JLOUNGE™
NATURAL NAIL BAR & SPA

Acupuncture Patient Information and Consent Form

Client Name_____ Date_____/_____/_____
Address:_____
Phone HM:_____ Wk Phone:_____ Cell Phone:_____
Email:_____(information kept private)
Emergency Contact/Phone: _____/_____
Date of Birth____/____/___ Age:_____ Gender: M / F
Occupation:_____ Marital Status:_____ Number of Children____
How did you hear about us?_____

Because this is a holistic approach to healthcare, it is important for the practitioner to have a complete understanding of the patient; physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible, and print all information. If there is confusion on any area of the form, indicate with a question mark. Thank you.

A: PRIMARY COMPLAINT: (describe your symptoms to the best of your ability):

_____
_____

B: SECONDARY COMPLAINT(S): (List any other symptoms you are experiencing, whether or not it may seem related to your primary complaint).

_____
_____

When did your primary complaint first occur _____

How Long or how often has it been occurring?

_____

To what extent does this problem affect your daily activities (work, sleep, eating, energy, etc.)?

_____
_____

When or under what circumstances does it seem to get better? worse?

_____

Have you undergone any other treatment for this condition?

_____

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MEDICAL HISTORY: (List relevant past illnesses, injuries, surgeries with dates)_____
_____

SIGNIFICANT FAMILY MEDICAL HISTORY: (List briefly and whom) _____
_____

ALLERGIES OR SENSITIVITIES: (List foods, drugs, medications, metals or skin care products you are **allergic or sensitive** to (please include reaction): _____
_____

LIFESTYLE:
Do you follow a regular exercise program? If so, Please describe: _____
_____
Relaxation Practice:_____
Sleep habits/hours of sleep per night:_____ do you feel rested?_____

Please describe your average daily diet:
Do you typically eat at least three meals per day? Y/ N If not, how many?_____
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks: _____
Drinks: _____

What particular diet or nutritional program do you generally follow? Example: (macrobiotic, vegetarian, meat & potatoes, low carb, etc.)
_____

Do you generally cook your own meals? _____

Please check any of the following habits that apply. Indicate how much and how often you consume them:
Cigarette smoking:_____ Coffee, tea, cola _____
Alcoholic beverages: _____ Recreational substances _____

MEDICATIONS/SUPPLEMENTS (prescribed and over-the-counter), **herbs, vitamins and supplements** you are currently taking or taken within last two months:
_____
_____
_____

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Please put a check next to conditions you have had. Indicate the length of time you have had this condition:

GENERAL:

Poor appetite:_____ Changes in appetite:_____ Cravings:_____
Strong thirst: _____ Weight gain: _____ Weight loss: _____
Bruise easily _____ Insomnia:_____ Disturbed sleep: _____
Night Sweats: _____ Sweat easily: _____ Fever: _____
Chills: _____ Tremors: _____ Fatigue/low energy: _____
Sudden energy drop (time of day): _____ poor balance: _____
Diabetes: _____ Hypoglycemia: _____ Anemia: _____
Allergies: _____ Enlarged Spleen:_____ Enlarged Liver:_____
Mononucleosis:_____ HIV:_____ AIDS:_____ Hepatitis(Specify A,B,C etc)_____
Thyroid Poblems (Specify):_____ Hormonal Imbalances:_____
Cancer (Specify type and location):_____
Gall Stones:_____ Kidney Stones:_____ Jaundice:_____
Glandular Problems:_____ Stroke:_____ Seizures:_____
Arthritis:_____ Autoimmune Disorders:_____ STD:_____
How would you describe your sex drive? High_____ Avg._____ Low:_____ Up and Down:_____
General Energy Level:_____

SKIN AND HAIR:

Rashes:_____ Itching:_____ Hives:_____
Eczema:_____ Acne:_____ Ulcerations:_____
Recent Moles:_____ Hairloss:_____ Dandruff:_____
Changes in hair or skin:_____ Any other hair or skin problems: _____

HEAD, EYES, EARS, NOSE, THROAT:

