Heather Conners
Acupuncture PLLC

Patient Information

Last Name:	First Name (Legal):	MI:
Preferred Name:	Date of Birth:	Today's Date:
Street Address:	City/State:	Zip Code:
Phone Number:	Email:	
Occupation:	How did you hear about us?	

Emergency Contact

Who could we contact in the case of an emergency?	
Their relationship to you:	Their phone number:
Please list any known allergies:	

Communication Consent

Preferred method(s) of communication: ☐ Text ☐ Call ☐ Email	Would you like to receive appointment reminders? ☐ Text ☐ Email

With my signature below, I give **Heather Conners Acupuncture PLLC** permission to contact me via my selected method(s) above for the purpose of appointment reminders, scheduling changes, or general communication regarding my care. I understand that text and email correspondence are not guaranteed to be **HIPAA Privacy Rule**–compliant, and I accept the risks associated with these methods if selected.

Patient Signature:	Date:
Responsible Party Signature (if different to patient):	Date:

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General Information

Please fill out the questions below as thoroughly as you can.

What are you looking for help with?
When did it begin? Does anything make it better or worse?
Are you currently under the care of any other healthcare providers? (MD, therapists, specialists, etc.)
Please list all medications or supplements you are currently taking, including dosages and what each is for.
Is there anything you'd like me to know that you feel may be affecting your quality of life right now?

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Health History Questionnaire

Please check all conditions that reflect your past or present health.
Use line provided to add additional details.

Cardiovascular

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack _____
- ☐ Stroke _____
- ☐ Irregular Heartbeat/Palpitations

Respiratory

- ☐ Asthma
- ☐ Shortness of breath
- ☐ COPD/Emphysema _____
- ☐ Chronic Cough _____

Digestive

- ☐ Acid Reflux/GERD
- ☐ Gas/Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's/Colitis _____
- ☐ Other _____

Neurological

- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness/Vertigo
- ☐ Tremors _____
- ☐ Seizures _____
- ☐ Numbness/Tingling _____

Mental/Emotional

- ☐ Anxiety/Panic Attacks
- ☐ Depression
- ☐ Major Loss
- ☐ Disordered Eating
- ☐ History of Trauma/PTSD/CPTSD
- ☐ Addiction/Substance Abuse
- ☐ Suicidal Ideation/Self Harm
- ☐ Hallucinations/Delusions/Paranoia

Metabolic/Endocrine

- ☐ Hyperthyroidism/Graves'
- ☐ Hypothyroidism/Hashimoto's
- ☐ Diabetes (Type 1/Type 2) _____
- ☐ Other _____

Immune/Autoimmune

- ☐ Frequent Colds/Infections
- ☐ Food Allergies/Sensitivities
- ☐ Lupus
- ☐ Rheumatoid/Psoriatic Arthritis
- ☐ Multiple Sclerosis
- ☐ Other _____

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Health History Questionnaire

Reproductive

- ☐ Painful Periods
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ Endometriosis
- ☐ Ovarian Cysts/PCOS
- ☐ Low Libido
- ☐ Fertility Issues/Trouble Conceiving _____
- ☐ PMS/PMDD _____
- ☐ Pregnancy Loss _____
- ☐ Menopause _____
- ☐ Erectile Dysfunction _____
- ☐ Impotence _____

Musculoskeletal

- ☐ Joint Pain/Arthritis _____
- ☐ Muscle Pain/Tension _____
- ☐ Injuries/Fractures _____
- ☐ Generalized Pain (Where, When, Quality)_____

Sleep

- ☐ Difficulty Falling Asleep
- ☐ Frequent Waking
- ☐ Snoring/Sleep Apnea
- ☐ Nightmares/Vivid Dreams
- ☐ Night Sweats
- ☐ Daytime Sleepiness/Fatigue

Rate the following from 0-10:

Energy: 0 1 2 3 4 5 6 7 8 9 10

Stress: 0 1 2 3 4 5 6 7 8 9 10

Additional Information

- ☐ Ear/Hearing Issues _____
- ☐ Eye/Vision Issues _____
- ☐ Kidney Issues/Stones _____
- ☐ Bladder Issues _____
- ☐ Sweating Issues _____
- ☐ Swelling/Edema _____
- ☐ Eczema/Psoriasis _____
- ☐ Acne/Boils _____

History of Cancer (Type, Year, Treatment) _____

_____

Major Surgeries (What, Year, Reason) _____

_____

Other Medical Diagnoses/Health History (physical & mental) _____

_____

_____

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Informed Consent to Treat

This document is meant to support you in making informed choices about your healthcare. It outlines the treatments you may receive, their potential risks, care recommendations, as well as your responsibilities as the patient. Your signature below indicates that you both understand and agree with the following statements, and that you consent to receive acupuncture and related therapies on yourself - or the patient named below for whom you are legally responsible - from **Heather Conners, Licensed Acupuncturist** "the practitioner."

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, manual massage, herbal or supplement recommendations, and nutritional or lifestyle counseling.

