



## **Your Health Information Rights**

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Emily King Quon, L.Ac.** is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect any copy of your health information.

You have the right to request **Emily King Quon, L.Ac.** amend your protected health information. Please be advised, however, that **Emily King Quon, L.Ac.** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information by **Emily King Quon, L.Ac.**

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

### **Changes to the Notice of Privacy Practices**

**Emily King Quon, L.Ac.** reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Emily King Quon, L.Ac.** is required by law to comply with this notice.

**Emily King Quon, L.Ac.** is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, you may request this at the front desk or by calling **310.801.9293**.

### **Complaints**

Complaints about your privacy rights, or how **Emily King Quon, L.Ac.** has handled your health information should be directed to the receptionist by calling this office at **Emily King Quon, L.Ac.** . If the receptionist is not available, you may make an appointment by calling for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

**DHHS, Office of Civil Rights 200 Independence Ave, SW Room 509 HHH Building, Washington, DC 20201**

I have read the Privacy notice and understand my rights contained in this notice. By the way of my signature, I provide **Emily King Quon, L.Ac.** with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described by the Privacy notice.

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Patient's Name (print)

Patient's Signature & Date

# **INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE**

I, hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbs, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and 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 interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

<i>To be completed by the patient:</i>	<i>To be completed by the patient's representative if the patient's a minor or is physically or legally incapacitated:</i>
NAME: _____ (PLEASE PRINT)	PATIENT: _____ (PLEASE PRINT)
PATIENT'S SIGNATURE: _____	PATIENT'S REPRESENTATIVE: _____
DATE SIGNED: _____	RELATIONSHIP OR AUTHORITY OF PATIENT: _____
ARE YOU PREGNANT? [ ] YES [ ] NO	WITNESS: _____

NAME OF CLINIC: King Quon Acupuncture

NAME[S] OF TREATING ACUPUNCTURIST[S]: Emily King Quon, L.Ac.

APPROVED BY CALIFORNIA ACUPUNCTURE ASSOCIATION (Rev. 12/92) malpractice carrier. #401-N-AC•MISSION PIUNTING (559) 227-7640 • (800) 693-2108  
This is only one example of informed consent. There are other forms that could satisfy legal requirements for documenting consent. You may wish to consult your own legal counsel and/or your

# Initial Evaluation Form

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released without your authorization

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please list the 5 major health concerns in your order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Based upon the chief complaint when did the problem start?  
\_\_\_\_\_

If pain, rate on a scale of 1-10

Circle one

Less pain

More pain

0    1    2    3    4    5    6    7    8    9    10



Minimal

Slight

Moderate

Severe

How long have you had this condition? \_\_\_\_\_ Have you had this condition in the past? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is your condition: (circle one)

