NICOLE FUGO ZIBELMAN, LAc

616 Petaluma Blvd N, Suite B - Petaluma, CA 94952

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____/_____/_____

ADDRESS _____
STREET CITY STATE ZIP

PHONE _____ EMAIL _____

MARITAL STATUS **M S D W** GENDER **M F** AGE _____

FEMALE PATIENTS: FIRST DAY OF LAST MENSTRUAL PERIOD _____/_____/_____
ARE YOU CURRENTLY PREGNANT? ***Y N***

EMERGENCY CONTACT (PARENT/GUARDIAN INFO FOR MINORS)

NAME _____ PHONE _____

RELATIONSHIP TO PATIENT _____

WHERE YOU REFERRED? IF SO, BY WHO _____ _____

INSURANCE INFORMATION:

INSURANCE NAME _____ MEMBER ID _____

PRIMARY CARRIER OF THE INSURANCE POLICY: SELF OR FILL IN BELOW

POLICY HOLDER NAME _____ DATE OF BIRTH _____

COPAY _____

BENEFIT INFO:
(office use only)

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HIPAA GUIDELINES:

PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM/DISCUSS ABOUT YOUR HEALTH CONDITION OR TREATMENT.

_____

PLEASE PRINT THE ADDRESS OF WHERE YOU WOULD LIKE ANY CORRESPONDENCE FROM OUR OFFICE TO BE SENT **IF OTHER THAN YOUR HOME ADDRESS.**

_____

PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL." **Y N**

PLEASE PRINT THE TELEPHONE NUMBER WHERE YOU WANT TO RECEIVE CALLS ABOUT APPOINTMENTS OF OTHER HEALTH CARE INFORMATION **OTHER THATN YOUR HOME PHONE NUMBER.**

_____

CAN WE LEAVE CONFIDENTIAL MESSAGES (I.E. APPOINTMENT REMINDERS) ON YOUR TELEPHONE ANSWERING MACHINE OR VOICEMAIL? **Y N**

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I ACKNOWLEDGE THAT I HAVE RECEIVED AND/OR DECLINED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT IT. ANY QUESTIONS I HAVE ASKED HAVE BEEN FULLY ANSWERED.

SIGNATURE _____ **DATE** _____

PRINT NAME _____

CLINIC POLICIES AND GUIDELINES:

PAYMENT OF SERVICES
Payment for treatments, herbs and other products are due at the time rendered. Cash, personal checks and credit cards are accepted. Please note there is a $50 fee for each bounced check.

MEDICAL INSURANCE PAYMENT
Any balances accrued in the form of copays, coinsurance, deductibles and/or rejected claim fees are the full responsibility of the patient. If payment has not been received on billed claims from the insurance company by 90 days from the visit, the patient assumes full responsibility of the balance

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment & progress. By signing below I authorize the release of medical information to process your claims.

CANCELLATION OF APPOINTMENTS / NO SHOWS
Cancellation of appointment(s) less than 24 hours prior to scheduled visit will be charged at the full rate. Payment is due before the next scheduled visit. Scheduled appointments missed by the patient (no shows) will also be charged at full rate

APPOINTMENT TIMES
Please be punctual for your appointment so that maximum time can be dedicated to you and your treatment. Late arrival will not extend your appointment time beyond its scheduled hour.

I HAVE READ AND REVIEWD THE CLINIC POLICIES. I UNDERSTAND AND ACCEPT THE TERMS OF THE TREATMENT GUIDELINES AS STATED ABOVE.

SIGNATURE _____ **DATE** _____

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INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatment and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

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.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatment can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will on occasion leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture are dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist listed above any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during breastfeeding or pregnancy. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes to my medications, before any herbal treatment is initiated.

Heat Treatments with Moxabustion ("Moxa") or a TDP Lamp: These methods are used to warm areas of the body to promote health and movement of qi. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exist.

Cupping: This technique involves a localized suction produced by small glass or plastic cups. There is the possibility of localized non-painful bruising from the suction. Very rarely a slight burn or blister may appear if cups are suctioned with heat.

