New Acupuncture Patient Information

Your first visit will last about 90 minutes. Follow-up treatments will take 45 - 60 minutes. For your first visit, please arrive 15 minutes prior to your scheduled appointment time to make sure all paperwork is completed and we can get your treatment started on time.

Acupuncture has been practiced for centuries, but may be very different from any health care experience you've had before. I will ask you a number of questions about your health and history, some of which may be unfamiliar to you. You may never have had a health intake that includes looking at your tongue and taking multiple pulses. It will only be unfamiliar the first time! I encourage you to ask me questions about your treatment and progress. Your treatment is individual, as is your response to it. By asking questions you are learning how your own body heals.

To prepare for your first visit:

1. Complete Forms:

    - *Prior to your appointment print and complete **Health History** and **Consent Forms** and bring them with you. The questionnaire will form the basis of an in-depth conversation we'll have at your initial consultation and enable me to customize an effective treatment plan for you.*

2. What to Bring

    - *List of medications, supplements, or herbs, etc. that you are currently taking. Bring any medical and lab reports that are related to your health concern.*

3. What to Wear

    - *Wear loose-fitting, comfortable clothing that is convenient for accessing areas such as the arms, legs, abdomen and back of the body during treatments.*
    - *Refrain from wearing any perfume, cologne or scented lotions. Many of our patients are sensitive to fragrances.*

4. What to Eat/Drink

    - *Eat a light meal prior to your appointment to prevent any possible light-headedness or nausea.*
    - *Don't drink caffeinated beverages (coffee, tea, energy drinks, etc.) or take any pain medications for at least 4 hours prior to your visits.*
    - *Don't eat or drink anything that changes the color of your tongue, and don't brush your tongue the morning of your appointments. In Chinese medicine, the tongue gives us valuable information about your* health.
    - *Use the restroom prior to your appointment. Acupuncture treatments can stimulate your bladder!*

5. After Treatment

    - *Go home: continue to relax. You may feel sleepy or hazy as your body responds to the treatment.*
    - *Refrain from overexertion, drugs or alcohol for at least six hours after treatment.*

Health History

Date: ____/____/____

Name	Gender	Age	Date of Birth _____/_____/_____
Address	City	State	Zip Code

Phone #
☐ Home _____
☐ Cell _____
☐ Other _____
email _____

Emergency Contact_____
Contact Phone # _____
Relationship _____

Occupation:	Height _____ Weight _____	Physician Name Physician Address Physician Phone #

Have you been treated by Acupuncture or Oriental Medicine before?

◉ No ○ Yes .... Last Treatment _____/_____/_____

Relationship status

○ Single	○ Divorced
◉ Married	○ Widowed
○ Living w/Partner	○ Other
○ Separated	

How did you hear about our clinic?

Main Concerns

When did this start? _____

Pain level- *please circle*

Pain Scale

Heat makes it:	○ Better	○ no change	○ worse
Cold makes It	○ Better	○ no change	○ worse
Damp makes it:	○ Better	○ no change	○ worse
Exercise makes it	○ Better	○ no change	○ worse

Other Health Concerns

1

2

3

Health History

	You	Year	Family		You	Year	Family
☐ Cancer – type(s) _____				☐ Osteoporosis			
☐ Diabetes				☐ Herpes			
☐ Hepatitis				☐ Aids/HIV			
☐ High Blood Pressure				☐ Other STD			
☐ Heart Disease				☐ Rheumatic Fever			
☐ Stroke				☐ Alcoholism			
☐ Seizure				☐ Allergies –Types _____			
☐ Thyroid Disease				☐ Mental Illness			
☐ Asthma				☐ Kidney Disease			
☐ Pacemaker				☐ Anemia			

Habits

Amount/Frequency

Coffee/Tea _____
Tobacco _____
Alcohol _____
Drugs _____

Exercise

Regularly? ☐ Yes ☐ No

If so, what and How Often:
_____

Medications

Please note what medications, herbs or supplements you use regularly

Medicine/Vitamins	Dosage	Reason	How Long?

Injuries & Surgeries

Please note area of body & date

Temperature

How warm / cold you feel (not in degrees) relative to other people?
do you wear more or less layers, etc.

Please indicate your body's overall relative Temperature Along The Line With an ***X***

COLD ◄——————————————► HOT

☐ Cold hands/ feet
☐ Chills
☐ Cold "in the bones"
☐ Areas of numbness

☐ Excessive thirst
☐ Thirst for cold /hot drinks
☐ Thirst, no desire to drink
☐ Absence of thirst

☐ Night sweats
☐ Unusual sweats

When? _____*am / pm*
*Where on body*_____

☐ Hot hands, feet, chest
☐ Hot flashes
☐ Hot in afternoon
☐ Hot at night

Moisture

Please indicate your body's relative moisture level along the line with an ***X***
Hair, skin, mouth, etc.

