Abundant Blessing Acupuncture & Herbs

299 W Hillcrest Dr, Ste 206, Thousand Oaks, CA, 91360 Tel: (805) 432-4936

New Patient Health Information

First Name:_____ Last Name:_____ Gender: F / M BirthDay: _____

Address: _____ City:_____ Zip: _____

Email: _____ Tel: (___)_____

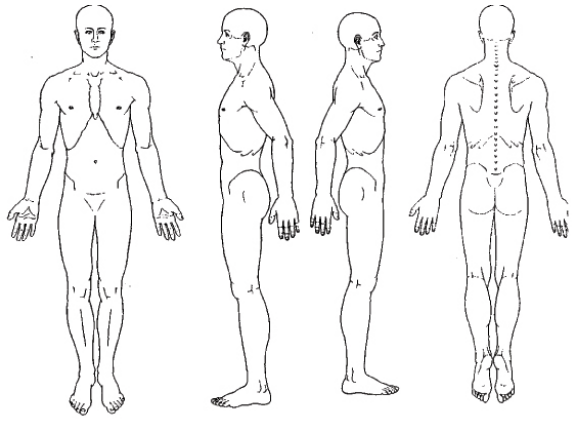
Marital Status: □Single □Married □Divorced □Widowed Occupation: _____

What trouble bothers you most today and How long it has been _____

_____

Please check any of the following as you feel are significant to you:

□ Pain: Yes/No Level: /10 Location



□ Migraine headache
□ Tension Headache
□ Cold / Flu / Bronchitis/ Pneumonia
□ Sore Throat / Cough
□ Hay fever / Allergies
□ Asthma
□ Sinusitis
□ Nose bleed frequently
□ Tongue Sores

□ Lack of thirst/forget to drink
□ Easy thirst / Dry Mouth / Dry Throat
□ Nausea
□ Poor or No appetite
□ Good appetite
□ Bad Breath
□ Bloating / Indigestion
□ Acid reflux
□ Abdominal Pain /Cramp/ ulcer
□ Bowel Movement ____times/___day
□hard/ □soft / □ Normal / □ loose
□ Hemorrhoid
□ Incontinence of Urine
□ Frequent Urination
□ Kidney Stones
□ Cloudy / Bubbling Urine
□ Painful Burning Urination
□ Night Urine ____times

□ Diabetes
□Dizziness / Vertigo / Ringing Ear
□Drinking or Drug
□ High Blood Pressure
□Hepatitis
□ HIV/ AIDS
□ Palpitation/ irregular heartbeat
□ Edema / Water retention

□ Color Blind □ Motion Sickness / Car Sick / Seasick □ Dry Eyes

□Eczema / Acne /Skin Eruptions □ Skin Tag on neck □ Hair Loss

□ Brittle Nails □ Fatty Modules under skin

□ Difficult to gaining Weight □ Difficult to lose weight

Energy Level:_____/10 Body feel □ always hot /get chills easily □ Cold hand and feet

My body accepts more on □ Winter season □ Summer Season

□ Insomnia □ Sleeping too much □ Night Sweats

□ Anxiety /Depression/ Worry □ ADD / ADHD

Men

□Potency Issue □ Prostatitis □ Fertility Issues

Female

Birth History: Pregnancies___ Births:____ Miscarriages:___ Abortions____

Menopause: □Yes

Menopause: No

Age when period begin _____ Duration of flow /days _____

Is your cycle regular? □Yes/□No

Date of last Period:_____ Do you think you are pregnant right now? No___ Yes____

Difficulties during period : □ Excessive flow □Less flow □Cramps □Clots □Breast Distension □ Emotional Change

Any other than above, please describe: _____

Family History: _____

Please list medicine you are taking: _____

Have you have any surgery & Date: _____

How do you know about this clinic? _____

If you know us from Groupon, please write down the groupon number: _____

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New Patient Intake Form

File No:_____

Patient's Name:_____ Date:_____/_____/_____

Chief Complaint: _____

_____

_____

_____

_____

_____

_____

_____

Physical Exam: Heart Rate: ___BPM Heart Rhythm: Normal/Abnormal BP:_____/_____mmHg

Tongue Body: Pale/ Pink/ Red/ dark Red/ Purple/ Blue

Coating: White/ Yellow/ Gray/ Black/ Half in Center or Side /Thin/ Thick/ Dry/ Slippery/ Greasy/ Scanty/ Graphic

Shape: Stiff / Cracked/ Swollen in Side Center Half /Tooth-marked/ Ulcerate/ Flabby/ Thin/ Narrow

Pulse: Lt:_____ Rt:_____

Superficial	Deep	Slow	Rapid	Deficient	Excess	Surging	Thready	Abrupt
Hesitant	Tense	Soft	Weak	Moderate	Knotted		Intermittent	Rolling String-taut

TCM Diagnosis: _____

Treatment Principles: _____

Acupuncture Treatment: _____

_____

(Technique: Tonify: - Sedating: ⊤ Moxa: △ Electro: E TuiNai: T Cupping:C)

Herbal Treatment: _____

_____

_____

Recommendations: _____

_____

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Cash Patient Service Fees:
Acupuncture Treatment Initial $70 Follow Up $60 5 Treatments $250
Herb $10 -- 30/week Cupping $40.
Cancelation fee $30 if fail to notice at least 2 hour before appointment

Date	Acu	Herb	Cup	PT	Total	Paid	Balance	Next Appointment

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aBlessingAcupuncture.com

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes 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.

1. USES AND DISCLOSURES 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 who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you.

Health Care Operations: We may use or disclose, as needed, your protected health information for our physician's practice. For example, but are not limited to,

quality assessment activities,
employee review activities,
training of medical students, licensing
billing or transcription services

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or

condition.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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 purposes of treatment, payment or health care 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.

3. 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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Office at (805)432-4936 for further information about the complaint process.

4. Acupuncture SAFETY

Acupuncture is performed by insertion needles through the skin, or by the application of heat to the body in an attempt to treat bodily dysfunctions or diseases, to body's physiological functions. Side effects include but not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possibly temporary aggravation of symptoms existing prior to acupuncture treatment.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity.

Cash Patient Fees:

Acupuncture Treatment	Initial $70	Follow Up $60	5 Treatments $250
Herb $10 -- 30/week	Cupping $40.	Massage	$70 for a Hour

Cancelation fee $30 if fail to notice at least 2 hour before appointment

This notice was published and becomes effective on **June 1, 2011.**

Patient Name: _____ Signature: _____ Date: _____