Patient Information

Please complete the following information for your patient file.
All of your patient file is confidential medical information and will be maintained as per our HIPAA guidelines.
We will never sell any of your information. Please let us know if you need copies of your patient file.

Patient NAME	
last:	first, MI

Today's DATE: _____

is this form? inital revised

Patient ADDRESSES: street	city	state	zip

PRIMARY PHYSICIAN INFORMATION
name:
phone number:
specialty:

Patient PHONE NUMBERS & EMAILS *Please indicate preferred contact number	
home:	text? Y / N
cell:	text? Y / N
work:	ext#
email:	

EMERGENCY CONTACT INFORMATION
name:
relationship:
phone number:
alternate phone number:

BIRTHDATE:	
AGE:	
GENDER:	
DATE of initial visit:	
marital status:	
occupation:	
company:	

Family (spouse, children, parents & others...)			patient at our clinic?
Name	relationship	age	

Have your ever had Acupuncture? Y / N

When: _____ By Whom: _____

How Many Treatments: 1 2-5 10-20 more? (_____ years)

How did it go? Results / Notes:

Who Refered you and/or How did you hear about our clinic?
Medical Professional:
Patient of our clinic:
Family member:
Other:

iowa acupuncture clinic

8230 Hickman Rd, Suite B
Clive, Iowa 50325
515-331-8948
www.iowaacupuncture.com

Services at Iowa Acupuncture Clinic: Fed ID# 391885325
Consulting Practitioner:
_____ Elizabeth Terrell, L.Ac. IA 004 NPI: 1710318852
_____ William Terrell, L.Ac. IA 005 NPI: 1194156240

signed:_____ date: ____/_____/_____

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clinic mission:

The iowa acupuncture clinic operates as a holistic traditional oriental medical clinic, specializing in acupuncture therapies, herbal medicine, lifestyle counseling and holistic health education.

We honor the holistic nature of life and one's health.

The iowa acupuncture clinic seeks to aid its patients in achieving a greater level of health and well-being. We focus on the individual person, educating them according to an ancient holistic style of oriental medicine. Most importantly, the iowa acupuncture clinic seeks to care for the individual needs of each person.

clinic history

The iowa acupuncture clinic was founded in 1997 by Elizabeth and William Terrell, L. Ac, MSOM., who:

1. were educated in Oriental Medicine at the prestigious Southwest Acupuncture College in Santa Fe, New Mexico,
2. possess Master of Science Degrees in Oriental Medicine (Elizabeth MSOM '95, William MSOM '96),
3. maintain Acupuncture Certification through the NCCAOM (dipl. Ac.); and
4. are Licensed Acupuncturists (L.Ac.) in Iowa.

clinic guidelines

In an effort to provide our clients with the best care, we request that you follow these guidelines:

1. The iowa acupuncture clinic is maintained as a peaceful, quiet healing space.
   Please limit noise and disturbances.
2. If you ever need any urgent attention, please speak as loudly as necessary.
3. We love and honor children as clients and guests. Please ask to wait with your child in our pediatric treatment area. Please leave the space as tidy as you found it.
4. Please place cell phones and other electronics on mute, and limit their use to necessity.
5. We maintain a toxin free environment for our staff and clientele who have environmental sensitivities.
   Please limit your use of cologne and perfume.
   Smoking is not permitted anywhere on our premises.
   If you have any special environmental needs, please let us know.
6. Payment is due upon completion of visit to clinic.
   Prompt payment discounts will be applied to any payments made at time of completion of visit.
   Please inform our staff, prior to treatments, if you will not be paying in full.
   Please ask for a receipt or insurance form for third-party reimbursement.
7. We all are human and make mistakes, please forgive us ours and we will respect yours.
8. The iowa acupuncture clinic is a health education and lifestyle center. We honor all questions.