Dizziness:_____ Concussions:_____ Colorblindness:_____
Glasses:_____ Spots in the eyes(floaters:_____ Eye strain:_____
Poor Vision:_____ Blurry Vision:_____ Nose bleeds:_____
Cataracts:_____ Night blindness:_____ Eye pain/strain:_____
poor hearing:_____ Facial Pain:_____ Headaches:_____ Migraines:_____
TMJ:_____ Grinding teeth:_____ Chronic sinus infections:_____
Recurrent sore throats:_____ sores on lips or tongues:_____
Ear ringing:___, if yes, what kind (pitch-low? high?, volume Low? high?) _____

RESPIRATORY:

cough:_____Coughing up blood:_____ Asthma:_____ Bronchitis:_____
Pain with inhalation:_____ Pneumonia:_____ Difficulty breathing:_____
Production of phlegm: how much?_____ (color?)_____
Frequent respiratory infections?_____ Sinus problems?_____
Any other lung problems?_____

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CARDIOVASCULAR:
High blood pressure:_____ Low blood pressure:_____Chest pain:_____
Irregular heartbeat:_____ Fainting:_____ Cold hands and feet:_____
swelling of hands:_____ Swelling of feet:_____ blood clots:_____
difficulty breathing:_____ Varicose veins:_____ poor circulation:_____
Cholesterol (high, low,)_____
Pain that travels down the left side of arm to the pinky finger?_____
Any other heart or blood vessel problems?_____

GASTROINTESTINAL:
Nausea:_____ Vomiting:_____ Belching:_____
Black stools:_____ Blood in stools:_____ Gas or bloating:_____
Gas or Bloating:_____ Diarrhea:_____ Constipation:_____
Rectal pain:_____ Hemorroids:_____ Indigestion:_____
Acid reflux:_____ Ulcers:_____ Abdominal pain/cramps:_____
Chronic laxative use:_____
Do you feel tired or sleepy after eating?_____ times?_____
Do you have daily bowel movement?_____ If not, how often?_____
Formed or loose/soft stools?_____
Any other problems with stomach or intestines:_____

GENITO-URINARY:
Pain on urination:_____ Frequent Urination:_____ Blood in Urine:_____
Urgency to urinate:_____ Unable to hold urine:_____ Kidney stones:_____
Decrease in flow:_____ Impotence:_____ Premature Ejaculation:_____
Sores on genitals:_____ Particular odor to urine:_____
Do you wake up at night to urinate?_____ If so, how often?_____
What color is your urine?(clear, light yellow, dark yellow, brown, etc)_____
Amount; (scanty or profuse)?_____
Prostate problems?:_____
Any other problems with genital or urinary functions:_____

WOMEN'S HEALTH:
First day of last menses: _____ Age of first menses: _____ Typical duration of bleeding: _____
Length of menstrual cycle: _____ Is it regular?: _____ If not, explain _____
Heavy bleeding or light flow? _____ Clotting? (size, quantity) _____
Color of blood (red, dark red, purple, brown, blackish): _____ Spotting between periods? _____
Discomfort or pain during periods? _____ When? _____
breast tenderness during menses or ovulation? _____
Premenstrual symptoms? please specify: _____
Have been diagnosed with: Pelvic inflammatory disease _____ Fibroids _____ Cysts _____

Cervical dysplasia _____ Unusual discharge? _____
Type of birth control? _____ How long? _____
Total # of Pregnancies: _____ Number of births:_____ Premature births: _____ Miscarriages: _____
Abortions: _____ Are you pregnant now? Yes / No / Maybe
If Pregnant: Approximate Due Date _____ Are you under the care of an OBGYN or Midwife? _____
Any complications or concerns? _____
Any symptoms causing discomfort during pregnancy? _____

MUSCULOSKELETAL:
Neck Pain:_____ Muscle Pain:_____ Knee Pain:_____ Hip Pain:_____
Back Pain:_____ if so, where?_____ Muscle weakness:_____
Hand/wrist pain:_____ Foot/ankle pain:_____ Shoulder/Arm Pain:_____ Leg Pain:_____
Any other Joint or bone problems:_____

NEUROPSYCHOLOGICAL:
Seizures:_____ Loss of balance:_____ Areas of numbness:_____
Lack of coordination:_____ Poor memory:_____ Concussion:_____
Depression:_____ Anxiety:_____ Irritability:_____ Easily Susceptible to stress_____
Have you ever been treated for emotional problems?_____
Any other neurological or psychological problems?_____

Informed Consent

I hereby consent to acupuncture treatments and related procedures associated with Chinese Medicine, by Amelia Vargas, L.Ac. I understand that the methods of treatment may include but are not limited to acupuncture, facial acupuncture, microneedling, moxibustion, cupping, gua sha, Tui-Na, electrical stimulation, Chinese herbology, Acutonics, shoni shin, nutritional counseling and skin care and facial services.

