LOUISVILLE COMMUNITY ACUPUNCTURE

919 Barret Ave 40204 – 502.589.6860

Welcome to Louisville Community Acupuncture!

About Community Acupuncture

Our setting emphasizes community, rather than individuality and to do this we treat everyone in a big room full of recliners. This is not traditional for acupuncture in America, but group settings have many benefits. Our space will achieve a collective need for healing whether it is for back pain or stress. No one needs to disrobe as we mainly use points on your arms and legs.

Louisville Community Acupuncture (LCA) is one of many community acupuncture clinics established in the country who are members of the People's Organization of Community Acupuncture (POCA). POCA is a multi-stakeholder cooperative whose mission is to make acupuncture affordable and accessible, while promoting a sustainable business model that works for patients and practitioners. To be a part of an even bigger community, learn more about the cooperative and to find POCA member clinics near your friends and family, visit www.pocacoop.com. Collectively, POCA clinics provide over 850,000 acupuncture treatments annually!

There are plenty of theories that circulate about acupuncture but all we can say is they are still being investigated. We have a strong view that people should be able to try it and allow themselves to use it to improve their health. Our goal is to provide a setting where most people can afford a series of treatments in order to get good results from our treatment plans.

This style allows you to be very flexible with time. Most treatments will end on their own between 30 and 45 minutes, but sometimes it's shorter and sometimes longer. If you know you'd like to be out by a certain time, just let us know beforehand what time you'd like to leave by. If your schedule is freer, just give us a meaningful look when you're ready as we make our way through the group room.

General Acupuncture Treatment Tips

- Turn those cell phones off while in the clinic.
- Anticipate being here from 60-90 minutes. We do our best to stay on schedule but with so many moving parts, things can get off slightly from time to time.
- Avoid wearing scented products as we are in a group room.
- Don't come starving.
- Wear clothing that can let the acupuncturists get to your elbows and knees
- Be considerate of the group space.
- We have music on, but feel free to bring your own headphones. Or earplugs (sometimes there's a snore)

Our Sliding Scale Philosophy

The purpose of the sliding scale ($15 - $35 per visit and a $10 new patient paperwork fee) is to make sure you are receiving affordable care enough to get good results. We do not ask for proof of income. The way we make acupuncture affordable and still make a living ourselves is to see multiple patients per hour. So take all the factors into consideration when picking what you pay: current income situation, recommended treatment plan, etc. Because of the sliding scale, we cannot do insurance billing but if you have insurance, we will be happy to give you a payment receipt that you can submit.

Please bring a friend and spread the word of health and community. By supporting this clinic, you are participating in making the benefits of acupuncture accessible to more people.

We are happy you are here!!!

LCA Staff

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Patient Registration and Health History

Patient Information	**Contact Information**
Today's Date ____ / _____ / _____ Name:_____ Address:_____ City, State, Zip_____ Age: _____ Date of Birth _____ / _____ / _____ Height: _____ Weight: _____ Gender: _____ Relationship Status: Live w/other(s) Live alone Single Married Separated Divorced Widowed Occupation:_____ Employer:_____	Home Phone: _____ Work Phone:_____ Cell Phone: _____ Email: _____ In case of emergency notify: _____ Relation: _____ Phone:_____ Patient's Representative:_____ (if under 18 or otherwise requiring guardianship) Relation:

Who is your doctor or other primary care provider? _____

Have you tried acupuncture before? Yes No How did you find us _____

YOUR HEALTH CONCERNS: WHY ARE YOU COMING FOR TREATMENT? DOES ANYTHING MAKE THIS CONDITION BETTER OR WORSE?

List any hospitalizations, surgeries, major injuries, or trauma: What and when?

