POWERS ACUPUNCTURE CLINIC

Acupuncture & Chinese Herbal Medicine
6789 Bismark Rd. Suite 200, Colorado Springs, CO 8092 Tel: (719) 638-8187 Fax: (719) 631-0691

Patient Name _____ Age _____ Male / Female _____

Date of Birth _____/_____/_____Height _____ Weight _____ Marital Status _____ Children_____

Phone (H) (_____) _____ - _____ Phone (Cell) (_____) _____-_____

Address_____

City _____ State_____ Zip _____ Occupation_____

Referred By _____ E-mail_____

Emergency Information (Please indicate who to notify in case of emergency)

Name _____ Relationship _____ Phone (_____) _____-_____

Primary Doctor Name: _____

Chief Complaint(s) Please indicate how long you've had the condition(s).

What kinds of treatments have you received?

List any Hospitalizations & Surgeries (include Date and Place**)**

List medications being taken (include dosage)

Family History (please include the relationship)

[] Migraines _____ [] Stroke _____ [] Heart Disease _____
[] High Blood Pressure _____ [] Allergies_____ [] Mental Illness _____
[] Asthma _____ [] Gall Stones_____ [] Arthritis _____
[] Cancer_____ [] Diabetes_____ [] Thyroid Disease_____
[] Glaucoma_____ [] Epilepsy_____

Are you allergic to any of the following? If yes, please specify)

[] Medicine [] Food [] Herbs [] Others

Do you have or are you any of the following?

[] Pacemaker [] Electric Implants [] Metal Implants [] Severe Bleeding Disorders
[] Pregnant [] HIV Positive [] Hepatitis A/B/C

Life style:

[] Exercise [] Sedentary [] Eat three meals every day [] Eat at regular time every day
[] Tea [] Coffee [] Soft drink [] Alcohol [] Cigarettes [] Drug

Confidential Patient Health History

Please check if you have had (in the past three months):

General

[] Anemia
[] Fatigue
[] Fever
[] Weight Loss
[] Sweats
[] Chills
[] Drug Addiction
[] Poor Appetite
[] Localized Weakness
[] Bleed or Bruise Easily
[] Peculiar Tastes or Smells
[] Strong Thirst (hot or cold drinks)
[] Sudden Energy Drop
[] Poor Sleep Habits
[] Tremors
[] Poor Balance
[] Cravings
[] Weight Gain
[] Alcoholism
[] Tetanus Shot
[] Frequent cold/flu

Skin and Hair

[] Rashes
[] Itching
[] Dandruff
[] Change in hair/skin texture
[] Ulcerations
[] Eczema
[] Open sore
[] Acne
[] Corns
[] Warts
[] Psoriasis
[] Recent moles
[] Loss of Hair
[] Hives
[] Nail Problems
[] Dry skin

Head, Eyes, Ears, Nose and Throat

[] Dizziness/Vertigo
[] Poor Vision
[] Cataracts
[] Ringing in ears
[] Sinus Problems
[] Grinding Teeth
[] Nasal Congestion
[] Headaches
[] Concussions
[] Eye Strain
[] Night Blindness
[] Blurry Vision
[] Poor Hearing
[] Nose Bleeds
[] Hoarseness
[] Migraines
[] Eye Pain
[] Color Blindness
[] Earaches
[] Spots in front of eyes
[] Recurrent Sore Throats
[] Facial Pain

Cardiovascular

[] High Blood Pressure
[] Low Blood Pressure
[] Palpitations
[] Irregular Heartbeat
[] Mitral Stenosis
[] Mitral Prolapse
[] Myocarditis
[] Pneumatic Heart Disease
[] Chest Pain
[] Varicose Veins
[] Swelling of Hands/Feet
[] Fainting
[] Coronary Heart Disease
[] Difficulty in Breathing
[] Hardening of Arteries
[] Phlebitis
[] Blood Clots
[] Cold hands/feet

Respiratory

[] Cough
[] Bronchitis
[] Difficulty breathing lying down
[] Emphysema
[] Coughing Blood
[] Pneumonia
[] Asthma
[] Pain w/ deep breath
[] Production of Phlegm
[] Pleurisy