Elizabeth Terrell, L.Ac. MSOM *William Terrell, L.Ac. MSOM*
Licensed Acupuncturists
Masters of Science Oriental Medicine

acupuncture guidelines

acupuncture is one of our clinic's most popular treatments, it is also it's most unique;
as such, please observe the following guidelines when receiving treatment:

1. It is best to wear comfortable, loose fitting clothes. During a treatment, we might need to access various parts of your body, usually your arms, legs, abdomen and back. If you are coming from work, we have hangers for your business clothes and we will provide you with a cover during your treatment.
2. Be sure to eat something during the mealtime prior to your visit. It is very important to have nourishment in your system during an acupuncture treatment. Acupuncture utilizes your body's energy much like an exercise session would, and if your blood sugar is low, you will not respond as quickly to the acupuncture treatments. Please ask us for a snack if you need one.
3. Allow plenty of time for your visit. You will need to spend about 1½ to 2 hours at the clinic during your initial visit. This time allows you to complete our initial paperwork, and allows us to ask you many questions, obtain an accurate diagnosis of your condition and give you an acupuncture treatment. Most of your return visits will last about 1 hour to 1½ hours. Please let us know if you require a quicker treatment.
4. The practice of acupuncture is a licensed medical specialty in the State of Iowa. As such, it is regulated by the Iowa Board of Medical Examiners, located at 400 SW 8th Street, Suite C, Des Moines, Iowa 50309-4686, phone: 515-281-5171. The medical board requires us to state the following:

   The practice of acupuncture in Iowa does not authorize a person to practice medicine and surgery in this state, and the services of an acupuncturist must not be regarded as diagnosis and treatment by a person licensed to practice medicine and must not be regarded as medical opinion or advice.

   All Practitioners are in full compliance with all regulations and rules promulgated by the Iowa Department of Public Health.
5. Elizabeth and William Terrell, L. Ac., MSOM practice acupuncture according to Traditional Chinese Medical (TCM) Theory. Please ask for your diagnosis and TCM medical references.
6. The iowa acupuncture clinic exclusively uses sterile, disposable, single use acupuncture needles.
7. If you have any questions, or concerns before, during or after your acupuncture, please call our clinic.

services:

range of prices vary with severity of health conditions treated
see brochure for definitions of services

TCM acupuncture and herbal medicine clinic

initial TCM diagnostic visit	$40
acupuncture treatment	$85
return consultation	$10-85
adjunct acupuncture therapies	$5-30
couples/group acupuncture (per person)	$70

I have read the above information and my signature endorses my understanding of the conditions.

Print Name _____ relationship to patient: _____

signature _____ date _____

Patient BIRTHDATE:		Phone #:
Patient NAME:		visit DATE:
last:	first, MI	

Services at Iowa Acupuncture Clinic: Fed ID# 391885325
Consulting Practitioner:
_____ Elizabeth Terrell, L.Ac. IA 004 NPI: 1710318852
_____ William Terrell, L.Ac. IA 005 NPI: 1194156240

signed:_____ date: _____

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8230 Hickman Road, suite B
Clive, Iowa 50325
Cell/text 515-331-8948

Patient Name: _____

Patient's Birthdate: _____

Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Patient Health Information, describes how health information about you may be used and disclosed, and how you can get access to your health information. The Notices are posted near the front desk and copies are available to all individuals receiving care.

Please review this information carefully.

Understanding your health record: A record is made each time you visit the Iowa Acupuncture Clinic. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health records is the physical property of the Iowa Acupuncture Clinic, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record.
You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our Responsibilities: The Iowa Acupuncture Clinic is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. The Clinic reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, the Iowa Acupuncture Clinic agrees not to use or disclose your health information without your authorization.

TO SHARE HEALTH AND MEDICAL INFORMATION

Patient Name: _____

Please list any persons, medical or otherwise, with whom you authorize us to discuss your health and medical condition. Examples include…family members, DOs, MDs, DCs, Nurse Practitioners, Massage Therapists, Psychologists, Counselors, etc.

