408 Investors Place, Suite 101 Virginia Beach, 23454
(757-295-8999)

Luke Acupuncture Consent Form

Acupuncture is performed by the insertion of needles through the skin. As a result of this type of treatment, there may be occasional local bruising, minor bleeding, feeling faint, temporary pain or discomfort. Moxibustion is a heat therapy utilizing moxa (mugwort leaf) to warm the acupuncture points. In rare cases it may cause minor burns like sunburn. Anything considered unusual should be reported immediately to Luke (Feng Sui).

In the treatment protocol, Luke may recommend taking Chinese herbs in bulk, powders or pill form. These herbs will be recommended to you in safe doses. Large doses of herbs taken without Luke's recommendation may cause side effect, such as upset stomach, etc. If any of symptoms occur without probable cause (i.e. eating something harmful), you should stop taking the herbs and notify Luke.

Please note that if you purchase the prepaid package, the payment is **non-refundable** after the first treatment has been provided. All sessions **must be used within one year** of purchase.

Health insurance coverage is not always a guarantee. You agree to pay the full amount of charges if your insurance refuses to pay or denies claims.

As a courtesy, your appointments are confirmed electronically the day before your scheduled appointment by a text message. You can reschedule/cancel your appointment from the appointment confirmation email.

Luke Acupuncture requests at least **24 hours' notice** for cancellations or rescheduling of appointments.

I have read and understand the information provided.

Full Name (Print) _____ Signature_____Date_____

(continue on next 5 pages)

Notice of Privacy Practices

This notice describe how health information about you may be used and disclosed, and how you can get access to your health information.

Understanding your health record: A record is made each time you visit Luke Acupuncture. Your symptoms, the practitioner's plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of Luke Acupuncture, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures.

Our responsibility: Luke Acupuncture is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. Luke Acupuncture reserves the right to change the practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Luke Acupuncture agrees not to use or disclose your health information without your authorization.

I _____
Full Name (Print)

understand my health information will be used and disclosed consistent with these notices.

Health History

Name_____ DOB_____ Sex_____

Address_____ City _____ State_____ Zip_____

Cell Phone_____ E-mail_____

Height_____ Weight_____

Referred By □ Family/Friends □ MD/Specialist □ Internet search □ Other

Main Complaint_____

Please **check** any disease you have in the past.

□ AIDS/HIV □ Hepatitis_____

□ Allergic to_____ □ Heart Disease_____

□ Cancer_____ □ Surgeries_____

□ Diabetes_____ □ Tuberculosis_____

□ Other significant illness_____

Medications (current and significant past medicines)

_____

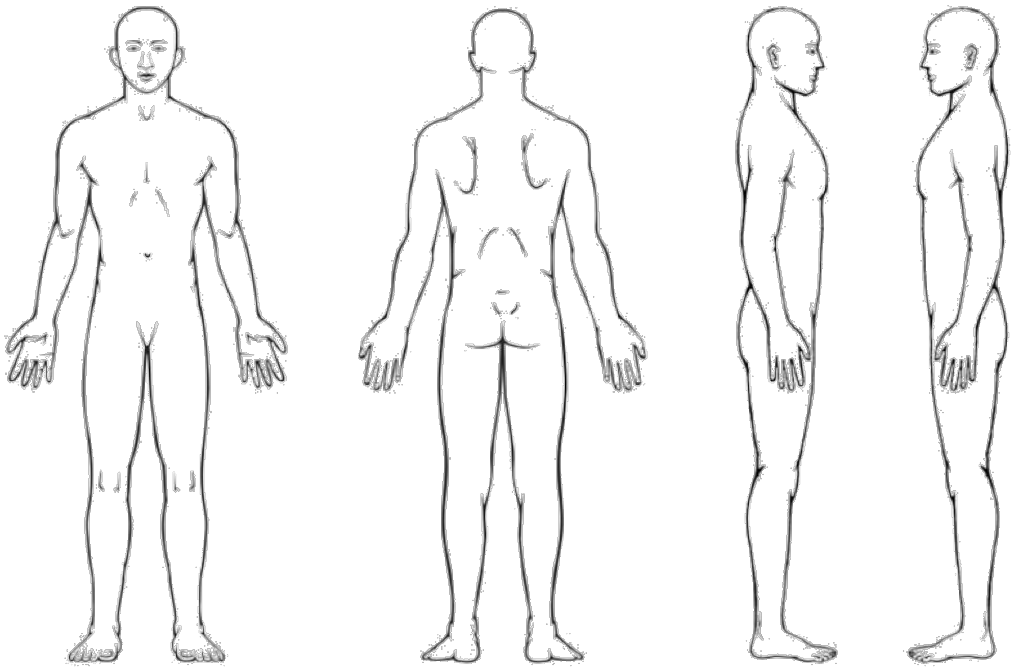
Treated for emotional problems?

_____

The following questions are **for female only**:

- ☐ Are you pregnant right now? _____
- ☐ Are you trying to get pregnant?_____
- ☐ Age of first menses_____
- ☐ Age of menopause _____
- ☐ # of pregnancies _____
- ☐ # of births _____

Circle areas of concern:



1. What's Your Energy Level? (Circle One) Exhausted / Low / Average / Good

2. Do you usually feel hotter than / colder than / same as those around you?

3. When you eat, do you get full easily / always hungry / normal?

Do you tend to have any of the following?

Bloating Burping Gas Heartburn Nausea

4. Do you have a daily bowel movement? Y N

4a. Do you tend to be constipated? Y N _____ per week

4b. Do you tend to have loose stools? Y N _____ per day

4c. Do you tend to have irritable bowel syndrome? Y N

5. How thirsty you usually feel? Not at all / Very Thirsty / Normal

5a. What water would you prefer? cold water / room temperature water

5b. How often do you urinate during the day? Every_____ Hours

5c. Do you wake up at night to urinate? _____ per night / per week

5d. Is your urine typically pale and clear? Y N

5e. Is your urine typically dark or concentrated? Y N

6. Do you sweat when you exercise? Y N

6a. Do you think that you sweat excessively? Y N

6b. Do you rarely sweat? Y N

6c. Do you have night sweats? Y N

7. Do you sleep through the night? Y N

7a. Do you have trouble falling asleep? Y N

7b. Do you have trouble staying asleep? Y N

7c. Difficulty getting back to sleep after waking up? Y N

7d. How many times do you wake up at night? _____

7e. What time of night do you typically awaken? _____

8. Are you still having a menstrual period? (for female only) Y N

8a. Were or are your periods regular? Y N

8b. Did you or do you have large blood clots? Y N

8c. Blood color tend to be darker maroon? Y N

8d. Did or do you have severe pain with your periods? Y N

8e. Did or do you tend to have mood changes? Y N

8f. How many days did or do your period last? _____

8g. Is your menstrual cycle about 28 days? _____

9. On a scale of 0 to 10, how much pain are you having right now. _____

Please describe your pain. Circle as many as apply:

Aching Burning Cramps Dull Numbness Sharp Shooting Throbbing Stiffness

10. Activities and movements that are painful are:

Bending Lifting Walking Sitting Standing Lying Down

11. Pain interferes with your:

Bathing Dressing Exercising Food Prep Sleeping Toileting Work Walking

12. How would you characterize your predominant mood?

Anxious Depressed Frustrated Happy Irritated Overwhelmed

Sad Stressed Worried