PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____

CITY/STATE _____ ZIP _____

RES. PHONE _____

CELL PHONE _____

EMAIL ADDRESS _____

EMPLOYER _____ BUS. PHONE _____

OCCUPATION _____

PRIMARY CARE PHYSICAN _____ PHONE _____

EMERGENCY FAMILY OR FRIEND _____ PHONE _____

REFERRED BY (how did you hear about me?) _____

AGE_____ BIRTH DATE _____ MALE _____ FEMALE _____

MARITAL STATUS M _____ S _____ D _____ W_____ CHILD _____

SYDNEY COOLEY
ACUPUNCTURE

HISTORY QUESTIONNAIRE

NOTE: Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often minor symptoms are major clues to delicate biochemical, energetic or somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Is your condition due to ☐ an accident ☐ an illness ☐ other_____

Did your accident occur while at work? ☐ Yes ☐ No When _____

Were you involved in an automobile accident? ☐ Yes ☐ No When _____

STATE your present complaint, injury or illness: _____

_____

_____

When did it begin? (Date) _____ Describe what caused it: _____

_____

_____

What makes it better? _____

What makes it worse? _____

Is it getting worse? ☐ Yes ☐ No Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Explain: _____

Who have you previously consulted about your present problems? _____

_____

Secondary Complaints: _____

Previous Medical Care: _____

Operations: Please indicate all surgeries, type and year _____

_____

Have you ever been advised to have any surgery which was not done?_____

Have you been hospitalized for anything other than surgery? _____

TREATMENT FOR OTHER CONDITIONS: _____

_____

PERSONAL HISTORY: Have you ever had/do you currently have:

☐ Scarlet fever ☐ Jaundice ☐ Rheumatic fever ☐ Gonorrhea/syphilis ☐ Pneumonia ☐ Anemia ☐ Rectal disease
☐ Gallbladder disease ☐ Pleurisy ☐ Epilepsy ☐ Bladder disease ☐ Diabetes ☐ Polio/meningitis ☐ Nephritis ☐ Cancer
☐ Nervous breakdown ☐ Food/drug poisoning ☐ TB/angina ☐ Hay fever/asthma ☐ Boils/infections ☐ Heart disease ☐ Hepatitis
☐ Alcoholism ☐ High blood pressure ☐ Miscarriage ☐ Mental disorder ☐ Drug problem ☐ A.I.D.S.

FAMILY HISTORY: Has your father or mother ever had:

☐ Cancer ☐ Stroke ☐ Scoliosis ☐ Kidney disease ☐ Glaucoma ☐ TB ☐ Epilepsy ☐ Diabetes ☐ Mental disorder ☐ Heart trouble
☐ Asthma ☐ Ulcers ☐ Arthritis ☐ Alcoholism ☐ High blood pressure ☐ Drug problem ☐ Allergies ☐ Other

Is there any familial disease tendency of which you are aware:_____

INJURIES: (Auto accidents, falls, etc.)

☐ Broken bones ☐ Concussion or head injury ☐ Dislocations ☐ Sprains ☐ Loss of consciousness

PROFILE

It is very important in Oriental Medicine to know how long a person has experienced his/her symptoms. Indicate with one check any condition that you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern. On the back of the form, please state duration, frequency, intensity, pain and severity of current symptoms.

WATER ELEMENT
☐ Hearing loss ☐ Dizziness ☐ Lower backache/neck pain ☐ Sinus congestion ☐ Edema ☐ Darkness under the eyes
☐ Emotional instability ☐ Aversion to cold ☐ Hair thinning or loss ☐ Premature aging ☐ Frequent urination
☐ Kidney stones ☐ Perspire very easily ☐ Weakness of legs/knees ☐ Asthmatic cough ☐ Rapid weight change
☐ Loose teeth ☐ Reduced sexual energy ☐ Thyroid problems ☐ Diabetes

WOOD ELEMENT
☐ Headaches ☐ Migraines ☐ Ringing in the ears ☐ Poor eyesight ☐ Eye infections ☐ Dry eyes ☐ Eczema ☐ Shingles
☐ Herpes simplex ☐ Warts ☐ Nervousness ☐ Convulsion, spasms ☐ Irritability ☐ Constipation ☐ Hemorrhoids
☐ Hepatitis ☐ Ulcer ☐ Vomiting ☐ Gallstones ☐ Indecisive ☐ Fullness below ribs ☐ Shoulder/neck tension
☐ Insomnia 11pm – 3am