You can add or remove persons from this list at any time

Person Authorized	Relationship	Phone (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact the Iowa Acupuncture Clinic. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

Authorized Signature:	relationship to patient:	Date:
_____	_____	_____

Witness Signature:	Date:
_____	_____

ADDITIONAL AUTHORIZATION TO SHARE HEALTH AND MEDICAL INFORMATION

Date	Add/Remove	Authorized Person	Relationship	Phone	Authorized Signature
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Iowa Acupuncture Clinic Owners & Acupuncturists:

Elizabeth Terrell, L.Ac. MSOM William Terrell, L.Ac. MSOM

Licensed Acupuncturists Masters of Science in Oriental Medicine

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Current Health Issues

Please use this form to list and describe any current health issues.
Be as specific as you wish. Ask for additional paper if necessary.
Reverse Side is your SUPERBILL receipt. Please ask for a copy to file with your Insurance Company

Main Health issues you want addressed:

How have issues changed since last visit?

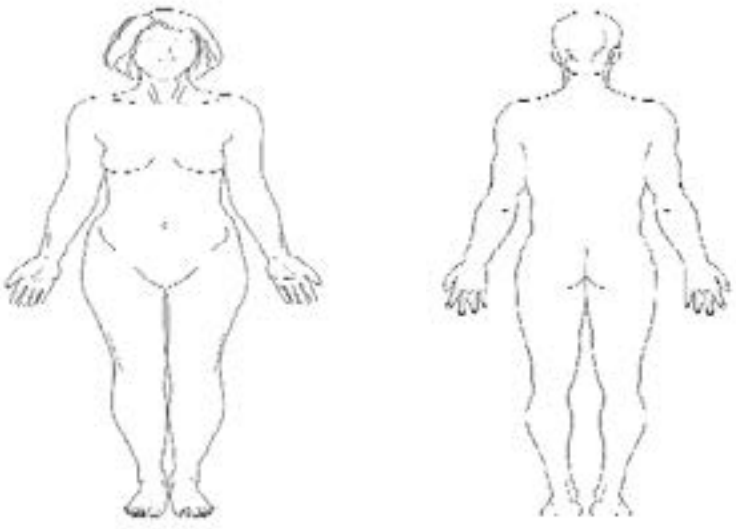
Are conditions worsened by work or life environment? Please Explain.

Have you had any medical testing since last visit? For what condition and what were the results?

Any new or changed medications/supplements?

Any changes to your exercise or relaxation activites?

Please use the diagram below to show any areas of
(P) pain, (N) numbness, (H) heat, (C) cold,
(S) swollen, (E) emotion, (A) acne, (R) rash



Patient NAME:		visit DATE:	email:
last:	first, MI		phone:

Patient NAME		Patient DOB:	Insurance Company:	visit DATE:
last:	first, MI	mm dd yyyy		
Patient ADDRESS			policy holder name:	policy #:
street:				
city:	st:	zip:	Terms: Payment due within 10 days of visit date Patient insurance assignment signature on file	

code.mod	PROCEDURES	qty	price	notes
99201.	first visit, minimal			
99202.	first visit, detailed			
99203.	first visit, extensive			
99211.	return visit eval, min			
99212.	return visit eval, detail			
97810	acupuncture			

Procedure Charges: $

Suggested Discount $

ICD	DIAGNOSIS	notes

Treatment notes:

tbl up
tbl dwn
chair
mobile

code	PRODUCTS	# pills	times / day	# days	Unit size	Unit price	Units	Total Cost	Notes
						x			
						x			
						x			
						x			
						x			
						x			

non-tax products $ + (taxable products $ x 1.07 tax = $) = Total Product Charge $

Product chrg: $ + Prior Balance: $ = Product sub: $ - Credit Check $ Cash = Product Bal Due: $

Procedure chrg: $ - Pmt at time of visit disc: $ + Prior Proc Bal: $ = Procedure sub: - Credit Check $ Cash = Procedure Bal Due:

insurance assign?
No / Yes & Bill: $_____
Outstanding $_____

Total Visit Due $ → Total Paid $

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signed:_____ date: ____/_____/_____

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Is this form?
___ **Initial**
or
___ **Update**

Patient History

Please complete this two sided form.

