
Blue Jasmin Acupuncture & Herbs
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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
 - g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
 - c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

Signature of Patient or Representative

Date

Print Patient Name

Patient Birth Date

1. Name _____
 First _____ Middle _____ Last _____

2. Address _____
 Street _____ City _____ State _____ Zip _____

3. Home Phone _____ 4. Business Phone _____

5. Cell Phone _____ 6. Email _____
 Preferred # to be contacted @? _____
 Do you want to be added to an email list for special promotions and discounts? Y N

7. Age _____ 8. Date of Birth _____ 9. Sex M F 10. Marital: M S D W

13. Occupation _____ 14. Employer _____

14. Employer's Address _____
 Street _____ City _____ St. _____ Zip _____

CASE HISTORY

15. Chief Complaint _____

16. Complaint result of: Auto Accident Injury Job Related Other

17. Date of accident/Injury/Other _____ / _____ / _____

18. Have you seen any other doctor about this condition? _____ If yes, when? _____
 Doctor's Name _____ Address _____

19. Have you had recent X-Rays? _____ If yes, when? _____ Area X-Rayed _____

21. Nearest relative not living with you: _____
 Address _____ Phone _____
 Street _____ City _____ State _____ Zip _____

22. In case of emergency, call: _____
 Name _____ Relationship to you _____ Street _____ City _____ Phone _____

FOR FEMALES: Are you pregnant? _____ IF YES, HOW LONG? _____

FOR MINORS: List both parents' names and addresses: _____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) Cash Check Master Card Visa

INSURANCE INFORMATION

Do you have a personal, group health or accident insurance? _____ If yes, give: _____
 Company Name _____ Address _____
 Subscriber Name _____ Group Number _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____
 (parent's signature if patient is minor)

How did you hear about the office? _____

Patient Health History

Name: _____ Gender: M/F Date of Birth: ____/____/____
(first) (middle) (last)

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

*Is it okay to send coupons, birthday cards, etc. to your home address? Y N

1. When and where did you last receive health care? _____

For what reason? _____

2. Have you had acupuncture before? Y N

3. Please identify the health concerns that have brought you to the acupuncture clinic in order of importance below:

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. (Females) Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History:	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. Height: _____ Weight: **Currently:** _____ **Past Maximum:** _____ **When?** _____

10. Blood Pressure: **What is your most recent blood pressure reading?** _____/_____/_____ **When was this reading taken?** _____

11. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Hospitalizations and Surgeries:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

13. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

14. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Depression Bipolar Eating Disorder

15. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness/Redness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

17. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

18. Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	Pacemaker
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

19. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Abdominal Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	IBS

20. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	STDs

21a. Female Reproductive (please circle any that you experience now and underline any that you have experienced in the past)

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	Morning Sickness

1. Age of First Menses: _____

4. Birth Control Type: _____

7. # of Abortions: _____

2. # of Days of Menses: _____

5. # of Pregnancies: _____

8. # of Live Births: _____

3. Length of Cycle: _____

6. # of Miscarriages: _____

21b. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge
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22. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Sciatica	Joint Pain (if so, where?): _____	

23. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy
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24. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold
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25. Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia	Cancer	Rashes/Eczema/Hives	Cold Hands/Feet	Autoimmune Disorders
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Is there anything else we should know? _____

26. Lifestyle:

- a. Do you typically eat at least three meals per day? Y N If no, how many? _____
- b. Exercise routine: _____
- c. Spiritual practice: _____
- d. How many hours per night on average do you sleep? _____ Do you wake feeling rested? Y N
- e. Level of education completed: High School Bachelors Masters Doctorate Other
- f. Occupation: _____ Employer: _____ Hours/Week: _____
- Do you enjoy work? Y/N Why/Why not? _____
- g. Nicotine/Alcohol/Caffeine Use: _____
- h. Have you experienced any major physical or emotional traumas? Y N
- Explain: _____
- i. How many 8 ounce glasses of water do you drink per day? _____
- j. Television habits: _____ Reading habits: _____
- k. Interests and hobbies: _____

Financial Policy

The first acupuncture visit is \$100 and generally lasts an hour and a half.

Each following acupuncture visit is \$65 and generally lasts one hour.

Tuning forks are an additional \$15 when added to an acupuncture session.

An herbal consultation with no acupuncture is \$50 plus the cost of the herbs.

Fees are payable by cash, check, or credit card (only Mastercard, Visa & Discover are accepted) at the time that services are rendered.

If a check is returned, you will be charged a \$25 fee.

Please be courteous and respectful of other patients who are waiting for appointments and cancel 24 hours in advance of your scheduled appointment time to avoid charges.

If you miss an appointment without canceling 24 hours in advance you will be charged the usual fee of \$65. Thank you for understanding.

Signature: _____ Printed Name: _____ Date: _____

Directions from the 101 Freeway heading Northbound:

Exit California Street, make a right onto California Street, make another right onto Santa Clara Street. You will past the post office which will be on your left-hand side. You will then come to the 4-way stop sign. You will see the Ventura Executive Suites on the left corner as you are passing through the intersection. Find 2 hour parking on the street. Suite 43 is located in the back corner of the building. Ask receptionist for assistance if needed.