Gua Sha: Gua Sha is light scraping on the skin in an area using a smooth-edged spoon or metal tool. This often results in mild bruising of the area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to TENS treatment may be used to stimulate the acupuncture points. A mild tingling sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after treatment. I understand **I must inform my practitioner if I have a pacemaker or have any heart or neurological conditions prior to having this treatment**.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my License Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed explanation. I give my permission and consent to treatment.

Signature	Date
Print name	

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PRIMARY REASON FOR VISIT _____

ADDITIONAL REASON(S) _____

_____

HAVE YOU SEEN A MEDICAL DOCTOR ABOUT THIS CONDITION? Y N

IF SO, WHO & WHEN? _____

WHAT MAKES YOUR CONDITION BETTER & WORSE? (MOVEMENT, REST, HOT/COLD, EATING, SLEEPING, ETC)

WORSE: _____ BETTER: _____

PLEASE LIST SIGNIFICANT TRAUMA, HOSPITALIZATION, SURGERY, X-RAYS, ETC:

(Please include accidents, falls, illness as well as emotional along with month/year)

_____

_____

ALLERGIES:

ARE YOU HYPERSENSITIVE OR ALLERGIC TO ANY FOODS, DRUGS, CHEMICAL OR ENVIRONMENTAL SUBSTANCES?

_____

MEDICATIONS AND SUPPLEMENTS:

Please list all medications (prescribed or over the counter) herbs, vitamins, supplements that you are taking:

_____

_____

_____

CHECK EACH THAT YOU CURRENTLY USE:

▢ Laxative ▢ Pain Reliever ▢ Antacid ▢ Cortisone ▢ Antibiotics ▢ Heart/Blood Medication

▢ Allergy Meds ▢ Thyroid Meds ▢ Sleeping Pills ▢ Antidepressants ▢ Birth Control Pills ▢ Hormones

HEALTH HISTORY:

▢ Anemia	▢ Alcohol/Drug Addiction	▢ Chronic Pain	▢ High/Low Blood Pressure
▢ Arthritis	▢ Blood Clotting Disorder	▢ Diabetes	▢ Seizure
▢ Asthma	▢ Cancer	▢ Eating Disorder	▢ Pacemaker
▢ Auto Immune	▢ Chronic Pain	▢ Hepatitis	▢ Thyroid Disorder

Do you smoke? (Tobacco / Marijuana) For how long? _____ How often? _____

Other serious health conditions: _____

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Height: _____ Weight: _____lbs { Weight 1 Year ago: _____lbs Maximum Weight _____lbs }

Blood Type: _____ Most Recent Blood Pressure Reading _____/_____ taken on _____ .

FAMILY HEALTH HISTORY: Please check any condition that applies to your immediate family: (M) Mother, (F) Father, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

High Blood Pressure _____ Diabetes _____ Heart Disease _____

Cancer _____ Stroke _____ Asthma _____

Seizures _____ Fertility Issues _____ Genetic Disorder _____

Other Serious Conditions _____

EXERCISE / MOVEMENT

How much exercise per week: _____ Length of Workout: _____ Activities: _____

How is your energy level? _____ When is it lowest? _____ Highest? _____

NUTRITION

Meals per day: _____ # of Snacks: _____ # of Caffeinated Drinks:_____ Alcohol per week: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Food Cravings: _____ Water Intake: _____ oz/day - { prefer cold / room temp / warm }

Food Allergies/Dietary Limitations: _____ Vegetarian / Vegan: Y N

SLEEP

Typical Bedtime: _____ Wakeup Time: _____ Do you feel rested in the morning? Y N

(Check all those that apply):

___ Difficulty Falling Asleep ____ Difficulty Staying Asleep ____ Dream Disturbed Sleep

___Insomnia (or History of) ____ Waking up at ___ am/pm & not able to fall asleep again

EMOTIONAL HEALTH

Have you ever been treated for a psychological concern? Y N Have you ever experienced sexual or physical abuse? Y N