Medication / Supplement / Herbal Medicine List

Please complete the following chart by listing all of the prescription medications, dietary supplements and/or herbal medicines that you are currently taking.describe your current health concerns and your medical history. Please be as detailed as you can. Please use extra pages or your own documents.

medicine/supplement/herb	dosage		medical reason / health benefit	dates taking	
	times/day	total mg/day		start	end

Surgeries / Medical Procedure History

Please use the following chart to list all surgeries, organ removal, cosmetic surgical procedures, or other invasive medical procedures (such as chemo-therapy, radiation, cataract surgery). Please include bone breaks and lacerations if they required extensive medical care. DO NOT INCLUDE HOSPITAL STAYS DUE TO ILLNESS, you will list those on the opposite page.

surgical procedure	dates performed	reasons for procedure	was it successful? what were results?

Patient BIRTHDATE:		Phone #:
Patient NAME:		visit DATE:
last:	first, MI	

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Patient NAME:		visit DATE:
last:	first, MI	

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signed:_____ date: ____/_____/_____

Personal Medical, Illness & Hospital History

Illness / Medical diagnosis Birth defect	dates	were you hospitalized? how long?	what was the result? is it still active illness

Family Medical History

Please list your family history. Add any grandparents, siblings and/or children that have significant medical history.

member	name	alive/dead	age	health / disease history
mother				
father				

List any allergies and the resulting symptoms	

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Patient Evaluation
Checklist

iowa acupuncture clinic

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Please use the following 2 sided checklist to describe your current (within the last 3 months) and/or past health issues (please add dates if serious illness).
Circle any and all symptoms that apply. Do not worry if symptoms seems contrary. Make any notes you wish.

Systemic

current	past	
☐	☐	hot body
		locations:
☐	☐	cold body
		locations:
☐	☐	overheats /gets cold easily
☐	☐	sweats easily
☐	☐	seldom sweats
☐	☐	sweats on: head / hands / feet
☐	☐	sweat has strong odor
☐	☐	red face
☐	☐	overweight
☐	☐	heavier in belly / middle
☐	☐	heavier in hips / legs
☐	☐	underweight
☐	☐	weight fluctuates easily
☐	☐	swollen face / hands
☐	☐	swollen legs / feet
☐	☐	acne: face / back / chest / belly
☐	☐	face pain

Respiratory

☐	☐	shortness of breath
☐	☐	fatigue / wheezing with exertion
☐	☐	cough (circle any/all)
		dry / wet / barking
☐	☐	difficulty inhaling / exhaling

Digestive / Bowel

current	past	
☐	☐	poor appetite
☐	☐	excessive appetite
☐	☐	pain before / after eating
☐	☐	mouth / teeth / gum pain
☐	☐	clear throat constantly
☐	☐	throat pain / reflux / Acid
☐	☐	difficulty swallowing
☐	☐	stomach / abdomen pain
☐	☐	bad breath
☐	☐	dry mouth
☐	☐	belching / hiccups frequently
☐	☐	taste in mouth (circle any/all)
		bitter metal sour sweet
☐	☐	bowels / rectum pain
☐	☐	flatulence frequently
☐	☐	undigested food in stool
☐	☐	bowel incontinence
☐	☐	painful bowel movements
☐	☐	hemorrhoids / bleeding

freq of BM times per _____ day or ____ week

typical BM texture (circle any/all):
formed diarrhea loose dry

BM color (circle any/all):
dark light yellow green red

shape of BM (circle any/all)
tube pencil thin pebbles
large small other:_____

Heart / Circulation

current	past	
☐	☐	cold hands / feet
☐	☐	dizziness
☐	☐	chest palpitation
☐	☐	chest tightness
☐	☐	shortness of breath at rest
☐	☐	short of breath w/ movement
☐	☐	fatigue: with movement / at rest
☐	☐	erratic pulse
☐	☐	fast / slow pulse
☐	☐	high blood pressure (BP)
☐	☐	normal BP w/medication
☐	☐	high BP w/ medication
☐	☐	low blood pressure