FIRE ELEMENT
☐ Dry scalp ☐ Skin eruptions, rashes ☐ Cysts, tumors ☐ Ear infections ☐ Sore throat, tonsillitis
☐ Lymphatic swelling ☐ Hot palms and soles ☐ Heart palpitations ☐ Aversion to heat ☐ Bitter taste in mouth
☐ Gum problems ☐ Nose bleed ☐ Facial redness ☐ Itching/burning skin ☐ Hot hands/feet ☐ Thirst
☐ Vivid dreaming ☐ Dark urine ☐ Night sweats

EARTH ELEMENT
☐ Indigestion ☐ Flatulence ☐ Food allergy ☐ Stomach ache/ulcer ☐ Diarrhea ☐ Anemia ☐ Halitosis
☐ Sores in mouth ☐ Heartburn ☐ Strong appetite ☐ Weak appetite ☐ Nausea ☐ Abdominal bloating
☐ Low body weight

METAL ELEMENT
☐ Bronchitis ☐ Asthma ☐ Shallow breathing ☐ Cough ☐ Sinus congestion ☐ Nasal infections

OTHER
☐ Fatigue ☐ Arthralgia ☐ Sciatica/nerve pain ☐ Cold hands/feet ☐ Tendonitis ☐ Bursitis

PAIN (please describe below) _____
_____

OTHER COMMENTS_____
_____

FEMALES ONLY

Are you or might you be pregnant? ☐ Yes ☐ No ☐ Maybe If yes, what month? _____

What method of birth control do you use? _____

Are you experiencing reduced sexual energies? ☐ Yes ☐ No Other difficulties? ☐ Yes ☐ No

Explain: _____

Do you have regular PAP tests? ☐ Yes ☐ No How regular? _____

PLEASE CHECK OR EXPLAIN IF APPLIABLE:

Menstrual Cycle

Age started: _____ Age stopped: _____

☐ Irregular _____
☐ Painful _____
☐ Excess blood _____
☐ Lack of blood _____
☐ Dark _____
☐ Light _____
☐ Heavy clotting _____
☐ Water retention _____
☐ Painful breast _____

Vaginal Discharge:

☐ Liquid _____
☐ Yellow _____
☐ Thick _____
☐ Bad odor _____
☐ White _____
☐ Other _____

Gynecological History of Operations:

☐ Ovaries _____
☐ Uterus _____
☐ Tubes _____
☐ Vagina _____
☐ Breast _____
☐ Other _____

Pregnancy:

Total Number: _____
Number of children: _____
Number of abortions: _____
Number of miscarriages: _____
Complications: _____

MALES ONLY

PLEASE CHECK OR EXPLAIN IF APPLIABLE:

☐ Reduced sexual energies: _____
☐ Premature ejaculation: _____
☐ Seminal emission: _____
☐ Impotence: _____
☐ Discharges: _____
☐ Pain associated with genitals: _____
☐ Other: _____

HABITS, DIET, MEDICINES, ALLERGIES

LAST PHYSICAL: Date _____ Practitioner _____ Results _____

HABITS:

Indicate below: Heavy, Moderate, Light, or None. If significant, comment.

Heavy	Moderate	Light	None	
☐	☐	☐	☐	Alcohol: _____
☐	☐	☐	☐	Coffee: _____
☐	☐	☐	☐	Tea: _____
☐	☐	☐	☐	Tobacco: _____
☐	☐	☐	☐	Exercise: _____
☐	☐	☐	☐	Sleep: _____
☐	☐	☐	☐	Appetite: _____
☐	☐	☐	☐	Energy: _____
☐	☐	☐	☐	Medication: _____
☐	☐	☐	☐	Vitamins: _____
☐	☐	☐	☐	Diet: _____
☐	☐	☐	☐	Teeth problems: _____
☐	☐	☐	☐	Drugs: _____
☐	☐	☐	☐	Salt: _____
☐	☐	☐	☐	Other: _____
☐	☐	☐	☐	Stress: _____

(Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning: _____

_____

Afternoon: _____

_____

Evening: _____

_____

Between meals: _____

_____

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

_____

_____

MEDICINES taken within the last two months (include vitamins, over the counter drugs, herbs)

_____

_____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.)

_____

_____

EMOTIONS AND PREFERENCES

Choose one or two EMOTIONS that seem predominant in your life (frequently experience, difficult to express, or in some way influential):_____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic experience you have had (e.g., divorce, change of residence, injury, death in family, bankruptcy, etc.):

Date Event

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

COLORADO MANDATORY DISCLOSURE STATEMENT

SYDNEY COOLEY 801 Florida Suite 12 Durango, CO 81301 • 970-426-8736

Education and Experience

Sydney Cooley earned her Masters of Oriental Medicine from the East West College of Natural Medicine in Sarasota, Florida in August 2005. The five year program consisted of 2908 hours of education, which includes 834 hours of clinical practice. She was certified as a Diplomat in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in December 2005. She has also been certified in Clean Needle Technique.

