Joyanne Kohler Acupuncture, LLC
1622 110th Ave., Hammond, WI 54015
(715) 220-9679
joyanne.kohler@live.com

PATIENT INFORMATION

Please complete the following questions so that we may get a clear picture of your health to address your concerns from a whole body perspective. Thank you for choosing Joyanne Kohler Acupuncture and we look forward to working with you!

Name (Last, First, Middle)				Today's Date
Age	Date of Birth	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Phone H: M:			E-mail Address	
Home Address				
City		State		Zip
Occupation			Business Phone	
Employer				
Spouse's Name				
Emergency Contact		Relationship		Phone

How would you like us to contact you for follow-up questions, appointment confirmations or responding to messages?

☐ Home phone ☐ Mobile phone ☐ Work Phone

May we leave messages on your phone voicemail? ☐ Yes ☐ No

How did you hear about Joyanne Kohler Acupuncture?

Major Complaint/Health Problem		
How long has this condition persisted?		
How did this condition develop?		
Is there anything that makes it better?		
Is there anything that makes it worse?		
Have you ever received treatment for this condition? ☐ Yes ☐ No		If yes, when?
Where?	By whom?	
What was the diagnosis?	What kinds of treatment?	
What were the results of the treatment?		

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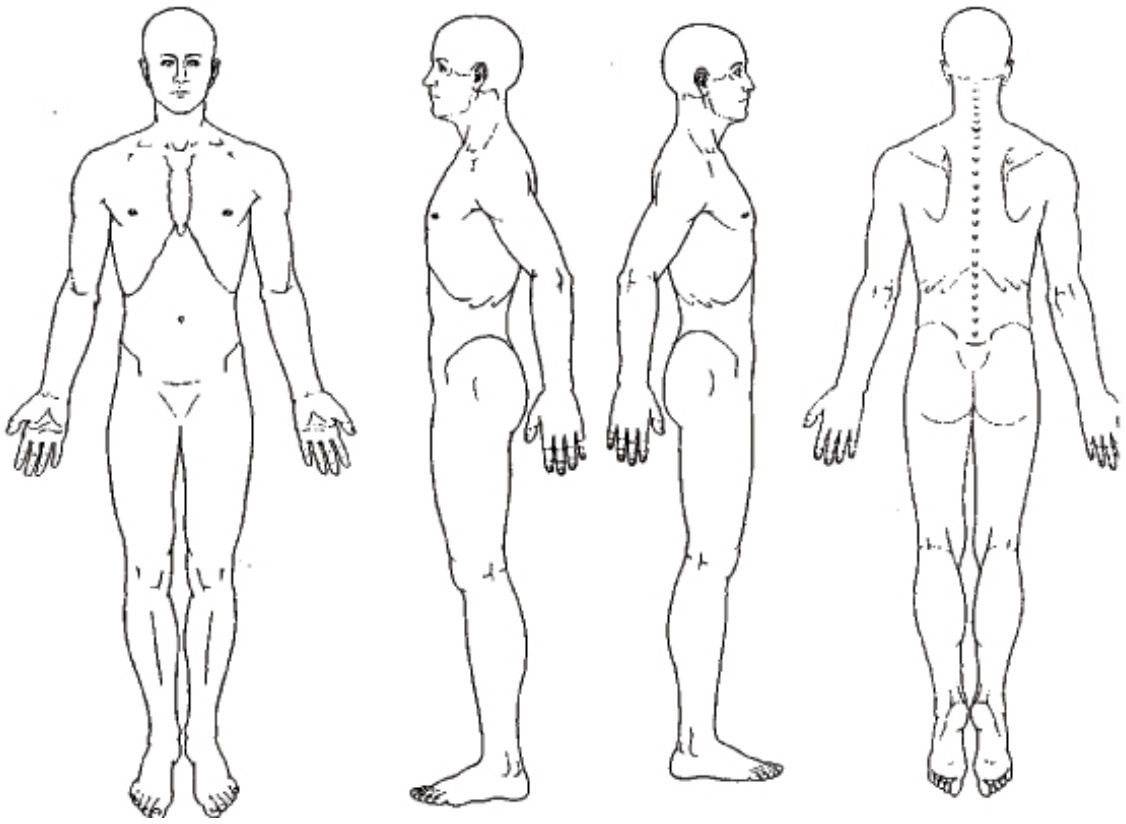
Please rate the severity of pain / effects on daily life.