I have been informed that acupuncture is considered a generally safe method of treatment, but some side effects may include: minor bruising, temporary numbness or tingling near a needling site, minor bleeding, and dizziness/fainting. Burns and/or scars are a potential risk of moxibustion. Temporary bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I do not expect the practitioner to anticipate and explain all possible risks and complications of treatment, but I wish to rely on her to exercise judgment during the course of treatment which she believes at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that I must inform, and continue to fully inform, the practitioner of any medical history and medications and/or supplements being taken currently. **I agree to notify the practitioner if I am pregnant or become pregnant at any point during the course of treatment.**

I recognize that acupuncture is not a substitute for medical diagnosis or treatment by a physician. It is expected that patients maintain care with a primary doctor or medical specialist, that pregnant patients are under the guidance of an appropriate healthcare provider, and that patients seeking adjunctive cancer care remain under the care of an oncologist.

By signing below, I confirm that I have read (or have had read to me) this consent to treatment. I have been informed of the risks of acupuncture and related procedures, have had the opportunity to ask questions, and understand that I may stop treatment at any time. I intend this consent to cover the full course of my present condition, as well as any future conditions for which I may seek treatment.

Last Name:	First Name (Legal):	Date of Birth:
Patient Signature:		Date:
Responsible Party Signature (if different to patient):		Date:

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Policies & Privacy Notice

Payment & Cancellation Policy

Payment is due at the end of your appointment. Preferred payment methods are cash, check, or Venmo. "Tap to Pay" compatible devices are also accepted (Apple Pay, chipped card, etc). We do not bill insurance directly, but we're happy to provide an emailed receipt for you to submit to your insurance for possible reimbursement.

Your appointment is reserved especially for you. To encourage keeping appointment times, we have a **24-hour cancellation policy.** Appointments canceled with less than 24-hours' notice, or missed entirely, will be **charged a $50 fee** to the card used to book, or added to your balance at your next appointment. Exceptions are considered for situations beyond your control.

Notice of Privacy Practices

Heather Conners Acupuncture PLLC is committed to protecting the privacy of your protected health information (PHI). Your PHI includes information on your health conditions and care, as well as any information that could be used to identify you. This Notice describes how we may use and disclose your PHI, your rights, and our legal obligations with respect to your medical information.

How your health information may be used:

- Treatment:
  - Coordinating with another healthcare provider in response to a health or safety concern.
  - In the event of a medical emergency.
  - Collaborating with another provider when deemed in the best interest of your care.
  - Making an appropriate referral.
- Public Health and Safety:
  - Reporting a threat of exposure to or spread of communicable disease.
  - Reporting child, elder, or dependent adult abuse or neglect.
  - Reporting reactions to medications or problems with products.
  - Reporting certain bodily injuries that may implicate a crime.
- Required by Law or Government Oversight:
  - Responding to a valid court order, subpoena, or other legal process.
  - Carrying out audits, inspections, compliance reviews, or licensing activities required to oversee this practice.
  - Responding to certain law enforcement or other government requests when disclosure is required by law.

Your health information will not be shared or disclosed beyond the scenarios described in this Notice. Any other disclosure will require written permission from you or your legally responsible party. In the event of a breach that may have compromised the privacy or security of your health information, you will be notified promptly.

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Policies & Privacy Notice

Your rights regarding your health information:

- Right to Inspect and Obtain Copies of Your Health Information:
  - You may put in a written request to review and/or obtain a copy of your medical record. You may be charged a reasonable fee to duplicate and assemble your copy.
- Right to Know Who Has Received Your Health Information:
  - You may put in a written request to receive a list of certain disclosures made of your health information. You have the right to ask for a description of how and where your health information was used for any reason other than for treatment, payment, or health operations.
- Right to Request Restrictions:
  - You have the right to ask us to limit the information we share. We are not required to agree to your request, and may refuse your request if it interferes with the law or we feel it will effect your care. We will make every effort to honor your request.
- Right to Confidential Communication:
  - You may request changes in how or where we can contact you. We are not required to agree to your request, but we will make every effort to honor reasonable requests.
- Right to Request a Change of your Health Information:
  - You may put in a written request to change or make an addition to your health information. While information from your record cannot be erased, you have the right to ask that we update or modify your records if you believe your record to be incorrect or incomplete. Please know that we are not required to agree to the amendment, and may deny your request. You will be provided a written explanation if your request is denied.
- Right to File a Complaint:
  - If you feel your privacy rights have been violated, you have the right to file a complaint. We cannot retaliate against you for making a claim. You may direct your compliant to Heather Conners Acupuncture PLLC, or to the Department of Health and Human Services (HHS).
- Right to Policy Access:
  - If the terms of this Notice change, you will be provided with a revised Notice of Privacy Practices. You may request a copy of this Notice at any time.

By signing below, I acknowledge that I have received and reviewed the Policies & Privacy Notice of **Heather Conners Acupuncture PLLC**. I understand the payment and cancellation terms, and I have been informed of my rights regarding my health information, and how it may be used or disclosed as permitted by law.

Patient Signature:	Date:
Responsible Party Signature (if different to patient):	Date: