General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____ May we contact them? Y/N

What is your gender? M F What was your sex at birth? M F

Do you identify as transgender or transsexual? Y/N don't know or don't understand the question (please circle choice)

Have you had Acupuncture or Oriental medicine before? Y/N

Are your presently under a doctor's care? Y/N Who and for what? _____

Are there any other therapies which you are involved? Y/N Who and for what? _____

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other _____

What are you health goals? _____

List any past or future surgeries. _____

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc...) _____

List exercise and sport activities you have been or are currently involved in: _____

Signs/Symptoms

❍ Abdominal pain/distention
❍ Abuse survivor
❍ Acid regurgitation
❍ Acne
❍ Asthma
❍ Bad breath
❍ Blood in stools
❍ Blood in urine
❍ Blurry vision
❍ Breast lump/pain
❍ Bruise easily
❍ Chest pains
❍ Chills
❍ Cold hands/feet
❍ Concussion
❍ Confusion
❍ Constipation
❍ Cough
❍ Coughing blood
❍ Dark stools
❍ Decreased libido
❍ Depression
❍ Dizziness/vertigo
❍ Dry throat/mouth
❍ Diarrhea
❍ Ear aches
❍ Enlarged thyroid
❍ Eye pain/strain/tension
❍ Excessive phlegm Color of
❍ Excessive saliva
❍ Fatigue
❍ Fever
❍ Frequent urination
❍ Gas/belching
❍ Grinding teeth
❍ Headache
❍ Hemorrhoids
❍ Heart palpitations
❍ Hiccup
❍ High blood pressure
❍ Impotence
❍ Increased libido
❍ Indigestion
❍ Intestinal pain/cramps
❍ Irritable
❍ Itchy eyes
❍ Itchy skin
❍ Joint pain
❍ Kidney stones
❍ Laxative use
❍ Limited range of motion
❍ Loss of hair
❍ Low back pain
❍ Migraine
❍ Mouth sores
❍ Mucous in stools
❍ Muscle cramps/pain
❍ Nasal congestion
❍ Neck/shoulder pain
❍ Night sweats
❍ Nocturnal emission
❍ Nose bleeds
❍ Numbness
❍ Odorous stools
❍ Pain upon urination
❍ Peculiar tastes
❍ Poor appetite
❍ Poor circulation
❍ Poor memory
❍ Poor sleep
❍ Premature ejaculation
❍ Psoriasis
❍ Rash
❍ Redness of eyes
❍ Seizures
❍ Seeing a therapist
❍ Short temper
❍ Shortness of breath
❍ Sinus pressure
❍ Skin fungal infection
❍ Spots in eyes
❍ Sweat easily
❍ Sore throat
❍ Sudden energy drop
❍ Swollen glands
❍ Teeth/gum problems
❍ Ulcerations
❍ Upper back pain
❍ Urgent urination
❍ Vomiting
❍ Wake to urinate
❍ Weight loss/gain
❍ Wheezing

Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N Is you cycle painful? Y/N Have you ever been pregnant? Y/N

Birth control? Y/N How long? _____ ❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

Medical History

Do you have any allergies? Y/N _____ If so, to what? _____

Do you take medication? Y/N _____ If so what types and how often _____

Do you take supplements? Y/N _____ If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

❍ Pneumonia
❍ Tuberculosis
❍ Hepatitis
❍ Diabetes
❍ Epilepsy
❍ Kidney Stone
❍ Drug reaction
❍ Heart attack
❍ Blood transfusion
❍ Anemia
❍ Arthritis
❍ Obesity
❍ Metal breakdown
❍ Jaundice
❍ Parasites
❍ Measles
❍ Mumps
❍ Syphilis
❍ Gonorrhea/Herpes
❍ HIV/Aids
❍ High/low blood pressure
❍ Heart disease
❍ Gout
❍ Cancer
❍ Mental illness
❍ Hypo/hyper thyroid
❍ Premature graying
❍ Seizures
❍ Multiple Sclerosis

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences (smoking, alcohol, recreational drugs)? _____