0	1	2	3	4	5	6	7	8	9	10

Please mark areas where you are experiencing pain.



Major surgeries	
Date	Problem/Surgery
Significant trauma (auto accidents, falls, etc.)	
Date	Trauma

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Childhood health history (select all that apply)

☐ Allergies ☐ Asthma ☐ Frequent Cold/Flu ☐ Frequent Earaches ☐ Frequent ☐ Sore Throats ☐ Premature Birth
☐ Received Recommended Vaccinations
☐ Other Significant Childhood Illnesses _____

Significant Illnesses (select all that apply)					
Neurologic:	☐ Migraines	☐ Seizures	☐ Epilepsy	☐ Peripheral Neuropathy	☐ _____
Mental Health:	☐ Depression & Anxiety	☐ Bipolar	☐ Seeing Therapist	☐ _____	☐ _____
Ear, Nose, Throat:	☐ Chronic Sinusitis	☐ Nasal Polyps	☐ Chronic Otitis Media	☐ _____	☐ _____
Respiratory:	☐ Asthma	☐ Pulmonary Embolism	☐ COPD	☐ _____	☐ _____
Cardiovascular:	☐ CVA	☐ Heart Failure	☐ Hypertension	☐ Atrial Fibrillation	☐ _____
Gastrointestinal:	☐ IBS	☐ GERD	☐ Gallstones	☐ Ulcers	☐ _____
Genitourinary:	☐ UTIs	☐ Kidney Stones	☐ STDs	☐ BPH	☐ Erectile Dysfunction
Immunologic:	☐ Autoimmune Disease	☐ Rheumatoid Arthritis	☐ Hepatitis	☐ HIV/AIDS	☐ _____
Endocrine:	☐ Hypothyroid	☐ Hyperthyroid	☐ Diabetes	☐ _____	☐ _____
Other:	☐ Cancer	☐ Bleeding Disorder	☐ _____	☐ _____	☐ _____

List current medications/supplements you are taking

Medication / Supplement	Date Began	For What Condition	Dose

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Please select any symptoms you currently have or have had in the past year.

TEMPERATURE
- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Hot flashes
- ☐ Acute chills
- ☐ Acute fever
- ☐ Excessive vivid dreams

ENERGY
- ☐ Too much/nervous
- ☐ Good energy
- ☐ Okay energy/slightly low
- ☐ Low energy/fatigue

THIRST
- ☐ Thirsty & drink cold
- ☐ Thirsty & drink hot
- ☐ Thirsty, but don't drink
- ☐ Not thirsty

PERSPIRATION
- ☐ Sweat with little exertion
- ☐ Night sweats
- ☐ Don't sweat

HEAD & SENSES
- ☐ Poor vision
- ☐ Red/Itchy eyes
- ☐ Poor hearing
- ☐ Ear ringing
- ☐ Earaches
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Sinus/Nasal problems
- ☐ Poor sense of smell
- ☐ Frequent sore throats
- ☐ Poor teeth
- ☐ Mouth/Tongue sores
- ☐ Lip sores
- ☐ Dry/Chapped lips
- ☐ Dry mouth & throat
- ☐ Dizzy/Lightheaded
- ☐ Fainting
- ☐ Heavy head & limbs

SLEEP
- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Not enough sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Disturbing dreams
- ☐ Sleep walk or sleep talk

LUNGS & HEART
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Frequent colds
- ☐ Seasonal allergies
- ☐ Slow heart rate
- ☐ Fast heart rate
- ☐ Irregular heart rhythm
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Low blood pressure

MUSCULOSKELETAL/EXTREMITIES

Pain, weakness or numbness in:
- ☐ Head
- ☐ Neck
- ☐ Shoulders
- ☐ Arms/Elbows
- ☐ Wrists
- ☐ Hands/Fingers
- ☐ Upper/Mid back
- ☐ Lower back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Ankles
- ☐ Feet/Heels/Toes
- ☐ Joint swelling
- ☐ Varicose veins
- ☐ Cold hands and feet
- ☐ All over body pain
- ☐ Restricted movement
- ☐ Broken bones
- ☐ Bone deformities
- ☐ Paralysis