Getting worse

Constant

Comes and goes

Medications you are currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

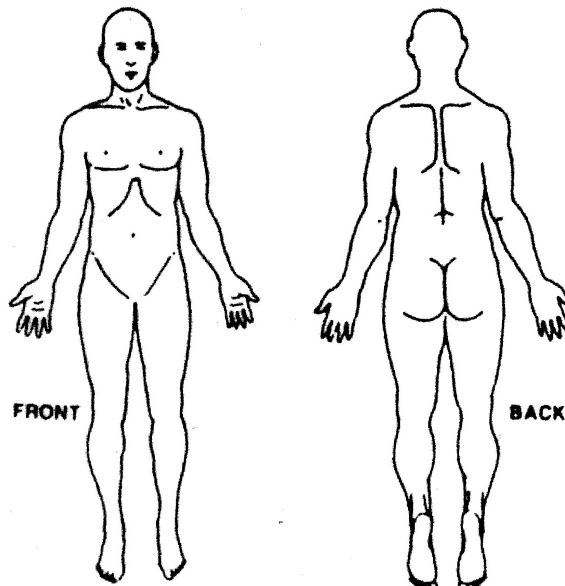
Other medications: \_\_\_\_\_

Herbs/Supplements you are currently taking: \_\_\_\_\_

List surgeries/Operations you have had and when? \_\_\_\_\_

Date of your last physical examination: \_\_\_\_\_ By whom? \_\_\_\_\_

**PLEASE MARK YOUR AREAS OF PAIN**



**Medical History** (Do you have or have you ever had?)

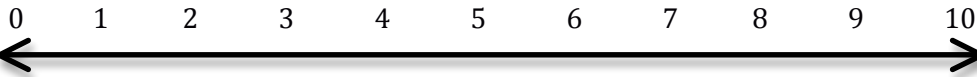
- Arthritis
- Asthma
- Anemia
- Heart Trouble
- Cancer
- Diabetes
- Epilepsy
- Stroke
- Kidney or Bladder Trouble
- Gallstones
- Ulcers
- Fatigue/Fibromyalgia
- High Blood Pressure
- Hepatitis
- Jaundice
- Sudden Weight Loss
- Sudden Weight Gain
- HIV +

Other: \_\_\_\_\_

**Family History:** (Has any member of your family had any of the above?) YES NO (Circle one)

If yes, which member & what did they have? \_\_\_\_\_

**Energy Level:** Please rank your overall energy level on a scale from 1(low) to 10 (high):



Do you experience an energy slump (circle if applies): After Meals After Lunch

**Stress:** What causes it? \_\_\_\_\_

- None
- Moderate
- Severe

**Sweating:**  Night Sweats  Excessive Sweating  Sweating with Slight Exertion  Rarely Sweats

**Circulation:** Feelings of...

- Hot areas? \_\_\_\_\_
- Cold areas? \_\_\_\_\_
- Cold limbs
- Bruises easily
- Bleeds easily

Other : \_\_\_\_\_

**Skin:** (check all that apply)

- Dry itchy
- Moist/Clammy
- Frequent rashes
- Burning
- Hair thinning
- Acne
- Dry scalp
- Bruises easily
- Hives

Other : \_\_\_\_\_

**Scars:** (list all scars from accidents and surgeries) \_\_\_\_\_

**Sleep:** (Circle all that apply) Falling asleep Staying asleep Excessive dreaming

Other: \_\_\_\_\_ How many hours do you sleep per night? \_\_\_\_\_

**Head:** Headaches/Migraines (what area?) \_\_\_\_\_

- Dizzy
- Memory loss
- Loss of balance

Other : \_\_\_\_\_

**Eyes:**  Eye pain  Blurred vision  Dry eyes  Darkness under eyes

Other: \_\_\_\_\_

**Ears:**  Poor hearing  Earaches  Ear infections  Ear ringing

Other: \_\_\_\_\_

**Nose:**  Frequent nose bleeds  Sinus issues  Frequent colds

Other: \_\_\_\_\_

**Throat:** [ ] Sore Throat [ ] Difficulty swallowing [ ] Swollen tongue [ ] Hoarseness [ ] Jaw Problems

Other: \_\_\_\_\_

**Chest:** [ ] Hard to breathe [ ] Wheezing [ ] Shortness of breath [ ] Pain/pressure in chest

[ ] Issues breathing at night [ ] Palpitations [ ] Persistent cough [ ] Coughing blood

[ ] Coughing phlegm Other: \_\_\_\_\_

**Bowels:** [ ] Diarrhea [ ] Constipation [ ] Bloody stools [ ] Black stools [ ] Mucus in stools

[ ] Hemorrhoids [ ] Lower bowel gas [ ] Stools have foul odor [ ] Colon problems

Number of bowel movements a day? \_\_\_\_\_

**Urine:** Color: \_\_\_\_\_ Amount: \_\_\_\_\_

[ ] Frequent Urination [ ] Hard to urinate [ ] Pain or burning on urination [ ] Frequent infection

\_\_\_Daytime [ ] Water retention [ ] Strong smelling urine [ ] Blood in urine

\_\_\_At night

**Musculoskeletal: Pain in:**

- |                       |                        |                                   |
|-----------------------|------------------------|-----------------------------------|
| [ ] Neck              | [ ] Upper Back         | [ ] Muscle spasm/cramps           |
| [ ] Shoulder          | [ ] Weak Ankles        | [ ] Loss of grip                  |
| [ ] Between Shoulders | [ ] Mid Back           | [ ] Loss of feeling in Hands/Feet |
| [ ] Arms/Wrists       | [ ] Stiff all over     | [ ] Swollen Knees/Elbows          |
| [ ] Hands/Fingers     | [ ] Lower Back         | [ ] Leg cramps at night           |
| [ ] Hip               | [ ] Sciatica           | [ ] Painful Joints                |
| [ ] Knee              | [ ] Tingling in Feet   | [ ] Weakness in Legs              |
| [ ] Big Toe           | [ ] Bones sore/painful | [ ] Bursitis                      |

**Neurological:**

- |                      |                         |                                |
|----------------------|-------------------------|--------------------------------|
| [ ] Nervousness      | [ ] Mood swings         | [ ] Suicidal                   |
| [ ] Depressed        | [ ] Poor coordination   | [ ] Seizures                   |
| [ ] Easily angered   | [ ] Memory confusion    | [ ] Tremors                    |
| [ ] Easily irritated | [ ] Muscle weakness     | [ ] Nerve pain                 |
| [ ] Frequent crying  | [ ] Poor concentration  | [ ] Numbness/tingling in limbs |
| [ ] Worry/anxiety    | [ ] Feel weak and shaky | [ ] Shingles                   |

Other: \_\_\_\_\_

**Females:**

Last monthly period? \_\_\_\_\_ Last PAP test? \_\_\_\_\_ Form of birth control? \_\_\_\_\_

Age started menses? \_\_\_\_\_ Age stopped? \_\_\_\_\_ Color: \_\_\_\_\_

No. Pregnancies? \_\_\_\_\_ No. Deliveries? \_\_\_\_\_ No. Miscarriages? \_\_\_\_\_ No. Abortions? \_\_\_\_\_

**Females [Cont.]:**

- Water retention     Low or no sex drive     Hot flashes     Food cravings
- Mood changes     Miss periods     Painful Breasts

Discharge:

- Yellow     White     Itching     Thick     Odor

**Males:**

- Low sex drive     Lack of sex drive     Impotence     Ejaculation causes pain     Discharges
- Premature ejaculation     Pain or burning while urinating     Prostate trouble

**Appetite:**

- Excessive appetite     Tired/weak if meal is missed     Excessive thirsty
- Poor appetite     Appetite keeps changing     Never thirsty

Specific food cravings: \_\_\_\_\_

**Digestion:**

- Stomach gas     Stomach pain     Bad breath
- Lower bowel gas     Stomach cramps     Sores in mouth
- Heartburn     Nausea     Weight gain
- Burning/belching     Vomiting     Weight loss
- Bitter/sour taste in mouth     Abdominal bloating... How long after eating? \_\_\_\_\_
- Food Allergies

**Nutrition:** List some of your favorite foods: \_\_\_\_\_

Do You?

- Skip breakfast     Eat a snack     Eat a hearty breakfast

How many meals a day do you eat? \_\_\_\_\_ When is your biggest meal? \_\_\_\_\_

How many glasses of water do you drink? \_\_\_\_\_

Do you use?

- Alcohol    Glasses per week: \_\_\_\_\_    Type: \_\_\_\_\_
- Tobacco    No. of packs per day: \_\_\_\_\_    How many years? \_\_\_\_\_

Do you:

- Eat raw fruits and vegetables at least 2x/day?     Always add salt?
- Eat green or yellow vegetables at least 2x/day?     Eat meat or dairy products 2 or more times a day?
- Eat frequently between meals?     Eat the same foods almost every day?
- Chew your food thoroughly before swallowing it?     Eat when you are not hungry?
- Drink juice, milk or other drinks instead of water when thirsty?     Eat until you feel full?
- Occasionally go on a crash diet?

**Patient Signature** \_\_\_\_\_