Center for The Healing Arts
Kim Perrone, L.Ac, RPh
Jessica Correa, Dip. O.M, L.Ac
Cassandra Romo, L.Ac
312 W Leuda St

Patient Information

Patient Name: _____

Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Phone Number: _____

Marital Status: _____ Sex: _____

Occupation: _____

Drug Allergies: _____

Referred by: _____

Primary Concern for Appointment: _____

Emergency Contact Information:

Name: _____

Relation to patient: _____

Phone number: _____

Additional contact person and phone number: _____

Financial Policy

Fees for all services and products are due at the time of service. I understand that insurance is not accepted at this office.
Payments may be made in the form of cash, check, or credit card.

Appointments

As a courtesy to other patients, please be on time for your scheduled appointment. Should you need to cancel or reschedule, please give 24 hours notice to avoid a $50.00 cancellation fee.

I have read the above statement and I agree to all terms and conditions.

Signature Date

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Informed Consent to Treatment

I consent to acupuncture and other procedures associated with Traditional Chinese medicine by Kim Perrone, Cody Klein, and Jessica Correa. I understand that methods of treatment may include, but are not limited to, acupuncture, 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 it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, dizziness, or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture may include spontaneous miscarriage, nerve damage, organ puncture, or lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, single-use needles and maintains a clean 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 (white are from plant, animal, and mineral 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/or tingling of the tongue. I will notify the clinic if I am or become pregnant. I do not expect Kim Perrone, Cody Klein, or Jessica Correa to be able to anticipate and explain all possible risks and complications of treatment. And, I wish to rely on her/him to exercise judgment using the course of treatment that they believe at the time and based upon the facts then known, is in my best interest. I understand the clinical and administrative staff may review my medical records and lab reports, but my records will be kept confidential and will not be released without my written consent. I acknowledge and specifically state that I understand that treatment with acupuncture (like treatment by other health services) cannot and does not guarantee specific results or cures. By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, and have been told about the risks for acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent to cover the entire course of treatment of my present condition(s) for which I seek treatment.

Print Name Date

Signature (parent if patient is a minor) Date

Practitioner or Staff Member Date

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COVID-19 Informed Consent

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic.

Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (check all the boxes)

- ❏ I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. *
- ❏ I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. *
- ❏ I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office. *
- ❏ I confirm I am not experiencing any of the following symptoms of COVID-19: Fever, Shortness of Breath, Dry Cough, Runny Nose, Sore Throat, Loss of Taste or Smell *
- ❏ I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. *

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Signature Date

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Appointment Cancellation and Reschedule Policy

As a courtesy to our staff and other patients, please be on time for your scheduled appointment. Should you need to cancel or reschedule, we request that you kindly give our office 24 hours notice. Please note, we are closed Saturday and Sunday. We understand emergencies happen, all messages received after hours of operation are time stamped with date and time received. Failure to show up for an appointment without proper notice will incur fees equal to appointment cost. A late appointment reschedule will result in a $50 charge. All charges must be paid in full before additional appointments can be scheduled.

I have read the above statement and I agree to the terms and conditions of this policy. I authorize the Center for The Healing Arts to process payments to my credit/debit card held on my secure client account in the event a missed appointment occurs.

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HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that my health care information at Center for The Healing Arts will be kept private and will not be discussed without my permission. Use and disclosure of my protected health information may be provided to a physician or other healthcare provider providing treatment to if authorized in writing. I understand that my protected health information may be used or disclosed if required by law.

I understand that staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and if I am not available, a message will be left on my voicemail. I am fully aware my cell phone is not a secure and private line.

By signing this form, I am giving the Center for The Healing Arts authorization to contact me by phone, email, or postal mail. I acknowledge that all information discussed during the assessment and treatment at Center for The Healing Arts will be held confidential except in the instance where my safety or the safety of others may be at risk

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Signature Date

Authorization for Release of Health Information (Optional)

I , _____

hereby authorize the Center for The Healing Arts the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information:

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(Pursuant to the requirement of section 183.6 (e) of this title and section 6.11, Subsection (d) V.A.C.S. article 4495b, governing the practice of acupuncture) I (patient name), _____ am notifying Center for The Healing Arts of the following:

I have or have not been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician should evaluate me for the condition being treated by the acupuncturist.

Signature Date

I have or have not received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Signature Date

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for one of the following conditions:

___ Chronic Pain
___ Weight Loss
___ Smoking Cessation
___ Alcoholism
___ Substance Abuse

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Primary reason for today's visit:

_____

_____

Is this an emergency?
YES NO
Date of illness or injury related to today's visit: _____

Is this a job related accident or injury?
YES NO
Have you had similar symptoms before?
YES NO
How long have you had this condition?
_____
Has your condition gotten progressively worse?
YES NO

Does this condition bother you when you :

WORK SLEEP OTHER: _____

What seems to make this condition better?

_____

What seems to make this condition worse?

