Address Image: Addre	Name			S# Iarital Status			Birthd Age	late / /
City, State, Zip Occupation Home Phone Work Cell Emergency Contact's Name & Phone Referred by Referred by Reason for visit today Have you had acupuncture Chinese herbal medicine before? Yes No Yes No How long have you had this condition? Is is getting worse? Does it bother your O Sleep Work Other (specify) What seems to make it better? What seems to make it worse? Are you under the care of a physician now? Yes No Physician's phone Other concurrent therapies Physician's phone Physician's phone Other concurrent therapies Health Insurance Info: Insurance Info: Insurance Info: Insurance Co. Name Policy # Address Phone City, State, Zip State, Zip State State Insurance Co. Name Policy # Outer of the other o	Address			and the second sec		ΩM□F		Wt
Home Phone Work Cell Emergency Contact's Name & Phone Referred by Reason for visit today Have you had acupuncture before? Yes No Chinese herbal medicine before? Yes No How long have you had this condition? Is it getting worse? Does it bother your Sleep Work Other (specify) What seems to make it worse? What seems to make it worse? What seems to make it worse? Are you under the care of a physician now? Yes No If yes, for what? Physician's name Physician's phone Other concurrent therapies Phone Health Insurance Info: Insurance Co. Name Insurance Co. Name Policy # Address Phone City, State, Zip Phone City, State, Zip Image: State Stat	Email							
Emergency Contact's Name & Phone Referred by Reason for visit today Have you had acupuncture before? Chinese herbal medicine before? Is if getting worse? Does it bother your Sleep Work Other (specify) What seems to make it better? What seems to make it worse? Are you under the care of a physician now? Yes No Physician's name Other concurrent therapies Health Insurance Info: Insurance Co. Name Address Phone City, State, Zip Medicare Info: Insurance Co. Name Phone City, State, Zip Medicare Info: Insurance Co. Name Phone City, State, Zip Outer so of the diverse calificant part of your medical history: Address Phone City, State, Zip Outer so of the diverse calificant part of your medical history: Address Phone City, State, Zip Outer so of the following calificant part of your medical history: Address Phone City, State, Zip Stricke Ot	City, State, Zip					Occupation		
Referred by Reason for visit today Have you had acupuncture before? Yes No How long have you had this condition? Is it getting worse? Does it bother your Step if yes What seemes to make it better? What seemes to make it better? What seems to make it worse? Are you under the care of a physician now? Yes No Physician's name Other concurrent therapies Health Insurance Info: Insurance Co. Name Address Phone City, State, Zip Medicare Info: Insurance Co. Name Phone City, State, Zip Address Phone City, State, Zip Date: [win] Address Phone City, State, Zip Date: [win] Out Past Medical History Date: [win] <			V	Vork		-	Cell	
Reason for visit today Have you had acupuncture before? Chinese herbal medicine before? Yes No How long have you had this condition? Is it getting worse? Does it bother your Sleep Work Other (specify) What seems to make it better? What seems to make it better? What seems to make it better? What seems to make it better? Are you under the care of a physician now? Yes No If yes, for what? Physician's name Physician's phone Other concurrent therapies Phone Other concurrent therapies Health Insurance Info: Insurance Co. Name Policy # Address Phone City, State, Zip		ct's Name & Pl	none					
Is it getting worse? Does it bother your Sleep Work Other (specify) What seems to be the initial cause? What seems to make it better? What seems to make it worse? Are you under the care of a physician now? Yes No If yes, for what? Physician's name Physician's phone Other concurrent therapies Health Insurance Info: Insurance Co. Name Policy # Address Phone City, State, Zip Medicare Info: Insurance Co. Name Policy # Address Phone City, State, Zip Cameer (type) Information Information Insurance Co. Name Policy # Address Phone City, State, Zip Cameer (type) Information Insurance Co. Name Policy # Address Phone City, State, Zip Cameer (type) Information Insurance Co. Name Policy # Address Phone City, State, Zip Cameer (type) Information Insurance Policy # Address Phone City, State, Zip Cameer (type) Information Info	and the second state of the sta	day			-			
Are you under the care of a physician now? Yes No If yes, for what? Physician's name Physician's phone Other concurrent therapies Physician's phone Health Insurance Info: Insurance Co. Name Policy # Address Phone City, State, Zip Medicare Info: Insurance Co. Name Policy # Address Phone City, State, Zip Phone City, State, Zip State, Zip Padlergies (list) Arterioxclernsis Asthma Depression Dallergies (list) Arterioxclernsis Other to following conditions yos currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.) Altergies Depression Other is conditions Other disorders Altergies Equipy Plearmaber (Date:) Altergies Geiter Altergies Geiter Altergies Geiter Altergies Geiter Altergies Geiter Attribution Dephysema Altergies Geiter	Is it getting worse? What seemed to be to What seems to make	Does the initial cause? e it better?	it bother y	our 🗆 Sleep	🗆 Wor	k 🛛 Other ((specify)	
Physician's name Physician's phone Other concurrent therapies			n now?	Ves 🗆 No	Ifv	es. for what?		
Other concurrent therapies Health Insurance Info: Insurance Co. Name Policy # Address Phone City, State, Zip		are or a physica			II J		hone	
Health Insurance Info: Insurance Co. Name Policy # Address Phone City, State, Zip Medicare Info: Insurance Co. Name Policy # Address Diabets (Type:) Seizures Address Surgery (list) Theremotic listory Check ary of the following conditions yon currently have, or have had	The second	eranies				i nysieiun s p	mone	
Insurance Co. Name Policy # Address Phone City, State, Zip Medicare Info: Insurance Co. Name Policy # Address Phone City, State, Zip Phone City, State, Zip Cancer (type) Diabetes (Type:) Seizures City, State, Zip Seizures Stroke Stroke Family Medical History Cancer (type) Diabetes (Type:) Seizures Callergies (list) Arteriosclerosis Cancer (type) Biabetes (Type:) Seizures Address Depression Heart disease Stroke Stroke Your Past Medical History Dabetes (Type:) Seizures Stroke Altor/div Diabetes (Type:) Stroke Stroke Altor/div Diabetes (Type:) Scarcer (bare in the past. Please also check if you feel any of the following are a significant part of your medical history.) Dahordive: Now in the past. Please also check if you feel any of the following are a significant part of your medical history.) Altor/div Depression Huitple Sclerones (Date:) Drebrendosis Altor/div Depression Plearend disease Woureed disorderes								
Address Phone City, State, Zip Medicare Info: Insurance Co. Name Policy # Address Phone City, State, Zip Phone City, State, Zip State, Zip Family Medical History Arteriosclerosis Adkensis Cancer (type) Diabetes (Type:) Stroke Stroke Adkoholism Depression Depression High blood pressure Our Past Medical History Diabetes (Type: Diabetes (Type:) Stroke Stroke Allergies Bipherson Allergies Epipesy Diabetes (Type:) Maltiple Stepesy Pracemaker (Date: Allergies Epipesy Asterna Pracemaker (Date: Anteriosclerosis Gout Asterna Pracemaker (Date: Asterna Pholog Manger taruana Outer (Specify) Asterna Pracemaker (Date: Asterna Probled pressure Birth trauna Heart disease						Policy #		7
City, State, Zip Modicare Info: Insurance Co. Name Address Policy # Address Policy # City, State, Zip Cancer (type) Diabetes (Type:) Seizures Adlergies Asthma Depression High blood pressure Cour Past Medical History Chillowing conditions yon currently bave, or bave bad in the past. Please also check if you feel any of the following are a significant part of your medical bistory.) Allergies Epilepsy Placemaker (Date:) Tybroid fisor dever and fisease Allergies Epilepsy Placemaker (Date:) Ulters Ulters Allergies Epilepsy Placemaker (Date:) Ulters Uverereal disease Allergies Bith frauma Heart disease Polio Major trauma Other (Specify) Allergies Bith frauma Heart disease Stroke Inducered foreer (Car, fail, etc-list) Uverered disease Allergies Bith frauma Heart diseases Stroke Induce						•		
Medicare Info: Insurance Co. Name Policy # Address Phone City, State, Zip								
Address Phone City, State, Zip								
Address Phone City, State, Zip	Insurance Co. Name	e				Policy #		
Family Medical History Allergies (list) Arteriosclerosis Cancer (type) Diabetes (Type:) Seizures Allergies (list) Asthma Depression Heart disease Stroke Your Past Medical History Diabetes (Type:) Stroke Stroke Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.) DAIbe/HIV Alcoholism Emphysema Munps Surgery (list) Tuberculosis Alcoholism Emphysema Munps Ucers Ulers Allergies Epilepsy Pacemaker (Date:) Ulcers Ulcers Arteriosclerosis Gout Pheumonia Thyroid disorders Whooing cough Asthma Heart disease Polio Major trauma Other (Specify) Asthma Heart disease Scarlet fever (Car, fall, etclist) Image: Stroke Your Diet Scarlet fever Scarlet fever Stroke Image: Stroke Image: Stroke Your Diet Low Soft Drinks/Fruit Juices Protein Intake Low Artificial Sugar	Address					and the second of the second s		
Allergies (list) Arteriosclerosis Cancer (type) Diabetes (Type::	City, State, Zip							
Allergies (list) Arteriosclerosis Cancer (type) Diabetes (Type:) Seizures Asthma Depression Heart disease Stroke Your Past Medical History Diabetes (Type:) Diabetes (Type:) Stroke Alcoholism Depression High blood pressure Albergies Diabetes (Type:) Multiple Sclerosis Surgery (list) Tuberculosis Albergies Epplepsy Pacemaker (Date:) Ulcers Ulcers Arteriosclerosis Gouter Pleurisy Ulcers Whooping cough Astenha Heart disease Polio Major trauma Other (Specify) Actribution Heart disease Polio Major trauma Other (Specify) Astenha Heart disease Polio Major trauma Other (Specify) Chicken pox Measles Stroke Image: Soft Drinks/Fruit Juices Stroke Appentit Low Coffee/Tea Protein Intake Low Artificial Sugar Thirst for water: (Sour own birth) Herpes (Type:) Scarlet fever Salty foods # gasses per day: Mater:	Family Medical H	listory			223			
Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.) Image: Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.) AlbryHIV Diabetes (Type:) Multiple Sclerosis Surgery (list) Tuberculosis Alcoholism Emphysema Mumps Utyphoid flever Utyphoid flever Allergies Epilepsy Pacemaker (Date:) Uters Uters Appendicitis Goiter Pleurisy Venereal disease Arteriosclerosis Gout Pneumonia Thyroid disorders Whooping cough Asthma Heart disease Polio Major trauma Other (Specify) Birth trauma Hepatifis (Type:) Rheumatic fever (Car, fall, etc-list)	-	 Arteriosclerosis Asthma 				Heart disease) re	
AIDs/HIV Diabetes (Type:) Multiple Sclerosis Surgery (list) Tuberculosis Alcoholism Emphysema Mumps Typhoid fever Allergies Epilepsy Pacemaker (Date:) Ulcers Appendicitis Gotter Pheurisy Ulcers Ulcers Arteriosclerosis Gout Pneumonia Thyroid disorders Whooping cough Asthma Heart disease Polio Major trauma Other (Specify) Asthma Heart disease Polio Major trauma Other (Specify) Brith trauma Hepatitis (Type:) Scarlet fever (Car, fall, etclist) (your own birth) Herpes (Type:) Scarlet fever	Your Past Medic	al History						
Arteriosclerosis Gout Pneumonia Thyroid disorders Whooping cough Asthma Heart disease Polio Major trauma Other (Specify) Birth trauma Hepatitis (Type: Rheumatic fever (Car, fall, etclist)	AIDs/HIV Alcoholism Allergies	 Diabetes (Type: Emphysema Epilepsy)	Multiple Sclerosis Mumps Pacemaker (Date:			ificant part of g	 Tuberculosis Typhoid fever Ulcers
Cancer High blood pressure Chicken pox Measles Seizures Chicken pox Measles Stroke Your Diet Average Daily Menu Image Daily Menu) Arteriosclerosis) Asthma) Birth trauma	☐ Gout ☐ Heart disease ☐ Hepatitis (Type:)	Pneumonia Polio Rheumatic fever		🛛 Major trauma		Whooping cough
Appetite Low Coffee/Tea Protein Intake Low Artificial Sugar Thirst for water: High Soft Drinks/Fruit Juices High Sweeteners Salty foods # glasses per day:	Cancer	High blood pressure	í 🗖	Seizures				
High 🗅 Soft Drinks/Fruit Juices 🗅 High Sweeteners 🗅 Salty foods # glasses per day: Average Daily Menu		Coffee/Tea P	rotein Intake 🗅 Lo	w 🛛 Artificial		🗅 Sugar		Thirst for water:
	•	ack	Noon	Snac	k	Evening	g	Snack

