _____ | Thyroid Disorder _____ |
| Thyroid Disorder _____ | Tobacco _____ |
| Tobacco _____ | Weight Problem _____ |
| Weight Problem _____ | Other Emotional Problems:_____ |
| Other Emotional Problems:_____ | Other:_____ |
| Other:_____ | |

MUSCULOSKELETAL

Do you have any pain anywhere? _____

☐ Muscle Cramps – Where?

☐ Joint Swelling – Where?

☐ Muscle Pain / Rheumatism – Where?

☐ Arthritis – Where?

☐ Tendonitis – Where?

☐ Bursitis – Where?

Describe Pain

☐ Sharp ☐ Fixed ☐ Sharp ☐ Fixed ☐ Sharp ☐ Fixed ☐ Burning ☐ Aching

☐ Other:_____

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Women Only
Hysterectomy – Ovaries Removed? _____Yes _____No
Could You be Pregnant Now? _____Yes _____No
Number Of: ___ Pregnancies ___ Births___Abortions___Miscarriages
Post-menopausal Bleeding? _____Yes _____No
When did your last period start? _____
Number of days for monthly cycle? _____
Number of days bleeding lasts? _____
Describe Menstrual Flow: ☐ Heavy ☐ Moderate ☐ Light ☐ None
Color of Menstrual Flow: ☐Dark ☐Bright red ☐Dark red
Birth control: ☐None ☐IUD ☐Birth control pills ☐Spermicide ☐Barriers
Do You Suffer From:
☐ Cramping (Mark as appropriate) ☐ Severe ☐ Mild ☐ During Period ☐ Before Period ☐ After Period
☐ Clotting (Mark as appropriate) ☐ Large ☐ Medium ☐ Small Are they dark colored? Yes_____
☐ Bleeding Between Periods
☐ Pelvic Inflam. Disease
☐ Endometriosis
☐ Mastitis
☐ Infertility
☐ Ovarian Cysts
☐ Hot Flashes

Men Only
☐ Impotence ☐ Discharge from Penis ☐ Testicular Pain or Lump ☐ Premature Ejaculation ☐ Weak Erection ☐ Prostate Problems ☐ Infertility ☐ Low Sex Drive

Is there anything else you would like me to know?
_____
_____
_____
_____
_____
_____
_____

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

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ACUPUNCTURE

# MANDATORY DISCLOSURE

Education and Experience

Serena Shaw received her Master's of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in April of 2015. This was a three-year program with 2,850 hours of course work and clinical work. She was certified as a Diplomat in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This included a certification in Clean Needle Technique as well. She is also a licensed Massage Therapist, receiving her certification from the Denver School of Massage Therapy and had been a practicing massage therapist for over nine years.

Serena has been trained in multiple adjunct therapies including herbal medicine, cupping, moxibustion, Tui Na, massage therapy, auricular acupuncture, Gua sha, and dietary and lifestyle recommendations.

Nourishing Energy Acupuncture complies with rules and regulations of the Colorado Department of Public Health and Environment, including proper sanitization practices and the use of sterile, single-use disposable needles.

Fee Schedule (subject to review each January and July):

Initial visit with exam..... $95.00 + cost of herbs Follow-up visit.....$75.00 + cost of herbs

Vaginal Steam Consult..... $45 Single Steam $50 3 Steam $145 5 Steam $225 10 Steam $450

Massage Therapy..... 30min $45.00 ..... 60min $75.00..... 90min $95.00

Herbal Consult.....$45 Cupping Only.....30min $45

Missed appointments (less than 24-hour notice).....$50 (cost of missed appointment)

Patient Rights

~ Patients may seek a second opinion and may terminate therapy at any time.

~Patient has the right to be informed about any technique or method of therapy used and the duration of those therapies if known.

~ Professional relationship. Sexual intimacy is never appropriate and should be reported to the Director of Registration in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Department of Regulatory Agencies. Any complaints should be directed to: Director of the Division of Registration in the Department of Regulatory Agencies, 1560 Broadway, Suite 1545, Denver, Colorado 80202, phone (303) 894-2464.

I have carefully read and understand the above and agree to the terms of this Client Disclosure Form.

Signature:_____ Date_____

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ACUPUNCTURE

# CONSENT TO TREAT

By signing below, I do hereby authorize Serena Shaw, Licensed Acupuncturist and massage therapist, at Nourishing Energy Acupuncture, to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: Acupuncture, Chinese Herbs, Moxibustion, Cupping, Tui-Na (Chinese Massage) and Western Massage Therapy.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases. I am aware that certain adverse side effects may result. These could include but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort. 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.

Chinese Herbs: I understand that Chinese Herbal formulas may be recommended to me to treat bodily dysfunction or diseases. 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 these substances. These could include but are not limited to: changes in bowel movement, abdominal pain or discomfort. Should I experience any problems that I associate with these substances, I should suspend taking them and call Nourishing Energy Acupuncture as soon as possible.

Cupping: I understand that cupping may be used to promote circulation of qi through the meridians. Cups may produce a red/purple color on the area treated lasting for 1–5 days.

Moxibustion: I understand that heat treatments using Artemesia vulgaris ("moxa") involves putting moxa on the head of a needle while inserted in the skin, or directly on the skin. The heat generated from moxa treatments may involve a slight discomfort or leave a blister or scar on the skin. I understand that I may refuse this therapy.

Tui Na and Massage: I understand that based on my condition that a variety of massage techniques may be employed to reduce muscle tension, release myofascial restriction, promote circulation, reduce pain and increase range of motion. These techniques may include traditional Chinese Tui Na techniques, myofascial release, deep tissue massage and Swedish massage.

