Body Mind Therapy

Today's Date

Patient Registration form

Name_____Birth date_____
(Last) (First) (MI)
Address _____zip_____

Sex (M /F) Age ( ) Marital Status (S) (M) (W) (D)

Referred by : _____
Phone # home: cell:
Email

Occupation
Emergency Contact (Name) (Phone #)

Any Medical Condition _____
Any surgery(Hospitalization) Special Diet yes[ ] no [ ]
Allergies
Numbers of Pregnancies Numbers of Children

Insurance Policy #_____

Have you or your family previously had, or do you presently have any of the following conditions?
Fill in [C] for present, [H] for history, [F] for family

	[ ]Diabetes	[ ]High cholesterol
[ ]AID/HIV positive	[ ]Epilepsy/Seizures	[ ]Pregnancy
[ ]Asthma	[ ]Heart disease	[ ]Stroke
[ ]Bleeding disorder	[ ]Hepatitis	[ ]TB
[ ]Cancer	[ ]High Blood pressure	[ ]Mental Illness
[ ]Thyroid disease	[ ] Rheumatic Fever	[ ]Kidney Disease

Main Problem(s) you would like addressed_____

How much do these problems affect your daily activities (work, sleep, sex, hobbies, etc)_____
How long have you had symptoms?_____

Have you been given diagnosis? If so, what?_____

Please list current medications _____

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Acknowledgement of Receipt of the Notice of Body Mind Therapy Privacy Practices

Health Insurance Portability and Accountability Act (HIPPA)

Body Mind Therapy adheres HIPPA regulations regarding your health and personal information and respects your privacy. Information obtained from you regarding your health is strictly confidential. In fulfillment of our privacy practice at Body Mind Therapy, this information will not be released unless you sign the release form for the third party payment, and emergency situations which are identified in the informed consent form.

I, the undersinged have received the Notice of Privacy Practices of Body Mind Therapy.

Signature of Patient _____ date _____

Authorization for Disclosure of Medical Information to Third Party Payer

I authorized Body Mind Therapy to release any medical or other information necessary to process medical claim of my treatment to the following third party

Duration : during the treatment
Purpose : Billing

Signature of Patient _____ date _____

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Informed Consent

I hereby request and consent to acupuncture treatment and / or herbal supplement recommendations for me provided by Yasuko Akiyama-Bevett, L.A.c. I understand that no promises or guarantees can be made regarding the outcome of treatment because of the uniqueness of each individual.

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
Indirect Moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. If you have numbness or neurological disorder which may makes unable to feel the heat, you need to inform the practitioner.
Gua sha involves scraping over a small area by using a smoth-edged instrument to increase blood circulation. It can cause bruising in the Gua sha site.
Cupping involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. It normally disappears in 3-5 days.
Tapping, Plum Blossom, Bleeding, Pricking all involve multiple needle pricks at the localized site. Slight bleeding or bruising at the site may occur. Only single –use disposable needle is used for these procedures.
Electrical Stimulation /TENS uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.

I understand that I should inform my acupuncturist whether or not a licensed physician has examined me with regard to my presenting complaint, and if so, what the Western medical diagnosis is. I agree to report my health information such as, **bleeding disorder, anticoagulant therapy, diabetes**, **pregnancy**, **pacemaker, hearing aid,** and **copper IUD.**

I have read the above consent, and have had the opportunity to ask questions and discuss this with my practitioner. I consent to the treatment that involves the above procedures for my present conditions and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Patient's Name (Please Print) _____

Signature _____ Date _____

Practitioner Yasuko Akiyama-Bevett, L.Ac.