_____

Are you currently under the care of a doctor?
YES NO
If yes, please provide your doctor's name and phone number:

_____

_____

Past Medical History
Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- ❑ AIDS/HIVDiabetes
- ❑ Multiple Sclerosis
- ❑ Thyroid Disorders
- ❑ Alcoholism
- ❑ Emphysema
- ❑ Mumps
- ❑ Tuberculosis
- ❑ Allergies
- ❑ Epilepsy
- ❑ Pacemaker
- ❑ Typhoid Fever
- ❑ Appendicitis
- ❑ Goiter
- ❑ Pleurisy
- ❑ Ulcers
- ❑ Arteriosclerosis
- ❑ Gout
- ❑ Pneumonia
- ❑ Venereal Disease
- ❑ Asthma
- ❑ Heart Disease
- ❑ Polio
- ❑ Whooping Cough
- ❑ Birth Trauma (your own birth)
- ❑ Hepatitis
- ❑ Rheumatic Fever
- ❑ Herpes
- ❑ Scarlet Fever
- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Seizures
- ❑ Chicken Pox
- ❑ Measles
- ❑ Stroke
- ❑ Other: _____ _____

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List medications you are currently taking;
(Name of medications, strength, how many per day, and for how long)

_____

_____

List substances or medications you are allergic to:

_____

List any major surgeries you have had:
(Date and reason for surgery)

_____

_____

List significant trauma you have had (auto accident, falls, etc.):

_____

List significant family history:

_____

_____

Your Diet

Appetite : low high Coffee: ____ Sugar: ____ Thirst for water: ____
Avg. oz of water daily: _____ Soft drinks: ____ Salty food: _____

Vitamins taken in the past two months: _____

Your Lifestyle

Alcohol _____ Drugs _____ Tobacco _____ Marijuana _____

Stress Type: _____

Occupational Hazards Type: _____

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General Symptoms

- ❑ Poor appetite
- ❑ Poor sleep
- ❑ Heavy appetite
- ❑ Healthy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Sweats easily
- ❑ Poor circulation
- ❑ Muscle cramps
- ❑ Strongly like cold drinks
- ❑ Shortness of breath
- ❑ Vertigo or dizziness
- ❑ Strongly like hot drinks
- ❑ Fever
- ❑ Bleed or bruise easily
- ❑ Recent weight loss
- ❑ Chills
- ❑ Recent weight gain
- ❑ Night sweats
- ❑ Peculiar taste: describe below _____ _____

Head, Eyes, Ears, Nose, and Throat

- ❑ Glasses
- ❑ Glaucoma
- ❑ Excessive Saliva
- ❑ Nose bleeds
- ❑ Eye strain
- ❑ Cataracts
- ❑ Sinus problems
- ❑ Poor vision
- ❑ Swollen glands
- ❑ Concussions
- ❑ Blurred vision
- ❑ Sores on lips or tongue
- ❑ Lumps in throat
- ❑ Ringing in ears
- ❑ Eye pain
- ❑ Teeth problems
- ❑ Excessive phlegm
- ❑ Poor hearing Itchy eyes
- ❑ TMJ
- ❑ Gum Problems
- ❑ Night blindness
- ❑ Dry Mouth
- ❑ Enlarged thyroid
- ❑ Red eyes
- ❑ Grind teeth
- ❑ Headaches
- ❑ Spots in eyes
- ❑ Facial pain
- ❑ Recurrent sore throat
- ❑ Migraines
- ❑ Earaches
- ❑ Color of phlegm
- ❑ _____
- ❑ Other neck issues
- ❑ _____

Cardiovascular

- ❑ High blood pressure
- ❑ Fainting
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Blood clots
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Bad breath
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Acid regurgitation
- ❑ Constipation
- ❑ Gas
- ❑ Laxative use
- ❑ Mucous stools
- ❑ Bloating
- ❑ Hiccups
- ❑ Black stools
- ❑ Intestinal pain or cramping bowel movements
- ❑ Anal fissures
- ❑ Itch anus and frequency: _____
- ❑ Burning anus: _____
- ❑ Rectal pain/ odor: _____
- ❑ Hemorrhoids Texture/form: _____

Musculoskeletal

- ❑ Neck/shoulder painLower back pain
- ❑ Muscle pain
- ❑ Joint pain
- ❑ Upper back pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use
- ❑ Other: _____

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Skin and Hair

- ❑ Rashes
- ❑ Psoriasis
- ❑ Hives
- ❑ Acne
- ❑ Ulceration
- ❑ Dandruff
- ❑ Eczema
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infection
- ❑ Other: _____
- ❑

Respiratory

- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Asthma;wheezing
- ❑
- ❑ Cough
- ❑ Coughing blood
- ❑ Tight chest
- ❑ Difficulty breathing when lying down

Neuropsychological

- ❑ Seizures
- ❑ Depression
- ❑ Numbness
- ❑ Anxiety
- ❑ Tics
- ❑ Irritability
- ❑ Poor Memory
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/ attempted suicide
- ❑ Seeing therapist
- ❑ Other: _____

Genitourinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Incomplete urination
- ❑ Urgent urination
- ❑ Venereal disease
- ❑ Blood in urine
- ❑ Bedwetting
- ❑ Incontinet
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stones
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Other: _____

Gynecological

- ❑ Age menses began: _____
- ❑ Painful period
- ❑ Vaginal odor
- ❑ Vaginal sores
- ❑ Irregular periods
- ❑ Clots
- ❑ PMS
- ❑ Breast lumps
- ❑ Date of last PAP: _____
- ❑ Date last period began: _____
- ❑ Age at menopause: _____
- ❑ Vaginal discharge, color: _____
- ❑ # of pregnancies: _____
- ❑ # of live births: _____
- ❑ # of premature births: _____

Are there any other health concerns we have not addressed that you would like to add?

_____

_____