Vaginal Steaming: I understand that vaginal steaming involves the use of herbal medicines and the use of hot steam and at times the use of a hot burner. I understand that with the use of hot substances there is the risk of burn or discomfort from the heat and I may refuse this therapy. As with other herbal therapies I am aware that certain adverse effects may result. Should I experience any adverse effects I will stop use and contact Nourishing Energy Acupuncture as soon as possible.

Most conditions require an average of 6-12 treatments, although some will respond within 4-6 treatments and others may require more. This depends on the severity and the chronic nature of the chief complaint.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved in the treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I have carefully 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:_____

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ACUPUNCTURE

# OFFICE POLICIES

Cancellations & missed appointments. Please provide 24-hour notice of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within 24 hours you will be charged a $50. Reasons for being dismissed/denied treatment: Patients who show inappropriate conduct, non-or-late payment of fees, or safety concerns may be denied treatment.

## FINANCIAL POLICY

our payment is due in full at the time of service. For your convenience, we accept cash, check or credit cards (Visa or MasterCard only). For checks returned to us as unpaid by your bank, you will be charged a $25 fee.

## INSURANCE POLICY

Many Insurance companies cover acupuncture! We are happy to verify coverage and check benefits for you. If you have insurance that covers acupuncture we will submit your claims for you. You are responsible for your deductible, co-payment, and any non-covered or excluded amounts under your policy. If your insurance denies payment of a claim you are responsible for billed charges. In the case that your insurance company sends a check directly to you for the payment of the treatment, you hereby agree to endorse the check to Nourishing Energy Acupuncture and Massage Therapy and turn over payment with accompanying Explanation of Benefits form.

| Procedure Code | Description of Service Billed | Charge | Time of Service Discount |
|---|---|---|---|
| 99203 | New Patient Evaluation | $95 | $95 |
| 97810 | Acupuncture, first 15 minutes | $70 | $75 |
| 97811 | Acupuncture, additional time | $50 | 0 |
| 97014 | Electric Stimulation | $10 | 0 |
| 97016 | Cupping Therapy | $20 | 0 |

## RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize Serena Shaw L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization. Please indicate your understanding and acceptance of these policies by signing below.

Patient Signature _____Patients Name _____Date_____-_____

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ACUPUNCTURE

# HIPPA NOTICE

YOUR HEALTH INFORMATION RIGHTS

You have the following rights related to your medical and billing records kept by Nourishing Energy Acupuncture:

Obtain a copy of this notice. You will view a copy of this notice at your first visit after its publication. Thereafter you may request a copy of this notice or any revisions from Nourishing Energy Acupuncture.

Authorization to use your health information.Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

Access to your health information. You may request a copy of your health information that Nourishing Energy Acupuncture keeps in your medical or billing record. Your request must be submitted in writing. We may charge for the costs of providing you access and for your copies.

Amend your health information. If you believe that the information we have about you is incorrect or incomplete, you may request that we correct or add information. Your request must be in writing and you may request a form for this purpose by contacting Nourishing Energy Acupuncture.

Request confidential communications.You may request that when we communicate with you about your health information, we do so in a specific way (e.g., at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

Limit our use or disclosure of your health information.You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, health care operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services.

Our Responsibilities

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our practice and business associates, provide this notice about our privacy practices, and abide by the terms of this notice. We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice. The new notice will be carried by us and will be available at your request.

Except for the purpose related to your treatment, to collect payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time. We are unable to take back any disclosure we have already made with your permission.

Patient or Parent/Legal Guardian Signature _____Date_____

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ACUPUNCTURE

# Raw Herb Cooking Instructions

Dose: __1 cup__ X _3__ times a day. ( A cup is a small teacup or sake glass size. Your herbs are medicine not the kind of tea you would sip on all day.)
* Note: You can drink it cold but I think that most of the time it taste better warm. Warm is also better for the digestion.

**Raw Herb Cooking Instructions**

You have __2__bags of raw Herbs. This will last you a roughly 2 weeks depending on how much evaporation there is.

1 bag will cook enough tea for about 6 days.

In a stainless steel pot (just make sure it doesn't have a nonstick coating or is copper etc.) add 5 cups of water. Add the contents of the bag into the water and let soak for 45 min (can be longer if you get busy). Roughly chop up the fresh ginger (if it is part of your formula) and add this to the other herbs in the pot. Turn the heat on and bring to a boil and cover. After it boils turn the heat down so the the herbs are simmering and cook for 45-60 min. Strain the tea off but keep the herbs.

Add 5 more cups of water to the herbs and cook again for another 30 min.
Strain the herbs out again and throw them out and keep the rest of the tea.
Mix the two batches together and store in a glass container in the refrigerator.

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ACUPUNCTURE

# PERMISSION TO TREAT & MEDICAL HISTORY

Name: _____
Email address_____
Permission to be contacted by Nourishing Energy Acupuncture: YES or NO

Pregnant or could possibly be pregnant: YES or No
Any medical conditions or history that is
important:_____
_____
_____
_____
_____

By signing below, I do hereby authorize Serena Shaw, Licensed Acupuncturist and massage therapist, at Nourishing Energy Acupuncture, to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: Acupuncture, Chinese Herbs, Moxibustion, Cupping, Tui-Na (Chinese Massage) and Western Massage Therapy.

Vaginal Steaming : I understand that vaginal steaming is performed with use of hot liquids infused with herbal medicines in an attempt to treat bodily dysfunction or diseases. I am aware that certain adverse side effects may result. These could include but are not limited to: light headedness, dizziness, cramping, headaches or changes in length of menstrual cycle. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop steam treatment at any time.

Signature:_____
_____Date:_____