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 ____________

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.*	$130
Follow-up Acupuncture Visits *Please allow approximately 1 hour.*	$90
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 $106 initial visit, $74 follow up

Veterans receive $65 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