Medical History

Name_____ Birth date_____ Age_____

Address_____
Street *City* *State* *Zip*

Home Phone (____)_____ W. phone (____)_____ Cell phone (___)_____

Which phone is best to leave messages on?_____

Whom can I thank for your referral? _____

Main Concern_____

For How Long_____

What has been diagnosed (by M.D., etc.) _____

Other Concerns_____

What have you found helpful for your main concern_____

_____

Have you ever had acupuncture or herbs_____

Dietary Restrictions_____

Dietary Emphasis_____

Food Cravings_____

Allergies_____

Social Drugs, past or present (coffee, alcohol, sugar, tobacco, marijuana, etc.)

_____

Are you taking any medications? Please list all medications, herbs, vitamins, and minerals you take with dosages, even if you take them only occasionally (you can bring these with you on your first visit as well):

_____

_____

_____

_____

Please list the locations of any scars that are numb, sore, painful or inflamed:

_____

_____

Emergency Contact Information

Name_____ Phone # _____

Relationship_____

Questions for Women

Gynecologist/Nurse Practitioner_____

Age of onset of menses: _____

Physical symptoms or emotional changes?_____

_____

Are there any problems with you menstrual cycle?

_____

Has it changed? _____

What do you experience? If it is changing, indicate how.

premenstrually_____
at the beginning of period _____
during _____
right after _____
mid-cycle _____

Are your periods regular? _____ Length of cycle (from first day of bleeding or spotting to the first day of next flow)_____

How many days of bleeding? _____generally heavy ____medium_____light_____

Is the blood: pale _____ bright red _____ dark _____ watery _____ clots_____thin _____

Are your periods painful? _____ When? _____

What do you do to relieve the pain? _____Does it work?_____

Breasts: unusual lactation or discharge_____fibroids_____Soreness_____when_____

Do you do a monthly self exam?_____Have you had a mammogram?_____

If so, why?_____

Number of pregnancies_____miscarriages_____abortions_____births_____

Any pregnancy complications or subsequent problems?

_____

Methods of birth control used_____

Complications?_____

Have you ever taken the pill?_____ For how long_____

Ever taken the morning after pill?_____ How many times?_____

Is fertility an issue?_____ How long have you been trying_____

Tests, drugs or other treatments_____

Age period stopped_____Cause_____

If hysterectomy, when, why, and what was removed_____

Physical symptoms or emotional changes with cessation of menstruation?

_____

Are you now taking HRT (Natural HRT or Conventional)?_____

Have you ever taken HRT?_____For how long_____ Does it help? _____

Are you taking any vitamins, herbs, or "non prescription" hormones for menopausal symptoms?
_____

Does it help, if yes, in what way?

_____

History of vaginal infections or unusual discharge _____

Other sexually transmitted diseases_____

Pain related to intercourse _____ Changes in sexual energy_____

When?_____
Relationship difficulties around sexuality_____

History of sexual assault or abuse _____

Did your mother take DES _____

Family history of ovarian, uterine, cervical, breast, or prostate cancer

_____

Family History

Use a C for a Current Problem or a problem still present at the death of the individual indicated
Use an H for a Historical Problem that is not present now or was not present at time of death
I understand that you may not be aware of these conditions in many cases; leave these blank

Condition or Disease	Biological Father	Biological Mother	Spouse or Partner	Brother(s)		Sister(s)		Children	
AGE of Individual									
Asthma									
Hay fever/ Seasonal Allergy									
Food Allergy / Sensitivity									
Eczema									
Psoriasis									
Other Skin Disorder									
Diabetes I - Juvenile									
Diabetes II – Adult									
Hyperthyroid or Graves Disease									
Hypothyroid or Hashimotos									
Osteoporosis or Bone Problems									
Rheumatoid Arthritis									
Other Arthritis or joint pain									
Lupus or other Immune Disorder									
Liver Disease									
Hepatitis									
Gallbladder Removed									
Gallstones									
Kidney Stones									
Kidney disease									
Heart Disease or problem									
Stroke									
High Blood Pressure									
Cholesterol problems									
Cancer – Include Type									
Digestive Disorder									
Weight Problem									
Anorexia, Bulemia, Eating Disorder									
Crohns, Ulcerative Colitis, Colitis									
Irritable Bowel									
Chronic Constipation									
Alcohol Abuse or Excess									
Insomnia									
Anxiety									
Depression									
Other:_____ _____ _____ ___ _____ __									

Chronological Life History

***Very Important! Please spend some time with this section and be as detailed as possible.

(examples: difficult birth such as premature delivery, C-Section, cord around your neck, etc., minor or major surgeries, broken bones, landmark emotional events, loss of consciousness...all the way from your birth to the present day)

First list age, then event

Endless Possibilities Acupuncture
845 Cedar Street
Santa Cruz, CA 95060
(831) 426-1093

HIPAA Notice of Privacy and Confidentiality & Patient's Rights

Patients' rights under HIPAA are described in the "Notice of Privacy Practices" The Notice will be made available to patients. These rights include:

1. Right to receive the 'Notice of Privacy Practices", which informs patients of their rights and how to exercise them. By law this notice is to be made available to patients, and a good faith effort to obtain the patient's acknowledgement of receipt is required.

2. Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copiers. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."

3. Right to Request and Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.

4. Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.

5. Right to Request Restrictions. Patients have the right to request restrictions on how they will be communicated with or how their PHI is released. Generally, every effort to try to accommodate reasonable requests for restrictions, e.g., where release of information could be harmful to the patient.

6. Right to Complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

Notice of HIPAA Privacy Practice

The attached Notice describes how health information about you may be used, and your rights, regarding the use of that information. Please review it carefully.

You have the right to:

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary)
- Ask to correct information that you believe is wrong in your health record
- Ask that your health information not be used for certain purposes, for example, research
- Ask that copies of your health record be sent to whomever you wish (charges may be necessary)
- Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes).
- Specify where and how you should be contacted
- Receive a paper copy of the full Notice of Privacy Practices

Who is authorized to see confidential Patient Health Information (PHI)?

The "Notice of Privacy Practices" describes the ways in which your PHI may be used without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.

1. Treatment of the patient, such as consultation between treating providers
2. Payment of health care bills (insurance claim submission, authorizations and payment posting)
3. Health care operations and business operations, including research (when approved by the IRB and with a patient's written permission); health care communications between a patient and their health care practitioner.

Written Authorizations

To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand or know what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with your practitioner or the privacy coordinator. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

- I acknowledge receipt of the "Notice of Privacy Practices" and "Patient's Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
- I understand and acknowledge that I may receive appointment reminder calls, newsletters, and cards, and I agree to receive these.

Signature_____ Date_____Date of Birth_____

Printed Name_____ Relation (if other than the patient)_____

Patient declined to sign receipt (signature of practitioner)_____

Patent unable to sign (witness signature)_____Reason unable_____

Informed Consent to Acupuncture Treatment and Care

I hereby request and consent to the performance of procedures which are within the scope of a California license to practice acupuncture. This includes, but is not limited to, acupuncture treatments on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists or students who now or in the future treat me while working under, associated with, or serving as backup for Dr. Maureen Rozenn.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion(moxa) and heat therapy, cupping, electro-acupuncture, medical massage modalities such as Tui-Na or Mayan Abdominal Therapy, dietary supplements, herbal therapy, and nutritional counseling. Moxibustion and heat therapy including heat lamps, tiger warmers, cone, pole and Japanese moxibustion may cause discomfort and in rare cases may cause burns. I will alert the acupuncturist, or person supervising the progress of my moxa treatment, immediately if any type of heat therapy is uncomfortable. The acupuncturist may choose to perform a form of moxibustion which consists of placing small rice sized pieces of moxa on an ointment barrier and lighting them to stimulate certain acupuncture points. I will decline the procedure if I do not wish to receive this or any other treatment.

I understand that acupuncture treatments are generally safe, but may have some side effects including bruising, numbness or tingling near the needling sites that may last a couple of minutes to a few days, dizziness or fainting, and nausea. I will notify the acupuncturist immediately if I feel uncomfortable at any time during or after treatment. There have been instances reported of spontaneous miscarriage and pneumothorax, although these side effects are very rare. Infection is another possible risk, although the acupuncturist only uses sterile, disposable acupuncture needles.

Herbs that have been used in treatment, or are recommended, are traditionally considered safe in the practice of Oriental Medicine, but may be toxic in large doses. Some of the possible side effects of taking herbs are: nausea, gas, hives, rashes, diarrhea, vomiting and tingling of the tongue. If I experience anything unusual during herbal treatment I will notify the acupuncturist immediately. I understand that some herbs and other therapies may be inappropriate during pregnancy. I will notify the acupuncturist if I think I may be pregnant.

Oriental medicine can be used to treat pregnant women for all sorts of disorders ranging from low back pain to the common cold. I understand that while labor induction and pain management during labor are within the acupuncturist's scope of practice, she does not specifically induce or treat women in labor. Treatment (pre-birth treatments) can be administered to prepare women for labor. Also, there are specific points and techniques traditionally used to help the mother promote correct fetal position. When treatment appropriate for my Chinese medical diagnosis is given during the last few weeks of pregnancy, or when past the due date, labor may start or a breech baby may turn. I understand this is a possibility and that if I am not willing to take this risk I will refuse treatment.

Cosmetic acupuncture results are not guaranteed. Facial skin is delicate and full of superficial blood vessels. Bruising can occur and scaring is a theoretical possibility.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the acupuncturist to be able to anticipate and explain all of the risks and complications. I wish to rely on the acupuncturist to exercise judgment and perform, during the course of my treatments, based upon the facts then known, the therapy that is in my best interest.

I understand that results are not guaranteed. I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

Patient Signature_____Date_____
(Or Patient Representative)

Acupuncturist Signature_____Date_____

Terms of Care - Our Cancellation Policy

Please Read Carefully!

By signing below, I agree that I have read in full and will adhere to the following office policies without exemption:

- Patients are solely responsible for tracking and keeping any appointments scheduled online or via the front desk.
- If you are 15 or more minutes late, you have missed your appointment and are responsible for full payment of your appointment cost.
- If you're sick, please keep your appointment (we can help!). If you're too ill to drive, contact us ASAP.
- Cancellations must be 48+ hours in advance to avoid a cancellation fee.
- The fee for cancellations under 48 hours is half the appointment price.
- The fee for cancellations under 24 hours is the full appointment price.
- The fee for no-shows and late arrivals by 15 minutes or more is the full appointment price.
- Three missed appointments in a row results in a discharge from care.
- Email reminders are in no way guaranteed, and they do not affect the cancellation policy in any way.
- If I do not read my appointment reminder correctly, or if my device causes a skewed representation of my appointment time via email reminder, I know that I am nonetheless responsible for my appointment time as it is scheduled in Dr. Rozenn's appointment software. I know that I am subject to cancellation fees if I miss my appointment for this reason. I know that email reminders are a courtesy only and relying on email reminders is an inappropriate way to keep track of my appointments.

_____

Printed Name Date

_____

Signature

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Directions

From Highway 17 or 1 North

1. From highway 17 or 1 North, exit into Santa Cruz towards 1 North to Half Moon Bay.
2. Go straight through the first light at River St. and Highway 9.
3. Go straight through the second light at the cross between Mission, Highway 1 and Chestnut.
4. Going straight through this light will put you on Chestnut Street.
5. Continue down Chestnut and make a left on Lincoln.
6. Three blocks down, make a left on Cedar Street.

The clinic is at the corner of Cedar and Walnut, in a Spanish-style adobe-colored building with scalloped roof, on the left. Turn left into Walnut, then make an immediate right into the parking lot. Be sure to park in one of several spaces labeled, "Customers." If the lot is full, there is metered street parking and a paid lot directly across Cedar Street from the clinic.

From North of Santa Cruz

1. If coming from North of Santa Cruz, follow 1 South into Santa Cruz.
2. It will become Mission Street.
3. Go right on Chestnut.
4. Go left on Lincoln.
5. Three blocks down, make a left on Cedar street.

The clinic is at the corner of Cedar and Walnut, in a Spanish-style adobe-colored building with scalloped roof, on the left. Turn left into Walnut, then make an immediate right into the parking lot. Be sure to park in one of several spaces labeled, "Customers." If the lot is full, there is metered street parking and a paid lot directly across Cedar Street from the clinic.

Maureen Rozenn, LAC, DAOM, FABORM
Doctor of Acupuncture and Oriental Medicine
845 Cedar Street, Santa Cruz, CA 95060
Phone: 831.426.1093 Fax: 831.426.6523

Hello, and Welcome!

Congratulations on taking the first step to better health!

Along with the enclosed paperwork, bring:
- **Herbs/supplements/drugs you are currently taking**
- **Pertinent lab work and imaging reports**
- **Your Chronological Life History**

Endless Possibilities Acupuncture, Inc. is an education-focused practice. Chinese medicine students, known as interns, assist me daily with various clinic duties. This includes observing patient visits, taking chart notes, and preparing patient materials based on my instructions during your appointment. If for any reason you do not wish to have a student observing your visit, please let me know, as your comfort is my first priority.

New Patient Visit (Regular) - Please allow 2.5 hours, cost is $200.00.
Women's Fertility Visit - Please allow 3 hours, cost is $250.00.
Follow Up Visits - Please allow 1.5 hours, cost is $130.00
These estimates include time for parking, checking out, etc.

- **While I do not bill insurance directly, you may request an insurance receipt from the front desk at the end of your visit.**

- **If you need to cancel or reschedule, please notify us at least 48 hours in advance by phone or email to avoid a late-cancelation fee.**

My schedule tends to book out in advance, with most appointment openings falling about **six weeks** from the current date. If you need your planner to book ahead, please bring it. If you can't get in on the appointment date you need, do not worry! We have a very effective cancellation list.

Ultimately, Chinese medicine yields the most profound results when there is a **solid partnership between doctor and patient**. If we work effectively together, you will learn more than you ever dreamed about your body, including how to maintain the balance we achieve in the clinic... in your own life, on your terms.

For more information about me and my practice, visit my website **www.AcupunctureSantaCruz.net**. You can also contact my office at office@AcupunctureSantaCruz.net. I look forward to your visit!

Sincerely,
Dr. Maureen Rozenn, LAC, DAOM, FABORM