Immune / Sinus / Allergy

☐	☐	frequent head colds
☐	☐	frequent flu
☐	☐	Covid infection
☐	☐	frequent allergies
☐	☐	stuffy nose
☐	☐	painful sinuses
☐	☐	headaches
☐	☐	eyes: itchy red watery
☐	☐	sneezing
☐	☐	hives
☐	☐	pet allergies

Notes / Extra Details :

Patient BIRTHDATE:		Phone #:
Patient NAME:		visit DATE:
last:	first, MI	

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signed:_____ date: ____/_____/_____

Patient Evaluation Checklist (...continued from front page)

Please use the following 2 sided checklist to describe your current (within the last 3 months) and/or past health issues (please add dates if serious illness).
Circle any and all symptoms that apply. Do not worry if symptoms seems contrary. Make any notes you wish.

Energy / Sleep

current past

energy level? high mod low

motivation?: high mod low

time to bed?: _____ regular irregular

time awake? _____ rested fatigued

hours of sleep per day: _____

- ☐ ☐ erratic energy / fatigue
- ☐ ☐ fatigued easily
- ☐ ☐ weak voice
- ☐ ☐ difficulty falling asleep
- ☐ ☐ wake frequently thru night
- ☐ ☐ to urinate?
- ☐ ☐ to eat?
- ☐ ☐ because of pain?
- ☐ ☐ disturbing dreams / nightmares
- ☐ ☐ vivid dreams
- ☐ ☐ night sweats
- ☐ ☐ hot / cold flashes
- ☐ ☐ daily need for nap

Urogenital

frequency of urine per day? _____

frequency of night urine? _____

typical color & quality of urine:

clear light dark fluorescent
bloody cloudy milky frothy

- ☐ ☐ painful or burning urination
- ☐ ☐ weak stream
- ☐ ☐ urgency
- ☐ ☐ incontinence / leaking
- ☐ ☐ sensation of need without urine
- ☐ ☐ low libido
- ☐ ☐ pain in groin
- ☐ ☐ pain during / after sex
- ☐ ☐ headache during / after sex

Women's Health

current past

_____ age of menarche

_____ days in length of monthly cycle

regular irregular

_____ days of menses flow, describe below

light medium heavy clots
painful hemorraging

PMS symptoms (circle any/all)? none
moody angry breast tender
sad low back pain cold body

vaginal discharge? none clear
white yellow dark blood

_____ age of menopause

_____ age of hysterectomy
partial or total

- ☐ ☐ prolapse of vagina / bladder
- ☐ ☐ hormone replacement therapy

any other symptoms in women's health?

Men's Health

- ☐ ☐ weak erection
- ☐ ☐ painful erection
- ☐ ☐ priapism / bent penis
- ☐ ☐ inability to orgasm
- ☐ ☐ inability to sustain erection
- ☐ ☐ prostate pain / swollen

any other symptoms?

Mental / Emotional

current past

predominant emotions
(check any/all)

- ☐ ☐ moody
- ☐ ☐ bored
- ☐ ☐ anger/frustration
- ☐ ☐ short temper
- ☐ ☐ joyful
- ☐ ☐ inappropriate laughter
- ☐ ☐ anxious
- ☐ ☐ mania
- ☐ ☐ obsessions
- ☐ ☐ grief
- ☐ ☐ depressed
- ☐ ☐ excessive crying
- ☐ ☐ inability to cry
- ☐ ☐ lack of emotions
- ☐ ☐ disturbed / restless
- ☐ ☐ pain / discomfort due
- ☐ ☐ Seasonal Affected Disorder
- ☐ ☐ Post-Traumatic Stress Disorder

Notes on emotions:

Notes/ Extra details:

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