In addition to acupuncture, Sydney has been trained in herbal therapies, electrical stimulation techniques, ion pumping cord treatment, gua sha, tui na, cupping, auricular acupuncture, ear seeds, and nutritional and lifestyle counseling.

Sydney is a member of the Acupuncture Association of Colorado, the East West College Alumni Association and the American Association of Oriental Medicine. She is a licensed acupuncturist in the state of Colorado. This license has never been revoked.

Sydney complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used.

Fee Schedule

See attached.

Patient's Rights

The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-7800.

I have read and understand this document.

Patient's or Guardian's Signature _____ Date _____

TREATMENT AND ARBITRATION AGREEMENT
AS PROVIDED BY STATE CODE OF CIVIL PROCEDURE

With regard to medical care and services provided or to be provided, IT IS AGREED that: The ATTENDING PRACTITIONER will provide services to the patient, to the best of his skill and knowledge which medical care in the light of circumstance, is possible and practical. The Patient Client will cooperate fully with the ATTENDING PRACTITIONER by following the instructions of the ATTENDING PRACTITIONER, by adhering to such treatment plan or course of action as may be set forth. IT IS AGREED that: Because of differences in human constitution and response, it is in no way possible to warrant the outcome of such medical care and service.

It is understood that any dispute as to medical malpractice, that is as to whether any services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state law, and not by lawsuit or resort to court process except as state law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional personal right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

In the event of any controversy between the Patient Client or a dependent (whether or not a minor) or the heirs-at-law or personal representative of the Patient Client, as the case may be, and the ATTENDING PRACTITIONER (including its agents and employees), involving a claim in tort or contractual, the same shall be submitted to arbitrating. Within fifteen (15) days after the Patient Client or ATTENDING PRACTITIONER shall give notice to the order of demanding arbitration of such controversy, the parties to the controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable amount of time after such notices have been given, the two arbitrators, so selected, shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of neutral arbitrator. All papers or others papers required to be served shall be served by United States mail. Except as provided herein, the arbitration shall be conducted in accordance with and governed by the provisions of Title 9 of the State Code of Civil Procedure. The Patient Client may withdraw from the arbitration portion of this agreement within thirty (30) days from the date of this agreement by notification of his intent to do so to the ATTENDING PRACTITIONER by registered mail.

By our signatures, we consent to this agreement and each acknowledges receipt of a copy thereof.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Specify if ☐ Patient ☐ Client ☐ Parent ☐ Guardian for _____

Date _____ Person's Signature _____

Person's Printed Name_____

Date _____ Attending Practitioner_____

FINANCIAL POLICY/FEE SCHEDULE

Initial Exam and Treatment *This visit is approximately 1hour and 30 minutes.* *A detailed evaluation will be given to form a correct diagnosis then treatment will follow.*	$120
Follow-up Acupuncture Visits *Please allow approximately 1 hour.*	$80
Non-Needle Cold Laser Therapy	$45
Cupping *Alone without acupuncture*	$40
Herbal Consultation	$40 + Cost of herbal medicine
Inquiry Consultation *For those who want to inquire about my services and whether or not I can help.*	No Charge

Students and seniors receive a 20% discount. Veterans receive $55 acupuncture treatments.
Some health insurance accepted.

Note: For any acupuncture treatment it is recommended to eat something at least 30 minutes prior and to avoid alcohol or caffeine. Acupuncture is a safe method of health care, however some patients may experience bruising occasionally.

All payments are due at time of service.

A 24-hour cancellation notice is requested.

A $20 fee will be charged for any returned check.

I have read and understand the above Financial Policy and I agree to the terms of this agreement.

_____ _____

Signature of Patient Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create distribute de-identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Office.

The right to request restrictions on certain uses and disclosure of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosure of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the client's medical decisions relative to the treatment situation.

I, _____ , hereby acknowledge that Sydney Cooley L. Ac., has provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be use and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Sydney Cooley, L. Ac. 970-426-8736

I also understand that I am entitled to receive updates upon request if Sydney Cooley amends or changes the Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Client (If signed by someone other than client.)

_____

Date