Practitioner	Use	Onl	Y
--------------	-----	-----	---

Your Lifestyle

Alcohol	🗅 Marijuana	Stress	Domlor Exercise	
🗅 Alcohol 🗅 Tobacco	Drugs	Occupational hazards	Regular Exercise Type	Frequency
			Туре	Frequency
General Symptom	IS			
Poor appetite	Poor sleep	Bodily heaviness	Chills	Bleed or bruise easily
Heavy appetite	Heavy sleep	Cold hands or feet	Night sweats	Peculiar taste (Describe)
Strongly like cold drinks	Dream-disturbed sleep	Poor circulation	Sweat easily	
Strongly like hot drinks	Fatigue	Shortness of breath	Muscle cramps	
Recent weight loss/gain	Lack of strength	Gamma Fever	Vertigo or dizziness	
Head, Eyes, Ears,	Nose, Throat			
Glasses (What age:)	Night blindness	Gum problems	Recurrent sore throat	Headaches
Eye strain	Myopia or Presbyopia	Sores on lips or tongue	Swollen glands	Migraines
Eye pain	Glaucoma	Dry mouth	Lumps in throat	Concussions
Red eyes	Cataracts	Excessive saliva	Enlarged thyroid	Other head or neck problems
Itchy eyes	Teeth problems	Sinus problems	Nosebleeds	14.6
Spots in eyes	Grinding teeth	Excessive phlegm	Ringing in ears (High or Low?)	-
Poor vision	🗅 ТМЈ	Color:	Poor hearing	<i>x</i> [*]
Blurred vision	🗅 Facial pain		Earaches	
Respiratory				
Difficulty breathing when	Tight chest	Cough	Color of phlegm	Coughing up blood
lying down	Asthma/wheezing	Wet or Dry?		Pneumonia
☐ Shortness of breath	Difficult inhalation? exhalation?	Thick or thin?	10 10	
Cardiovascular				
High blood pressure	Low blood pressure	Chest pain	🗖 Tachycardia	Phlebitis
Blood clots	G Fainting	Difficulty breathing	Heart palpitations	Irregular heartbeat
Gastrointestinal				
Ausea	Diarrhea	Intestinal pain or cramping	Bowel movements:	
□ Vomiting	Constipation	Burning anus	bower movements.	
Acid regurgitation	Black stools	Rectal pain	Frequency	Texture/form
Gas	Bloody stools	Anal fissures		
Hiccup	Mucous in stools	Laxative use	Color	Odor
Bloating	Hemorrhoid	What kind?		
Bad breath	□ Itchy anus	How often?		
Musculoskeletal				
Neck/shoulder pain	Upper back pain	Joint pain	Limited range of motion	Other (Describe)
Muscle pain	Low back pain	C Rib pain	Limited use	
Skin and Hair				
□ Rashes	🖵 Eczema	Dandruff	Change in hair/skin texture	Other hair or skin problems
Hives	Psoriasis	□ Itching	□ Fungal infections	Chief han of skin proofenis
Ulcerations	Acne	Hair loss		
Neuropsychologic	Poor memory	Irritability	Considered/attempted	Other (Specify)
Seizures Numbness	Poor memory Depression	Easily stressed	Suicide	Other (Specify)
Tics	Anxiety	Abuse survivor	Seeing a therapist	
Genitourinary				
	Blood in urine	Veneral diagona		
Pain on urination Frequent urination	Blood in urine Unable to hold urine	Venereal disease Bedwetting	Increased libido Decreased libido	Impotence Premature ejaculation
Urgent urination	Incomplete urination	Bedwetting Wake to urinate	Liney stone	Premature ejaculation Nocturnal emission
	- meompiere armation	- Wake to ut mate	- Kinney stone	- rocturnar clinission
Gynecology				
Age menses began	Duration of flow	Vaginal discharge	Breast lumps	Date of last PAP
		(color)	# Pregnancies	
Length of cycle (day 1 to day 1)	Irregular periods Deinfel controls	□ Vaginal sores	# Live births	Det la construction
Eeligin of cycle (day 1 to day 1)	Painful periods	Vaginal odor Clots	# Premature births Age at menopause	Date last period began
Dengin of cycle (day 1 to day 1)			Age at menopause	
	D PMS			
Other			· · · · · · · · · · · · · · · · · · ·	