What are your hobbies/pleasures? _____

Web of Wellness

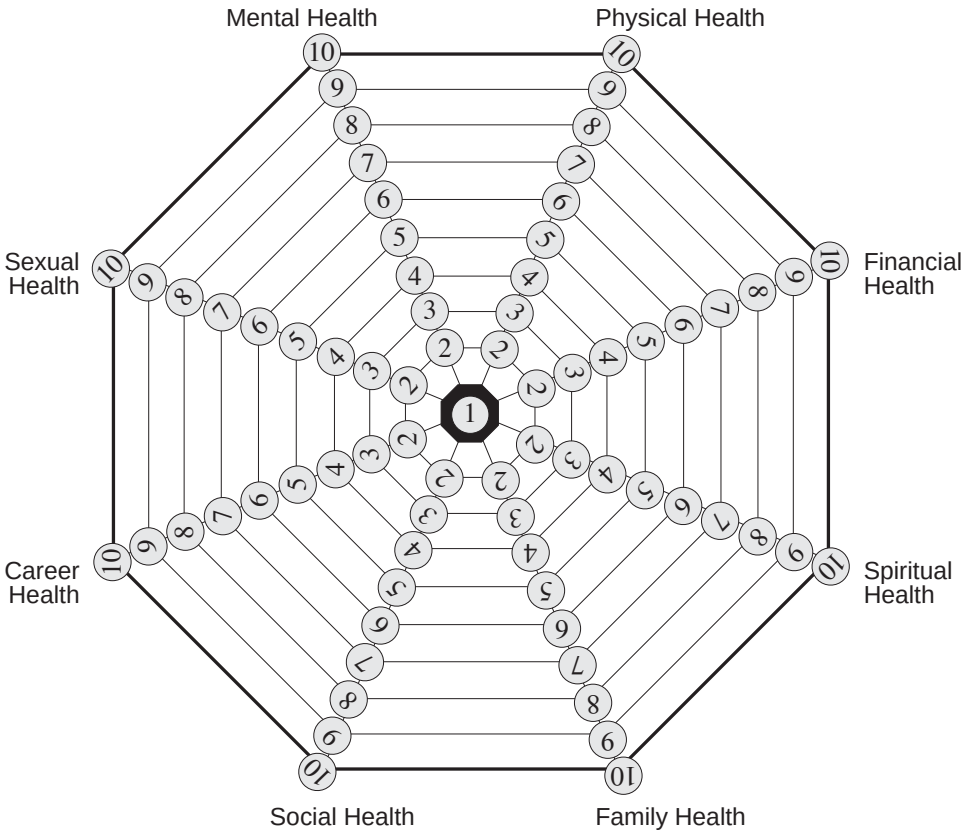
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

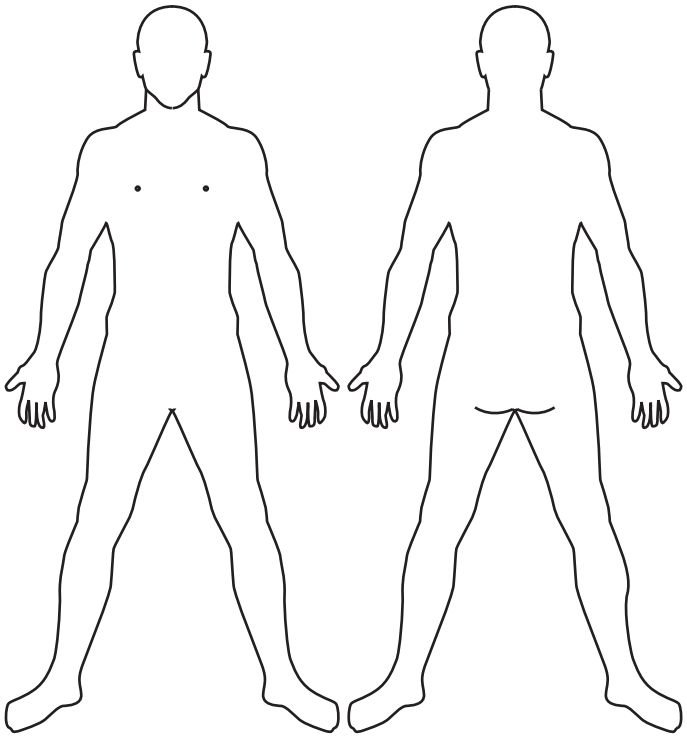
All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit



Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.

Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Patient and Practitioner Agreement

I have found that maintaining clear professional boundaries support and facilitate my patient's healing process. To optimize the therapeutic value of our relationship, I ask you to read and agree to the following guidelines:

1. New patient appointments are one and a half hours long. Please fill out all the initial paperwork and have your health history complete before arrival or be twenty minutes early. Please use descriptive words, not "good" and "fine," to describe your condition and symptoms. At this time I will give you a treatment plan with an estimated amount of treatments needed to heal your chief complaint.

2. Follow-Up appointments are approximately forty-five minutes to an hour long. These appointments are important to assess the progress of your treatment and reevaluate the treatment plan if there is no progress. The standard treatment plan for a chronic condition is ten treatments once per week, with expansion of time in between treatments until the condition is healed and you are released.

3. Be on-time for appointments please. It is my intention to respect your time as well as my own. All scheduling of appointments is done to provide you with the full amount of time designated for the type of appointment you have scheduled. It is my goal to start and end on time. I ask that you arrive on time for all appointments.

4. Cancellations: Appointments can be cancelled up to 24 hours before a scheduled visit. Within 24 hours, or a "no show," you will be charged $40 late cancellation fee.

5. Telephone Messages: I am often unable to receive calls during treatment times, therefore please leave a message on my voicemail. When leaving a message, please be sure to include your name, phone number, and times you are available to receive a return call. Please do not leave messages containing confidential or complicated information. It is better to schedule a phone appointment for matters of this nature. If I have not returned your call within 48 hours, please call back.

6. Phone consultations have a $40 fee for 30 min or less time. Fees are not charged for phone calls made to clarify issues discussed during an office visit, questions concerning treatment, or brief progress reports on the effectiveness of treatment. However, please feel free to call as needed.

