LOUISVILLE COMMUNITY ACUPUNCTURE

909 Barret Ave 40204 – 502.589.6860

Welcome to Louisville Community Acupuncture!

We have been providing safe, affordable acupuncture for the Louisville area since 2014. We primarily treat in a group setting for at least a few reasons. It allows us to see more people easily and make acupuncture more affordable. The group setting also encourages your engagement in a collective space for healing. Covid made this latter variable extremely difficult for our business model in 2020, but we are pushing through, and we want to reassert the value of healing together.

Our initial influence for community acupuncture developed out of working at and visiting other community acupuncture clinics and much of the model employed there was crafted by the Community Acupuncture Network (CAN) which later evolved into the People's Organization of Community Acupuncture (POCA). We loved their aims of making acupuncture more accessible and affordable to the communities they operated in and it is a goal we constantly strive for.

We charge on a sliding scale of $20-$40 per treatment in the community room. You pick what you pay on the scale, which might sound confusing but shouldn't be. There is no need to prove your income or financial situation. Allow it to provide you with some flexibility and maintain treatment plans. Acupuncture often takes more than one visit. We have some private room treatments available at a flat fee of $45 on certain days (please see the schedule). All new clients have an initial paperwork/consultation fee of $10 on their first visit.

General Acupuncture Treatment Tips and Clinic Awareness (please initial)

____ Wear a mask while in the building—we have some available if you did not bring one

____ Turn those cell phones off while in the clinic

____ Anticipate being here for 45-75 minutes

____ Avoid wearing scented products as many people come into our space through the day

____ Don’t come starving

____ Wear clothing that can let the acupuncturists get to your elbows and knees

____ **Be considerate of the space. It is for everyone who enters, not just one person**

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 ____ / _____ / _____	Home Phone: ___________________________________
Name:____	Work Phone:____________________________________
Address:______________________________________	Cell Phone: ____________________________________
City, State, Zip__________________________________	Email: ____
Age: ______ Date of Birth _____ / _____ / ________	In case of emergency notify:
Height: ________ Weight: ______________________	____
Gender: ____________	Relation: _____________ Phone:_________________
Relationship Status: Live w/other(s) Live alone	
Single Married Separated Divorced Widowed	
Occupation:___________________________________	Patient's Representative:_____________________________
Employer:_____________________________________	(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:

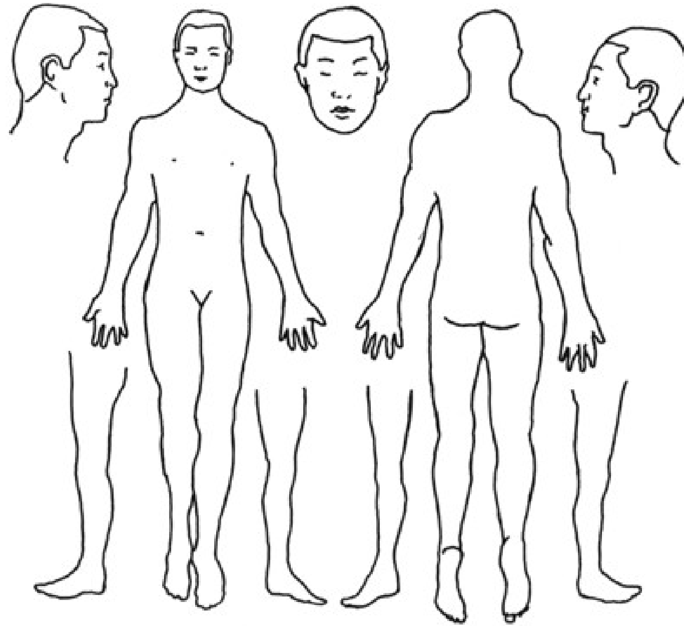
PREGNANCIES ______

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**

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CONSENT FOR EMAIL CONTACT

Risks of using email

Transmitting patient information poses several risks of which you should be aware. You should not agree to communicate via e-mail without understanding and accepting these risks. The risks include, but are not limited to, the following:

1. The privacy and security of e-mail communication cannot be guaranteed.
2. Employers and online services may have a legal right to inspect and keep e-mails that pass through their system.
3. Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
4. Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
5. Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of Louisville Community Acupuncture or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
6. Email may be permanent. Even after the sender and recipient have deleted their copies of the email,back-up copies may exist on a computer or in cyberspace.
7. Use of email to discuss sensitive information can increase the risk of such information being disclosed to others.
8. Email can be used as evidence in court.

Although we will endeavor to read and respond promptly to your email, we cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, **you should not use email for medical emergencies or other time-sensitive matters**.

Emails about medical issues may be made part of your medical record and may be seen by staff with authorized access. **Email communication is not an appropriate substitute for clinical assessments.** You are responsible for following up on emails and for scheduling appointments when warranted. If your email requires or invites a response and you have not received a response within a reasonable time period it is your responsibility to follow up on this.

I, ____, **consent** to making contact with authorized employees of Louisville Community Acupuncture for the purposes of communicating personal health information (PHI) via e-mail.

or

I, ____, **decline** the use of e-mail communication with authorized employees of Louisville Community Acupuncture for the purposes of communicating personal health information (PHI) via e-mail.

____ ____________

Signature Date

____

Preferred e-mail address (if applicable)

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No Show/Late Cancelation Policy

(please initial)

________ I am aware that scheduling an appointment restricts the availability of appointments for other clients

________ I am aware that appointments canceled with less than 24 hours notice are subject to a “Late Cancellation” fee of

- $20 for community room treatments
- $30 for private room treatments

________ I am aware that appointments I schedule and do not show up for are subject to a “No Show” fee of

- $20 for community room treatments
- $30 for private room treatments

________ I am aware that I may not be permitted to schedule follow-up appointments if I do not settle existing No Show/Late Cancelation fees

____
Patient Name (printed)

____
Patient Signature   Date