Gastrointestinal

[] Nausea
[] Vomiting
[] Bad Breath
[] Abdominal Pain or Cramps
[] Indigestion
[] Ulcer
[] Constipation
[] Gas
[] Blood in Stools
[] Rectal Pain
[] Chronic Laxative Use
[] Colitis
[] Diarrhea
[] Belching
[] Black Stools
[] Hemorrhoids
[] Acid Reflux

Genitourinary

[] Bed Wetting
[] Kidney Infections / Stones
[] Genital Herpes
[] Cystitis
[] Blood in Urine
[] Painful Urination
[] Venereal Disease
[] Incontinence
[] Frequent Urination
[] Bladder Infections
[] Prostate Problems

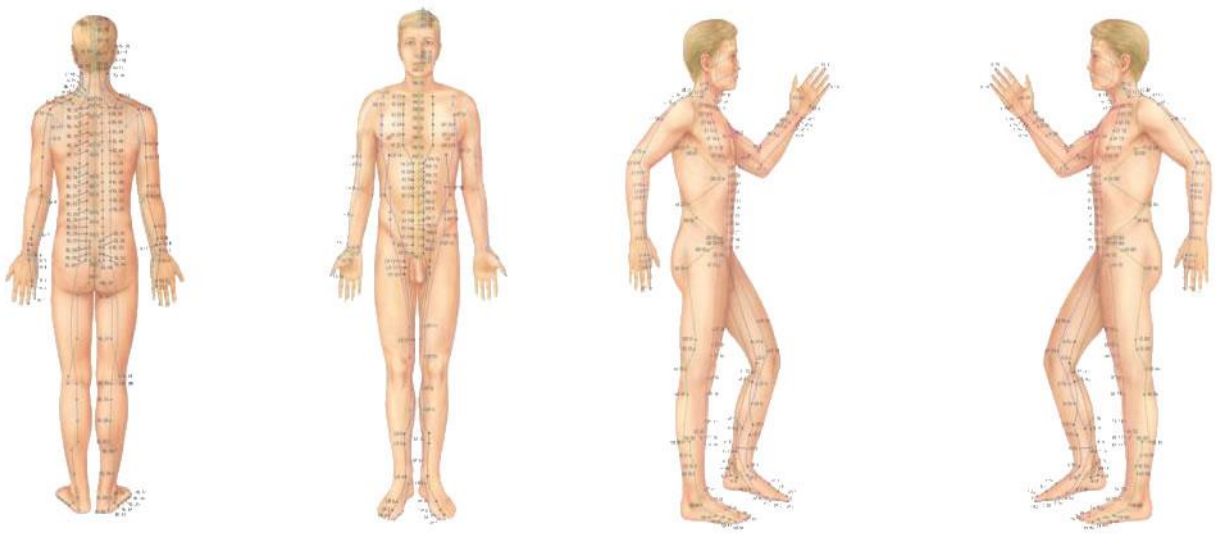
Pregnancy and Gynecology

[] Number of Pregnancies
[] Number of Abortions
[] Number of Births
[] Number of Miscarriages
[] Use of Birth Control
[] Hot Flash/Night Sweats
[] Age at 1st Menstruation
___ Time between Menstruation
___ Duration of Menstruation
___ First Date of Last Menstruation
[] Irregular Periods
[] Frequent changes in emotion
[] Unusual Character (heavy/light)
[] Vaginal Sores
[] Vaginal Discharge
[] Breast Lumps
[] Uterine Fibroids
[] Osteoporosis

Musculo-skeletal

[] Neck Pain
[] Back Pain
[] Hand/Wrist Pain
[] Muscle Pains
[] Muscle Weakness
[] Shoulder Pain
[] Knee Pain
[] Foot/Ankle Pain
[] Hip Pain

Please indicate on the figures below the areas of the body you experience your pain:
[] dull/achy [] sharp/stabbing [] burning [] tingling [] numbness [] electrical



Neuropsychological

[] Seizures
[] Areas of Numbness
[] Concussion
[] Bad Temper
[] Difficulty Concentrating
[] Dizziness
[] Lack of Coordination
[] Depression
[] Easily susceptible to stress
[] Loss of Balance
[] Poor Memory
[] Anxiety
[] ADD

Infection

[] Measles
[] Rheumatic Fever
[] Malaria
[] Small Pox
[] Mumps
[] Tuberculosis
[] Chicken Pox
[] Whopping Cough
[] Typhoid Fever
[] Scarlet Fever