7. Colds, Flus, Acute Situations: Most non-threatening situations can be treated by Traditional Chinese Medicine. Even for acute situations, however, an office visit is preferred to a phone consultation. Phone consultations for acute complaints are subject to a phone consultation fee.

8. Emergencies: Please use common sense. If the condition is life threatening or becomes severe, contact your physician or go to the Emergency Room. Please follow the medical advice given by your medical doctor. Herbal remedies can interfere with some standard medical treatments. This is why a complete account of your medications is important, and any changes should be reported to Amy to add or change in your file.

9. Confidentiality: Chinese medical treatments and your records are confidential. If you wish me to communicate with another health care provider, you must complete a written release.

10. When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

11. Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

12. It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

13. Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

14. Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

15. Qi imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance inany of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

16. I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

17. Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentially lead to a full expression of your body's innate wisdom.

18. Sexual misconduct, in any form, is unacceptable. By scheduling an Acupuncture treatment, you understand that any illicit or sexually aggressive remarks, advances or gestures will result in the immediate termination of your treatment. If a session is terminated by Amy because of sexual misconduct, you agree to full payment of the scheduled appointment.

Equal care will be provided to all patients regardless of age, race, ethnicity, physical ability, religion, sexual orientation, or gender identity /expression.

Acupuncture Clinic Disclosure Statement & Informed Consent

Amy Norton, ACU 1271, is in compliance with the State of Hawaii Revised Statutes, chapter 436E. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Hawaii department of commerce and consumer affairs board of acupuncture.

Practitioner Education, Certification and Experience

Amy C. Norton, L.Ac., earned her Masters Degree in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in 2011. She is designated a Diplomat of Acupuncture by NCCAOM. She is a Licensed Acupuncturist in the State of Hawaii. She has also completed a five hundred hour certificate training program in Five Element acupuncture which treats emotional trauma and physical complaints that have an emotional root. None of Amy's licenses, certificates or registrations have ever been suspended or revoked. Amy's training included adjunctive therapies such as Moxibustion, Massage, Dermal Friction Technique, Infrared, Cupping, Herbs, Gwa Sha, Auricular Therapy, Dietary and Lifestyle Recommendations.

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I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis.

(Signature) _____ (date) _____

Medication Log

Patient Name:_____ Birthdate:_____

Medical/ Allergy Alerts:

Home Phone:_____ Work Phone:_____

Occupation:_____

Pharmacy:_____ Pharmacy Phone:_____

Date Rx	Medication	Dosage	Qty.	Freq.	Refills: Date & Initial				Stop Date

Notes:_____

_____

_____

_____

_____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Amy Norton L.Ac.,

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Private Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My Email address is: _____

_____ I do not request a copy of the Privacy Notice at this time.

I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Amy Norton L.Ac., to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my to my rights, I may speak with the Practitioner about my concerns.

_____ _____

Signature of Patient/Guardian Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW AMY NORTON L.Ac., IS REQUIRED, BY LAW, TO MAINTAIN THE PRIVACY AND CONFIDENTIALITY OF YOUR PROTECTED HEALTH INFORMATION AND TO PROVIDE PATIENTS WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION.

Disclosure of Your Health Care Information

Treatment

She may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. I"t s'our policy to provide a substitute healthcare provider, authorized by Amy Norton L.Ac., to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider s'absence due to vacation, sickness, or other emergency situations."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment is not made as arranged, our office may utilize an outside collection agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Worker s'Compensation

If applicable, we may disclose your health information as necessary to comply with the state Workers' Compensation Laws

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for you, your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information to coroners or medical examiners.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation and Research

Though highly unlikely or probable, we must inform you that there may be a need to release your health information to organizations involved in procuring, banking, or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Your Health Information Rights

You have the right to request restriction on certain uses and disclosures of your health information. If services are paid in full by cash, you may restrict that information to any insurer for purposes other than treatment. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication,
or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to request that we amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information by Amy Norton L.Ac.

You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and
will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this notice.

Complaints

Complaints about your privacy rights or how Amy Norton L.Ac., has handled your health information should be directed to Amy Norton L.Ac., by calling this number (970) 584-0864. If Amy is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which Amy Norton L.Ac., handled your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue S.W.
Room 509F HHH Building
Washington, DC 20201
For Additional Information About Your Privacy Please Visit:
www.hcfa.gov/medicaid/hippa

Please feel free to request a copy for your records.

Fee Schedule (Due at Time of Service):

Adult Accupuncture Treatment …….....	$150.00 + Cost of Herbs
Pediatric Accupuncture Treatment…….....	$100.00 + Cost of Herbs
Five Element Accupuncture Treatment.....	$200.00 + Cost of Herbs
Reiki.....	$300.00
Bio-Eletro-Magnetic Energy Regulation (BEMER) Session...	$35.00 Ala Carte or $25.00 Add on $280.00 Package of 10
Home Visits.....	$50.00 Surcharge

Kama'aina Discount With State ID

Discount Packages Available