CREATIVE INTEGRATIONS
acupuncture, herbs, wellness

Creative Integrations Wellness Center
1151 Dove Street, Suite 115
Newport Beach, CA 92660
949.757.0097 (o/f)

This is a CONFIDENTIAL questionnaire to determine the most appropriate plan for you

Name _____ Date _____

Home Address _____ City _____

State _____ Zip _____ Home Phone _____ Work _____

Occupation _____ Person responsible for your account _____

Email _____ Appt Time Preference _____

Emergency Contact _____ Phone _____

Who can we thank for referring you? _____

Sex __ M __ F Height _____ Weight _____ Birth Date _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed # of Children _____

Previous Acupuncture? Yes No When _____ With Whom? _____

Please indicate any illnesses you or a blood relative (parent, grandparent or sibling) have had:

ILLNESS	You	Relative	When?	ILLNESS	You	Relative	When?
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Dis.	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tubercolosis	☐	☐	_____
Pacemaker	☐	☐	_____				

Sexually Transmitted Diseases: ☐ Gonnorhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

Please indicate the use and frequencyof the following:

Coffee/Black Tea: _____ Tobacco: _____ Daily Water Intake: _____

Recreational Drugs: _____ Alcohol: _____ Soda Pop: _____

List any medications and supplements you are currently taking: (continue on back if needed)

Medicine	Dosage	Reason	How Long	Prescribed by	Last checkup (date)

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have

List any allergies, food sensitivites or food cravings you may have

List any accidents, surgeries, or hospitalizations (include date)

Lab results (please include copies)

Clinical Notes

HPI: ☐ Onset ☐ Location ☐ Duration ☐ Characteristics ☐ Aggr/Alev ☐ Related Factors ☐ Treatment

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you might be experiencing

	Great	Good	Fair	Poor	Bad	**Your Comments**
Significant Other	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

For Women

Age of first period (menarche) _____
# of days in cycle _____
Age of last period (menopause) _____
Number of day of flow _____
Color of flow _____
Clots? ☐ yes ☐ no color _____

Are you pregnant ☐ yes ☐ no # of pregnancies _____
# of live births _____ # of abortions ____ # of miscarriages _____
Date of last: Gynological exam _____ Pap Smear _____
Mammogram _____ Bone Density Scan _____
Results _____
_____

Average number of pads you useper day: 1st day ____ 2nd day ____ 3rd day ____ 4th day ____ + days _____

Have you ever been diagnosed with: ☐Fibroids ☐Fibrocystic Breasts ☐Endometriosis ☐Ovearian Cysts ☐PID Other _____

Location of Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _____

Nature of pain (indicate before, during and after menses)

Cramping _____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

Other symptoms related to menses

☐ Discharge ☐ Diarrhea ☐ Vaginal dryness
☐ Nausea ☐ Constipation ☐ Headache
☐ Swollen Breasts ☐ Mood swing ☐ Ravenous appetite
☐ Poor appetite ☐ Hot flashes ☐ Night sweats
☐ Increased libido ☐ Insomnia ☐ Decreased libido

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of urination: daytime _____ nightime _____ color of urine: ☐ clear ☐ murky odor: _____

Please check all symptoms you experience:

☐ Prostate problems ☐ Delayed stream ☐ Dribbling ☐ Rentention of Urine ☐ Incontinence
☐ Rectal dysfunction ☐ Increased libido ☐ Decreased libido ☐ Premature ejaculation ☐ Impotence
☐ Back pain ☐ Groin pain ☐ Testicular pain ☐ other _____

Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not have ever experienced. Please indicate as follows

No Mark ( ) = never experience **Check Mark** (√) = sometimes experience **Plus Sign** (+) = frequently experience

____ lack of appetite
____ excessive appetite
____ loose stool or diarrhea
____ digestive problems, indigestion
____ vomiting
____ belching, burping
____ heartburn/reflux
____ feeling of retention of food in the stomach
____ tendency to become obsessive in work, relationships . . .

____ insomnia, difficulty sleeping
____ heart palpitations
____ cold hands & feet
____ nightmares
____ mentally restless
____ laughing for no apparent reason
____ angina pains

____ abdominal pain
____ chest pain
____ sciatica pain
____ pain or coldness in the genital area
____ headaches

____ cough
____ shortness of breath
____ decreased sense of smell
____ nasal problems
____ constipation
____ skin problems
____ feeling of claustrophobia
____ bronchitis
____ colitis or divirticulitis
____ hemorrhoids
____ recent use of antibiotics

____eye problems
____ jaundice (yellowish eyes or skin)
____ difficulty digesting oily foods
____ gall stones
____ light colored stool
____ soft or brittle nails
____ easily angered or agitated
____ difficulty in making plans or decisions
____ spasms or twitching of muscles

____ low back pain
____ knee problems
____ hearing impairment
____ ear ringing
____ kidney stones
____ hair loss
____ urinary problems

____ fatigue
____ edema
____ blood in stool
____ black tarry stool
____ easily bruised
____ difficult to stop bleeding
____ asthma
____ tendency to catch cold easily
____ intolerance to weather changes
____ allergies
____ hay fever
____ dizziness
____ tendency to faint easily
____ high cholesterol levels
____ sudden weight loss

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New Patient Instructions and Office Policies

(Please initial where indicated)

Please fill out and sign all forms before your appointment. It is preferable for us if you fax or email your completed paperwork 3 days before your appointment. You will also need to sign an arbitration agreement at your 1st appointment.