Colorado Mandatory Disclosure Statement

Education and Experience

Dr. Eva Lihui Ai received a Ph.D. degree in internal medicine of Chinese Medicine from Liaoning University of TCM, in China, in 2012. Additionally Dr. Ai earned her Master of Science degree in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in 2009. This program consists of 2,850 hours of education including 560 hours of clinical internship treating the public. She was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 2009. This includes certification in Clean Needle Technique and Chinese Herbology. Eva's training includes adjunctive therapies such as moxibustion, tui na, gua sha, acupressure, cupping, auriculotherapy, shonishin, diet, and lifestyle recommendation. She is a Licensed Acupuncturist in Colorado. Her license has never been suspended or revoked. This clinic complies with the rules and regulations set forth by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single use, disposable, factory-sterilized needles are used.

Fee Schedule

Initial Consultation $50
Acupuncture Treatment..... $70
Herbal Consult only (herb cost is separate)..... $40
House-call, Hospital Visits(Minimum Charge)..... $130

Pre-pay 5 sessions package..... $325
Pre-pay 10 sessions package..... $600
(Without finishing the whole package, refund will be based on regular price $70 per treatment.)
(Pre-pay package is good for two years from the date of purchase.)

Cancellation Policy

A fee of $70 will be charged unless you provide within 24 hour notice to cancel or reschedule prior to the date of your appointment.

Patient's Rights

The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies (DORA). The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact:

Director of Registrations, Acupuncturists Licensure,
1560 Broadway, Suite 1350,
Denver, Colorado 80202
Tel: 303-894-7800.

I have read and understand all the information above.

Signature:

_____**Date:**_____

Consent to Receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from Powers Acupuncture Clinic. I understand that acupuncturists practicing in the state of Colorado are not primary care providers.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of sterile, single-use needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage/shonishin as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. This is the application of an electric current to the needles. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Cupping: I understand that I may be offered cupping, which is the application of suction using glass cups for the purpose of relieving pain, increasing energy, breaking up stagnation, and treating disease conditions. This therapy leaves bruises which may be quite dark. I need to protect the area for the next 48 hours from excessive or prolonged exposure to wind, sun, or direct spray from a shower. (A quick shower is fine.) This is because the pores are opened and may be quite sensitive. I understand that I will be asked each time this therapy is applied if I want it and that I may refuse it.

Ear Seeds: I understand that I may be offered ear seeds, which are seeds taped on an auricular acupuncture point in the ear. I understand that the ear has a minimal blood supply and that an inflammation of the outer ear is very serious. I agree if I receive ear seeds to remove them if they irritate or bother me. I agree to keep my ears clean and to remove them after the time frame discussed with my practitioner. I understand that if the outer ear becomes infected due to my negligence in removing these seeds in a timely manner, that I need to seek western medical care and am fully responsible for the charges. I understand that I may refuse this therapy.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. (If I ask for and receive a more detailed explanation, both practitioner and patient will initial next to item.) I give my permission and consent to treatment.

Signature:

_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data you maybe used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more policy, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

i. How we may use and share health data about you:
   a) Treatment – to give you medical treatment or other types of health services
   b) Payment – To bill you or a third party for payment for services provides you.
   c) Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

ii. Disclosures where we do not have to give you a chance to agree or object: a) To you
   b) As required by federal, state, or local law
   c) If child abuse or neglect is suspected
   d) Public health risks (for public health activities to prevent and control spread of disease)
   e) Lawsuits and disputes (in response to a court or administrative order)
   f) Law enforcement (to help law enforcement officials respond to criminal activities)
   g) Coroners, medical examiners and funeral directories
   h) Organ or tissue donation facilities if you are an organ donor
   i) To avert a threat to an individual or to public health safety

iii. Disclosures where we have to give you a chance to agree or object:
   a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories
   b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

iv. Other use of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

v. You have the following rights relating to the health data we keep about you.
   a) Right to inspect your health record and to receive a copy of your health record upon request
   b) Right to amend information in your health record you believe is inaccurate or incomplete
   c) Right to know to whom we have disclosed your health information
   d) Right to ask for limits on the health information data we give out about you
   e) Right to receive communication from us about your health information in alternate ways
   f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of Patient or Representative **Date**

Print Patient Name **Patient Birth Date**