Have you ever considered or attempted suicide? Y N Have you ever been treated for substance abuse? Y N

Please rate your overall stress level: LOW MEDIUM HIGH

Are you currently working with a therapist or counselor? If so, who?: _____

If possible, please describe the most challenging emotion you experience: _____

When do you most often feel this emotion? _____

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What experiences or activities bring you the most happiness? _____

_____

What goals do you have for your acupuncture treatment? _____

_____

PLEASE CHECK ANY SYMPTOMS YOU CURRENTLY EXPERIENCE AND STAR ONES YOU HAVE HAD IN THE PAST

GENERAL
____ Poor or Change in Appetite
____ Poor Sleep
____ Fatigue / Low Energy
____ Fevers / Chills
____ Bleed / Bruise Easily
____ Night Sweats / Hot Flashes
____ Sweat Very Easily
____ Colder than those around you
____ Warmer than those around you
____ Weight loss or gain
____ Libido LOW - MED - HIGH
____ High Stress

NOSE AND SINUSES
____ Frequent Colds
____ Nose Bleeds
____ Sinus Congestion (frequent)
____ Allergies/Hay Fever
____ Sinus Problems
____ Loss of Smell

IMMUNE SYSTEM
____ Chronic Fatigue Syndrome
____ Chronic Infections
____ Frequent Swollen Glands
____ Slow Wound Healing
____ Frequent Antibiotic Use

HEAD/NECK
____ Headaches
____ Migraines
____ Jaw Pain / TMJ
____ Teeth Grinding
____ Goiter

MOUTH/THROAT
____ Recurrent Sore Throat or Strep
____ Gum Problems
____ Mouth Sores (Cold Sores)
____ Dry Throat (frequent)

SKIN
____ Skin Rashes (frequent)
____ Eczema or Psoriasis
____ Acne / Boils
____ Itching
____ Fungal Infections
____ Hair Loss
____ Dry Skin/Scalp
____ Change in Hair Texture
____ Weak or Ridged Nails
____ Abnormal Moles
____ Spontaneous Sweating

RESPIRATORY
____ Shortness of Breath
____ Frequent Coughs
____ Chest Tightness
____ Asthma
____ Difficulty taking a full breath
____ Coughing up mucous- color?
____ Bronchitis
____ Pneumonia

HEADACHES
____ Tension Headaches
____ Migraines

NEUROLOGIC
____ Seizures/Tremors
____ Paralysis
____ Muscle Weakness
____ Numbness or Tingling
____ Vertigo / Dizziness
____ Stroke

CARDIOVASCULAR
____ Chest Pain or Pressure
____ Irregular Heart Beat
____ Palpitations/Fluttering
____ Swollen Hands/Feet

EYES & EARS
____ Itchy / Watery / Dry Eyes
____ Swollen / painful eyes
____ Blurred Vision
____ Glaucoma
____ Color Blindness
____ Double Vision
____ Hearing Loss / Difficulties
____ Ringing in Ears
____ Earaches/ Ear Infections (frequent)

GENITO-URINARY
____ Pain / Burning with Urination
____ Frequent Urination
____ Dark or Cloudy/Smelly Urine
____ Inability to hold Urine (even with coughing/running/sneezing)
____ Urinary Tract Infection (UTIs)
____ Kidney Stones
____ Kidney Infection

DIGESTION
____ Abdominal Pain / Cramps
____ Trouble Swallowing
____ Heartburn / Acid Reflux
____ Change in Appetite
____ Nausea and/or Vomiting
____ Gas / Bloating
____ Belching / Passing Gas Frequently
____ Diarrhea
____ Constipation
____ Mucous or Blood in Stools
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong/Foul Smelling Stools
____ Undigested Food in Stools (frequent)
____ Irritable Bowel Syndrome (IBS)
____ Crohns or Ulcerative Colitis

Bowel Movements: How Often? _____
Stools: _____ Hard, Dry _____ Firm
_____ Soft _____ Loose

CIRCULATION
____ Faintness / Dizziness
____ Easily Bruised
____ Anemia
____ Varicose Veins / Spider Veins
____ Cold Hands / Feet