Payment by check, cash or credit card is expected at the time of service. Fees are $175 for initial visit/treatment (about 1.5 hours), $110 for follow-ups (about 1 hour – up to 75 minutes), and $155 for re-evaluations (more than 1 year since last treatment) or extended visits (80-90 minutes). We do not bill insurance companies. Many insurance policies cover acupuncture, so at your request we will issue you a super-bill. Once you submit it to your insurance company, they will reimburse you directly. There is a $25 return check fee.

We are located within Suite 115. If nobody is up front to greet you, please have a seat and someone will be with you shortly. The restrooms are in the center of the courtyard (outside of the suite). The restroom requires a code; the code is written on the bulletin board in the waiting room.

Cancellation: Your scheduled appointment is our first priority. If you need to cancel or reschedule, please notify us at least **2 days (48 hours)** in advance to avoid the cancellation fee. **A missed appointment or cancellation within 48 hours will be charged at full rate.** Initial _____

If you are feeling sick on appointment day (cold, flu, sinus infection, migraine, etc.), it is more important than ever to come in. Please don't worry about "spreading" it. We help sick people here. We take many precautions to make sure you stay in your little bubble with respect to spreading anything. If you can get into your car and drive – it is important you come in. Initial _____

Feel free to arrive 5 or 10 minutes early, have some water, use the restroom, and relax. **If you arrive late, we may not be able to extend your treatment time, as that would take away from another patient's treatment. If you arrive 20 minutes or more after your appointment time, we may not be able to see you AND you will be charged for a late cancellation.** Initial _____

Wear something very comfortable and loose fitting. **If it has been more than 4 hours since your last meal, eat a small snack prior to your treatment. (This is important to prevent dizziness or fainting)** Initial _____

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Email Policy: All questions regarding scheduling appointments, picking up herbs/supplements or general office issues should be sent to **frontdesk@creativeintegrations.net**. Any personal questions regarding your case should be emailed to gina@creativeintegrations.net. **Please note that if the email question takes Gina longer than 10 minutes to read and answer then you will be billed a pro-rated treatment amount appropriate to the amount of time spent answering your question. You may, of course, bring all questions with you to your treatment and ask Gina then if you prefer.**
Initial _____

The success of your treatments depends on a couple things:

- The healing partnership between you and your healthcare provider. You always have a choice in whether or not to follow the suggestions given to you. Understand that some of the recommendations (like dietary changes, exercises, stretching, herbs, supplements, etc.) are crucial to facilitate the healing process.

- Consistency. Exercising once does not allow for cardiovascular strength and weight loss, nor do inconsistent and infrequent workouts. Likewise, if you are inconsistent in treatment recommendations (acupuncture, herbs, diet, stretching, etc.), it will take longer to reach your goals. We give you homework often, and the more you do it, the less you will need to come in! Ultimately our goal is to give you better insight to your health so you don't need to come in as often, if at all.

Congratulations on your commitment to your health! Welcome to Creative Integrations. We look forward to serving you! If you have any questions, please ask!

I have read and agree to the above.

_____ _____
Signature Date

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the f uture treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not. I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the office medical and administrative staff may review my medical records and lab reports, but all 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, or have had read to me, this 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 condition(s) for which I seek treatment.

Patient's Name _____ Are you pregnant? _____

Patient's Signature_____ Date Signed _____

Name of Acupuncturist: Gina Zuleger

Creative Integrations Acupuncture, Herbal & Wellness Center

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____

Print Name of Patient Representative _____

Signature of Patient Representative _____ Date_____

Relationship or Authority of Patient _____

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. Please review it carefully.

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 ofit 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 partypayers. 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 your health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your PHI.

Marketing
This office will not use or disclose your PHI for marketing communications without your written authorization. This office may send birthday/thank you cards, notice of clinic events, newsletters, and/or appointment reminders.

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 April 14, 2003.

I acknowledge consent for use and disclosure of PHI and receipt of this Notice of Privacy Practices.

_____

Signature of Patient (or of patient's personal representative) Date

_____

Printed Name of Patient (or of personal representative; and relationship to patient)

OFFICE USE ONLY
I attempted to obtain the patient's signature on this HIPAA Notice of Privacy Practices, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____