CURRENT MEDICATIONS AND SUPPLEMENTS:

FAMILY HISTORY: INDICATE ANY RELATIVES AFFECTED BY THE FOLLOWING:

Epilepsy/Seizures	HIV+	Bronchitis	Addiction
Anemia	Hepatitis A/B/C	Tuberculosis	Other_____
Bleeding or hemorrhage	Thyroid disorder	Chicken Pox	
Heart disease	Asthma	Cancer	
Diabetes	Pneumonia	Emotional imbalance	

YOUR HISTORY: DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Epilepsy/Seizures	HIV+	Bronchitis	Addiction
Anemia	Hepatitis A/B/C	Tuberculosis	Other_____
Bleeding or hemorrhage	Thyroid disorder	Chicken Pox	
Heart disease	Asthma	Cancer	
Diabetes	Pneumonia	Emotional imbalance	

PATIENT PROFILE: Please check any that apply to you

LIFESTYLE:

- ☐ EXERCISE REGULARLY
- ☐ EAT MUCH FRIED FOODS
- ☐ EAT MUCH MEAT
- ☐ EAT A LOT OF SWEETS
- ☐ VEGETARIAN
- ☐ DRINK ALCOHOL
- ☐ DRINK COFFEE
- ☐ SMOKE CIGARETTES
- ☐ USE DRUGS

GASTRO-INTESTINAL:

- ☐ EXCESSIVE APPETITE
- ☐ LOW APPETITE
- ☐ FATIGUED AFTER MEALS
- ☐ HYPOGLYCEMIA
- ☐ INDIGESTION / REFLUX / HEARTBURN
- ☐ NAUSEA / VOMITING
- ☐ GAS / BLOATING
- ☐ ABDOMINAL PAIN / STOMACH ACHE
- ☐ STOMACH ULCER
- ☐ GALLSTONES
- ☐ EATING DISORDER
- ☐ LESS THAN 1 BM A DAY / CONSTIPATION
- ☐ DIARRHEA / LOOSE STOOL
- ☐ HEMORRHOIDS
- ☐ BLOOD IN STOOL
- ☐ IBS

GENITO-URINARY:

- ☐ FREQUENT URINATION
- ☐ POOR BLADDER CONTROL
- ☐ BURNING / PAIN ON URINATION
- ☐ DARK URINE
- ☐ CLOUDY URINE
- ☐ FREQUENT URINARY TRACT INFECTION
- ☐ KIDNEY STONES

CARDIO-VASCULAR:

- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ PALPITATIONS / IRREGULAR HEARTBEAT

TEMPERATURE / PERSPIRATION:

- ☐ HOT / COLD BODY SENSATION OVERALL
- ☐ AVERSION TO HEAT OR COLD
- ☐ COLD HANDS / FEET
- ☐ HOT FLASHES
- ☐ NIGHT SWEATS
- ☐ SPONTANEOUS SWEATING
- ☐ SWEATY PALMS / FEET

SKIN:

- ☐ RASH / ITCHING / HIVES
- ☐ ACNE / BOILS
- ☐ HAIR FALLING OUT
- ☐ WEAK / BRITTLE NAILS
- ☐ SLOW WOUND HEALING

HEAD/EARS/EYES/NOSE/THROAT:

- ☐ HEADACHES / MIGRAINES
- ☐ JAW PAIN / TMJ

- ☐ IMPAIRED HEARING / HEARING LOSS
- ☐ RINGING IN EARS
- ☐ DIZZINESS
- ☐ EARACHE

- ☐ SPOTS IN FRONT OF EYES
- ☐ POOR NIGHT VISION
- ☐ TEARING OR DRYNESS
- ☐ RED / INFLAMED / ITCHY EYES

- ☐ SINUS PROBLEMS
- ☐ NOSE BLEEDS
- ☐ LOSS OF SMELL

- ☐ MOUTH ULCERS / SORES ON TONGUE
- ☐ BAD BREATH
- ☐ BLEEDING GUMS
- ☐ RECURRENT SORE THROAT

RESPIRATORY:

- ☐ FREQUENT COLDS/SINUS INFECTIONS
- ☐ CHRONIC ALLERGIES
- ☐ ENVIRONMENTAL SENSITIVITY

SLEEP:

- ☐ LESS THAN 6-8 HOURS PER NIGHT
- ☐ NOT RESTED UPON WAKING
- ☐ DIFFICULTY FALLING / STAYING ASLEEP
- ☐ INSOMNIA

EMOTIONAL/PSYCHOLOGICAL:

- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ MOOD SWINGS
- ☐ IRRITABILITY
- ☐ DIFFICULTY CONCENTRATING
- ☐ WORRY
- ☐ FEEL SAD A LOT
- ☐ CRY UNCONTROLLABLY
- ☐ MUCH FEAR / TERRORS
- ☐ HISTORY OF ABUSE
- ☐ CONSIDERED OR ATTEMPTED SUICIDE

GYNECOLOGICAL:

- ☐ MAY BE PREGNANT
- ☐ PMS
- ☐ PAINFUL PERIODS
- ☐ HEAVY PERIODS
- ☐ CLOTS WITH PERIOD
- ☐ IRREGULAR CYCLE
- ☐ BLEEDING BETWEEN PERIODS
- ☐ PARTIAL / TOTAL HYSTERECTOMY
- ☐ CHRONIC VAGINAL INFECTIONS
- ☐ ABNORMAL PAP
- ☐ ENDOMETRIOSIS
- ☐ OVARIAN CYSTS
- ☐ UTERINE FIBROIDS

PERIOD LASTS _____ DAYS

_____ DAYS BETWEEN PERIOD

AGE AT MENOPAUSE _____

NUMBER OF:

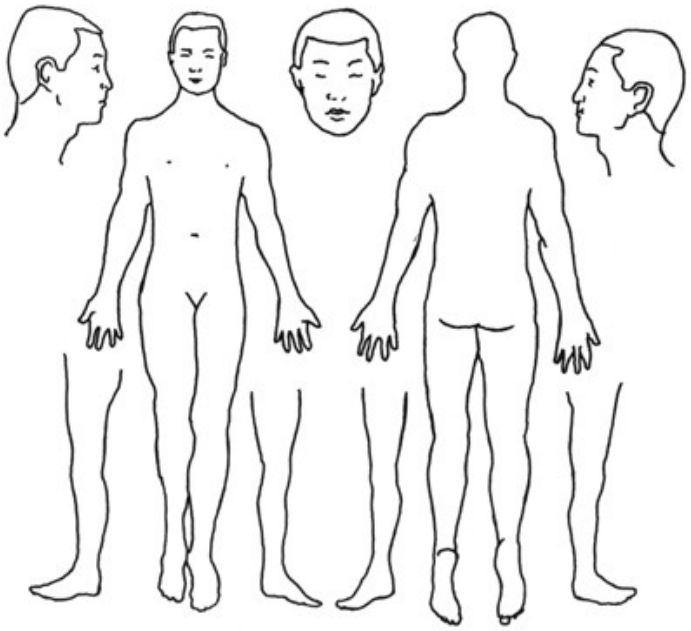
PREGNANCIES _____

ABORTIONS _____

MISCARRIAGES _____

BIRTHS: _____VAGINAL_____ CESAREAN

Indicate painful or distress areas:



Are there any other issues you want to discuss with us?

Please circle any of the following conditions you have or suspect you might have

- Hypertension and cardiac conditions
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss/gain in excess of 15% your body weight in less than a 3 month period
- Suspected fracture or dislocation
- Suspected systemic infection(s)
- Suspected hemorrhagic disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Diabetes

Are you currently under the care of a physician for this or any of these conditions?

If YES, please list the name and contact information of the treating physician

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality, for the above conditions

Signature: _____

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INFORMED CONSENT TO TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, bodywork, and nutritional counseling.

I am hereby informed that the aforementioned treatment methods are all generally safe but that there may be some side effects or risks, as follows

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Highly unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although Louisville Community Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment.

Potential risks of moxibustion include blistering, burns, and scarring. Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days. Cupping can also cause blistering of the skin in some instances.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. My health information will be handled in accordance with the Summary of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; payment and healthcare operations received, incurred or carried out at this practice.

Signature **Date**

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SUMMARY OF PRIVACY PRACTICES

We don't do anything with your health data without your written consent.

We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if want to read the complete details.

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 provided to 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 directors
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 uses 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 read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from Louisville Community Acupuncture at any time.

Signature **Date**