ENDOCRINE
____ Hypothyroid / Hashimoto's
____ Heat / Cold Intolerance
____ Hypoglycemia
____ Diabetes (I or II)
____ Seasonal Depression
____ Infertility Challenges
____ Other: _____

MENTAL EMOTIONAL
____ Mood Swings
____ Anxiety / Nervousness
____ Depression
____ Poor Concentration
____ Angry Outbursts
____ Sadness / Weepy

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MUSCLES / JOINT / BONES	**FEMALE REPRODUCTIVE HEALTH**	**MALE REPRODUCTIVE HEALTH**
____ Neck Pain	____ Irregular Menstrual Cycles	____ Hernia
____ Jaw Pain	____ Spotting/Bleeding btwn Periods	____ Testicular Masses
____ Shoulder Pain	____ Pain during Intercourse	____ Testicular Pain
____ Arm/Wrist Pain	____ Heavy or Excessive Menstrual Flow	____ Varicoceles
____ Knee Pain	____ Painful Menses	____ STD _____
____ Back Pain (Low Middle Upper)	____ Vaginal Itching/ Burning	____ Premature Ejaculation
____ Sciatica	____ Colored Vaginal Discharge	____ Prostate Disease
____ Heaviness of Limbs	____ Menopausal Symptoms	____ Low Libido
____ Muscle Pain / Tension	____ Vaginal Dryness	____ Fertility Challenges
____ Muscle Spasms / Cramps	____ STDs/STIs _____	____ Low Sperm Count/Abnormalities
____ Restless Leg Syndrome	____ Breast Pain / Tenderness	
____ Areas of Numbness	____ Breast Lumps	Semen Analysis Results: _____
____ Loss of Strength	____ Uterine Fibroid or Ovarian Cysts	
____ Tingling Sensations	____ Polycystic Ovarian Syndrome (PCOS)	Are you sexually active? Y N
	____ Endometriosis	

REPRODUCTIVE HEALTH (WOMEN ONLY)

First Day of Last Menstrual Period: _____ Age of first Menstrual Cycle: _____

How many days do you normally Bleed? _____ Is your cycle regular (28- 30days)? Y N (If no, how long? ___

How heavy is your bleeding? HEAVY AVERAGE LIGHT Do you use: ___ PADS ___ TAMPONS ___MENSTRUAL CUP

Color of Blood: __ Pale Red/Pink __ Bright Red __Dark Red __ Purple __Brown

Have you gone more than 2 months without getting your period? Y N

Do you ovulate regularly? Y N If yes, what day of your cycle? _____ Is ovulation painful? Y N

Do you observe cervical mucus changes with ovulation? Y N Bleeding with ovulation? Y N

Do you experience PMS? ___ Cramps __ Headache ___ Mood Swings ___ Breast Tenderness __ Emotional

Are you sexually active? Y N

Do you currently use birth control? Y N

___ Birth Control Pills ___ IUD ___ Nuva Ring ___Condoms __Diaphragm __ Rhythm Method __ Other

Have you ever been on birth control in your life? Y N How long /yrs? _____ What type? _____

# of Pregnancies: _____ # of Live Births: _____ # of Miscarriages:_____ # of Abortions:_____

(__ Vaginal birth __ Cesarean Birth)

Currently Trying to Conceive? Y N - If so, for how long? _____

Currently Pregnant: Y N - If yes, how far along?: _____

Currently Breastfeeding: Y N Difficult or Premature Births: Y N

Date of last PAP?_____ Abnormal PAP in the past? Y N

OB/ MIDWIFE: _____

Additional Notes:

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MUSCLES, JOINTS & BONES

Do you have pain or muscle tightness? If yes, please circle on chart below.

Pain is (check all that apply):

▢ Sharp ▢ Dull ▢ Aching ▢ Numb ▢ Superficial ▢ Deep ▢ Burning ▢ Tingling

▢ Pain better with heat ▢ Pain better with cold ▢ Pain better with movement ▢ Pain worse in AM / PM