I have been informed that acupuncture is a safe method of treatment, however it may have minor side effects, including bruising, numbness or tingling near the needling sites which may last a few days, and in rare cases, dizziness or fainting. This facility only uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of moxibustion. Bruising is a common side effect of cupping and gua sha treatments, and may last a few days to a week. Although rare and uncommon, there have been cases reported of nerve damage, organ puncture, including lung puncture (pneumothorax) and spontaneous miscarriages. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

If I am receiving facial renewal acupuncture, I understand that facial bruising is a possible risk. I will inform my acupuncturist if I have high blood pressure, frequent migraines, or have had resurfacing treatments such as, laser, microdermabrasion, or chemical peels within the last 3 weeks. It is not appropriate to perform facial acupuncture in the situations of pregnancy, acute colds and flus, acute herpes outbreaks or acute allergic reactions.

I understand that there are some acupuncture points and Chinese herbs that are inappropriate during pregnancy. I will notify the acupuncturist should I become pregnant or if I am trying to become pregnant.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that are used are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. If I experience any gastrointestinal upset, headache, rashes or allergic reactions or any unpleasant side effects from the herbs I will stop taking them and immediately inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand the practitioner and administrative staff may review my medical records and reports, but all of 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 and understand this consent to treatment and that I have read and understand the colorado mandatory disclosure form. I have been informed about the risks and benefits of acupuncture and other procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment

_____ _____

Signature of Patient or Patient's Representative Date

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HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can access this information.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPAA," it is our legal duty to safeguard your Protected Health Information (PHI). Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office. You may also request a copy of this Notice from us, or you can view a copy of it in our office. This Notice will remain in effect until it is replaced or amended.

During the course of our relationship with you, we will use and disclose PHI about you for treatment, payment, and healthcare operations. We gather personal information and health information from you, other healthcare providers, and third party payers. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside our practice. You may specifically authorize us to use PHI for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your PHI.

DISCLOSURE

This office may use or disclose your PHI without your consent or authorization when required by law.

PATIENT RIGHTS

1. Upon written request, you have the right to review and receive copies of your PHI.
2. Upon written request, you have the right to receive a list of disclosures about your PHI.
3. You have the right to request additional restrictions on the use and disclosure of your PHI, as permitted by law.
4. Upon written request, and as permitted by law, you have the right to request that we amend your PHI.
5. You have the right to receive all notices in writing.

If you have questions about this Notice or any complaints about our privacy practices, please contact our office. Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201. This Notice went into effect on March 1, 2008.

I acknowledge consent for use and disclosure of PHI and receipt of this Notice of Privacy Practices. I have read and understand this document.

_____	_____	_____
Patient's Name	Patient's Signature	Date

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Disclosure Form and Informed Consent

Amelia Vargas earned her Master of Sciences in Acupuncture and Oriental Medicine degree from South West Acupuncture College in Boulder Colorado. This four year program consisted of 3000 educational hours including 1095 hours of clinical practice. She is certified as a Diplomate in Acupuncture and Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). This includes certification in Clean Needle Technique and Chinese Herbology. Amelia's training also includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, facial renewal acupuncture, and dietary and lifestyle recommendations. She is a licensed Acupuncturist in the state of Colorado and is a member of the Acupuncture Association of Colorado. Additionally, Amelia is a Colorado licensed Esthetician and a practitioner of Acutonics and craniosacral therapy, and is certified in Facial Rejuvenation Acupuncture, Constitutional Facial Renewal Acupuncture, Facial Soundscapes Harmonic Renewal, and Oriental Medicine Pediatrics and Obstetrics. None of these licenses or certificates have ever been revoked or suspended.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Suggested Fee Schedule
Initial Consultation and Treatment 60-75 min - $100 + cost of herbs
Follow-up Treatment 45-60 min - $75 + cost of herbs
Pediatric Chinese Medicine 30 min - $50
Facial Renewal Acupuncture 60 min- $125
Ultimate Facial Renewal Acupuncture (includes facial products, Stem Cells and Microcurrent) 90min - $195

Patient's Rights
-The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
-The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
-In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
-The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.