



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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Dis.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Sexually Transmitted Diseases:  Gonorrhea  Syphilis  HIV  HPV  Chlamydia  Herpes

**Please indicate the use and frequency of 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)



## For Women

Age of first period (menarche) \_\_\_\_\_ Are you pregnant  yes  no # of pregnancies \_\_\_\_\_  
 # of days in cycle \_\_\_\_\_ # of live births \_\_\_\_\_ # of abortions \_\_\_\_\_ # of miscarriages \_\_\_\_\_  
 Age of last period (menopause) \_\_\_\_\_ Date of last: Gynecological exam \_\_\_\_\_ Pap Smear \_\_\_\_\_  
 Number of day of flow \_\_\_\_\_ Mammogram \_\_\_\_\_ Bone Density Scan \_\_\_\_\_  
 Color of flow \_\_\_\_\_ Results \_\_\_\_\_  
 Clots?  yes  no color \_\_\_\_\_  
 Average number of pads you use per day: 1st day \_\_\_\_ 2nd day \_\_\_\_ 3rd day \_\_\_\_ 4th day \_\_\_\_ + days \_\_\_\_\_  
**Have you ever been diagnosed with:**  Fibroids  Fibrocystic Breasts  Endometriosis  Ovarian 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 \_\_\_\_\_ nighttime \_\_\_\_\_ color of urine:  clear  murky odor: \_\_\_\_\_

**Please check all symptoms you experience:**

Prostate problems  Delayed stream  Dribbling  Retention 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 ... <hr style="border: 1px solid black;"/> ____ 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 <hr style="border: 1px solid black;"/> ____ cough ____ shortness of breath ____ decreased sense of smell ____ nasal problems ____ constipation ____ skin problems ____ feeling of claustrophobia ____ bronchitis ____ colitis or diverticulitis ____ 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 <hr style="border: 1px solid black;"/> ____ 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 ____ insomnia, difficulty sleeping ____ allergies ____ hay fever ____ dizziness ____ tendency to faint easily ____ high cholesterol levels ____ sudden weight loss
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**CREATIVE INTEGRATIONS**  
acupuncture, herbs, wellness

Creative Integrations Wellness Center  
1151 Dove Street, Suite 100  
Newport Beach, CA 92660  
959.757.0097 (o/f)

### New Patient Instructions and Office Policies

Please fill out and sign all forms before your appointment. Please fax or mail forms so they are received 3 business days before your initial appointment (when possible).

An arbitration form for you to sign will be given to you at your 1st appointment.

Payment by check, cash or credit card is expected at the time of service. Fees are \$145 for initial visit/treatment, \$95 for follow-ups, and \$145 for extended visits (85-100 minutes). Generally, we do not bill insurance companies. Many insurance policies cover acupuncture, so at your request we will issue you a superbill so you can bill your insurance for reimbursement. There is a \$25 return check fee.

We are located within Suite 100, sharing the suite with Wetzler Integrative Physical Therapy Center. Please walk into the main lobby and check in with the front desk staff. Have a seat and either the front desk staff or Gina will bring you back to the appropriate room when ready.

Your scheduled appointment is our first priority. If you need to reschedule, please notify us at least 1 business day (24 hours) in advance to avoid a service charge. A missed appointment or cancellation within 24 hours will be charged at full rate.

Please allow approximately an hour and a half for your first visit and one hour for subsequent visits. An effective, thorough acupuncture treatment is not dependent on time.

All treatments are tailored to patient needs, and as we become familiar with your health patterns, less time is sometimes needed for consult.

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. Do your best; sometimes there are roadblocks on our paths!

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!)



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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 suggestions (diet, 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.

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.

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Signature and 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 future 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 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 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.

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

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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: \_\_\_\_\_