CONSENT TO TREATMENT

BLOSSOM HEALTH

_____, hereby authorize Sharon Pruss, L.Ac., to I, (patient) administer treatment of acupuncture and other techniques relevant to my diagnosis. I have the right to refuse any form of treatment.

Treatment may include but is not limited to the following:

- 1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
- 2. Heat treatments using conventional heat lamp or "moxibustion" (burning Artemesia Vulgaris herb). With any heat treatment, there may be a risk of burning.
- 3. Massage technique of *gua sha*. This technique may cause redness on the skin at the site of treatment. Slight bruising and tenderness may persist after the treatment.
- 4. The placement of suction (vacuum) cups on the skin. These cups may produce a red or purple mark on the skin at the site of cup placement. Slight bruising or tenderness may remain after the treatment.
- 5. Electrical stimulation of the needles may be used, producing a tapping sensation at the needles' location.
- 6. The use of press-tacks, press-balls, magnets, intradermal needles, non-insertive needles, and other various techniques that can be applied and used in the office. There is a possibility that these could cause irritation of the skin.

- I have been informed that I have the right to refuse any form of treatment.

- I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment.

- I also understand that there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to treatment.

- I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks with treatment--including, but not limited to, local bruising, slight bleeding, fainting, temporary pain and discomfort, and nausea. Very rare risks might be a punctured lung and infection.

- I understand that an emotional response to the treatment(s) can occur in some patients.

- I do not expect the acupuncturist to be able to anticipate and explain all risks and possible complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

- I understand that no guarantee can be made concerning the results of treatment.

Signature of Patient or Legal Guardian:

Printed Name of Patient: Date

Blossom Health Sharon Pruss, L.Ac. 310.621.4553

SUMMARY OF PATIENT PRIVACY POLICY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

This notice is to inform you that we are in compliance with the law concerning privacy of your health information, HIPAA. This is a short summary; the full length explanation of HIPAA is available to you upon request. If you are concerned about how we may use your information, please read the long version called, "Notices of Privacy Practices." By signing this form, you acknowledge the understanding of this Notice.

We, at this clinic, do not share your protected health information (PHI) with anyone other than with an entity that you agree to share information with. By signing this form, you agree to allow us to use your information for pertinent reasons: products and services, healthcare operations, and billing for payment of products and services. These reasons are fully described in the "Notices of Privacy Practices." This type of information includes your name, social security number, birth date, address, insurance company, phone numbers, your health history questionnaire, and any and all related medical charting with regards to products or services we provide to you.

Patients can request to have anyone accompany them in the room during treatment. The patient then acknowledges that personal health information may be shared with this person. We do not share your PHI with anyone else in the clinic other than those listed here or pertinent staff of the clinic for the purpose of clinic operations.

We have the right to contact you by phone, mail, or email if you list this information in your consent form. This contact could be regarding scheduling, promotions, or other pertinent reasons of the clinic, but we will not give PHI to anyone else as a result of these types of contact.

Signature

Date