DRY ◄——————————————► OILY

☐ Dry skin
☐ Dry hair
☐ Dry eyes
☐ Dry brittle nails

☐ Dry mouth
☑ Dry lips
☐ Dry throat
☐ Dry nose /Nosebleeds

☐ Edema /Swelling_____
☐ Rashes_____
☐ Itching _____
☐ Dandruff

☐ Weight gain / loss
☐ Oily skin
☐ Oily hair
☐ Pimples

Digestion

Please indicate your body's overall digestion along the line with an ***X***

diarrhea ◄——————————► constipation

BM: How often? _____x / every _____days
- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas
- ☐ Belching
- ☐ Bloating
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☑ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Excessive hunger
- ☐ Poor appetite
- ☐ Ulcer
- ☐ Hemorrhoids

Energy

Please indicate your body's overall energy level along the line with an ***X***

low ◄——————————► high

- ☐ Sudden energy drop
  Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☑ Body / Limbs feel weak
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easily
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

Female Reproductive

Are you sexually active? Y ☐ N ☐

menses (if applicable)

Age at first menses _____
Length of full cycle _____ days
Length of menses ____ days
Last menses start date ____ / ____
# of pregnancies ____
# of births ___premature ___Miscarriages
___Abortions

- ☐ Birth control pill (hormonal)
- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)
- ☐ Cramps Before bleeding___
  First day___During period___
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Mid-cycle spotting
- ☐ Yeast infections

menopause

Age changes began _____
Age at last menses _____

- ☐ Hot flashes _____x/ day
- ☐ Vaginal dryness
- ☑ Night sweats _____x / week
- ☐ Loss of sex drive

Male Reproductive

Are you sexually active? Y ☐ N ☐
- ☐ Change of sexual drive
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☑ Hernia
- ☐ Hemorrhoids

Emotions

What emotion(s) dominate your experience?

- [ ] Anger
- [ ] Irritability
- [ ] Anxiety
- [ ] Worry
- [ ] Obsessive thinking
- [ ] Sadness
- [ ] Grief
- [ ] Depression
- [ ] Fear
- [ ] Timid / shy
- [ ] Indecision

Urinary (if applicable)

- [ ] Decrease in flow
- [ ] Dribbling
- [ ] Difficulty starting / stopping
- [ ] Incontinence
- [ ] Kidney stones
- [ ] Urgency to urinate
- [x] Frequent urination
- [ ] Pain on urination
- [ ] Burning sensation
- [ ] Cloudy urine
- [x] Blood in urine

Sleep

hours per night _____

- [ ] Difficulty falling asleep
- [ ] Wake ___x/ night @_____am / pm
- [ ] Wake to urinate *How often?*_____
- [ ] Disturbing dreams
- [ ] Restless sleep
- [ ] Not rested upon waking

Head, Eyes, Ears, Nose, Throat

- [ ] Poor hearing
- [ ] Ringing in ears
- [ ] Excess earwax
- [ ] Sore throat
- [ ] Frequent Coughs
- [ ] Swollen Glands
- [ ] Hoarseness
- [ ] Trouble Swallowing
- [ ] Poor vision
- [ ] Night Blindness
- [ ] Headache
- [ ] Migraine
- [ ] Head Injury
- [ ] Dizziness
- [ ] Vertigo
- [x] Hay Fever
- [ ] Sinus congestion
- [ ] Nose Bleeds
- [x] Loss of Smell
- [ ] Phlegm (*color*_____)
- [ ] Red eyes
- [ ] Itchy eyes
- [ ] Teary Eyes
- [ ] Dry Eyes
- [ ] Cataracts
- [ ] Glaucoma
- [ ] Spots in front of eyes
- [ ] Dental problems
- [ ] Mouth sores
- [ ] Jaw Problems /TMJ
- [ ] Teeth Grinding

Thank You For Taking The Time To Complete Prior To Your First Treatment

NewportCare®
Medical Group
3300 West Coast Highway
Newport Beach, CA 92663

Acknowledgment of Receipt of Notice of Privacy Practices

The practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices

Patient Name(Print) _____

Signature _____

Relationship to Patient _____

Date _____

Documentation of Attempt to Obtain Acknowledgment of Receipt of Privacy Practices

Attempt to Obtain Acknowledgment

An attempt was made to obtain an acknowledgment of Notice of Privacy Practices on

The Acknowledgment was not obtained because:

*The patient was undergoing emergency treatment

*The patient declined to sign the Acknowledgment

*Other _____

Patient Name(Print) _____

Signature _____

Relationship to Patient _____

Date _____

NewportCare®
MEDICAL GROUP
3300 WEST COAST HIGHWAY
NEWPORT BEACH, CA 92663

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request you organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requests, and by agreeing to such requests: you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Patient Name(Print)

Signature

Relationship to Patient

Date

Phone: 949 / 491 - 9991 FAX: 949 / 258 - 5858
www.NewportCare.org

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of Acupuncture treatments and other Chinese Medicine procedures on me by Juline Busuioc or other licensed acupuncturists who may be employed by or contracted with Juline Busuioc.

"Acupuncture" is the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. Acupuncture may allow for the relief of one's symptoms without the need for medications or other invasive therapies, and improve the balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

I understand that methods or treatments may include, but are not limited to: Acupuncture, Moxabustion, Cupping, Electro- Acupuncture, Tui-Na (Chinese massage), Gua-sha, and Nutritional Counseling.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment.

I understand that in the practice of acupuncture there are some risks including but not limited to: slight pain or discomfort at the site of needle insertion, infection, minor bruising/bleeding, weakness, fainting, nausea, burning, pneumothorax, spontaneous miscarriage, and aggravation of problematic symptoms existing prior to acupuncture treatment.

I understand that it may be necessary for my acupuncturist to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives permission to release any medical records for the reasons set forth in this paragraph.

I have read the above consent form. I have had an opportunity to ask questions, and by signing below, I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment, present and future.

"With this knowledge, I voluntarily consent to the above procedures."

_____

Patient Name (*Please Print*)

_____ _____

Signature of Patient Date

SUBMIT RESET