APPETITE & DIGESTION
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Excessive saliva
- ☐ Dry mouth
- ☐ Lump sensation in throat
- ☐ Abdominal pain
- ☐ Stomachaches
- ☐ Bloating/Distention
- ☐ Gas
- ☐ Belching/Hiccups
- ☐ Heartburn/Reflux
- ☐ Nausea/Vomit
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Alternating loose/const.
- ☐ Cramps with BM
- ☐ BM-incomplete evacuate
- ☐ Hemorrhoids
- ☐ Bowel incontinence

GENITOURINARY
- ☐ Clear urine
- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Burning urine
- ☐ Scanty or dribbling urine
- ☐ Profuse urine
- ☐ Wake at night to urinate
- ☐ Incontinence
- ☐ Frequent UTIs
- ☐ Bladder prolapse
- ☐ Uterine prolapse

DIET & LIFESTYLE
- ☐ Poor diet
- ☐ Smoke cigarettes
- ☐ Drink alcohol
- ☐ Use drugs
- ☐ Too little activity/exercise
- ☐ Exercise excessively
- ☐ Eating disorder
- ☐ Job stress/concerns
- ☐ Family stress/concerns
- ☐ Other stress/concerns

MENTAL & EMOTIONAL
- ☐ Forgetful/Poor memory
- ☐ Poor concentration
- ☐ Irritable/Angry
- ☐ Sad
- ☐ Tearful/Weepy
- ☐ Anxious/Worried
- ☐ Can't stop thinking
- ☐ Fearful
- ☐ Manic
- ☐ Depressed
- ☐ Hard to express emotions
- ☐ Frequently sigh or yawn

SKIN, HAIR AND NAILS
- ☐ Thick, scaly skin/nails
- ☐ Thin skin/nails
- ☐ Dry skin/nails
- ☐ Bruise easily
- ☐ Discolored skin
- ☐ Lumps
- ☐ Acne
- ☐ Abscesses/Infections
- ☐ Nail fungus
- ☐ Prematurely gray hair
- ☐ Hair loss
- ☐ Dry/Brittle hair

FAMILY HISTORY
- ☐ Autoimmune disease
- ☐ Cancer
- ☐ Heart disease
- ☐ Thyroid disorder
- ☐ Mental illness
- ☐ Fertility concerns

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WOMEN ONLY

GYNECOLOGICAL HISTORY (If you are post-menopausal, please answer to the best of your recollection.)

Are you pregnant or could you be pregnant? ☐ Yes ☐ No

What age did menstruation begin?	Do you menstruate regularly? ☐ Yes ☐ No	If yes, How long is your cycle?
Do you menstruate irregularly? ☐ Yes ☐ No	If yes, cycle varies from _____to _____ days	
When was your last period?	How many days do you bleed?	

Do you have PMS symptoms? ☐ Yes ☐ No			Do you have clots? ☐ Yes ☐ No
Check all that apply:			What color is the blood?
☐ Bowel changes	☐ Breast changes	☐ Acne	
☐ Cramps/Backache	☐ Food cravings	☐ Nausea	Do you spot between periods? ☐ Yes ☐ No
☐ Irritability/Anger	☐ Sad/Weepy	☐ Other	

Are you currently using birth control? ☐ Yes ☐ No	If yes, what method are you using?
How many pregnancies?	Are you trying to get conceive? ☐ Yes ☐ No
How many children?	
How many premature births?	Do you have chronic vaginal discharge? ☐ Yes ☐ No
How many miscarriages?	Do you get yeast infections regularly? ☐ Yes ☐ No
How many abortions?	Was your last PAP normal? ☐ Yes ☐ No Date _____

Have you ever been diagnosed with any of the following?

☐ Cancer of Reproductive Organs	☐ PID	☐ Ovarian cysts
☐ Endometriosis	☐ Fibroids/Endometrial Polyps	☐ Breast cancer

MEN ONLY

GENITOURINARY HISTORY

Have you experienced or ever been diagnosed with any of the following?

☐ Cancer of Reproductive Organs	☐ Coldness or Numbness of the External Genitalia	☐ Pain or Swelling of the Testicles
☐ Premature Ejaculation	☐ Erectile Dysfunction	☐ BPH
☐ Number of Children _____	☐ Date of last PSA _____	

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NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Privacy Pledge: Joyanne Kohler Acupuncture is committed to full compliance with federal and state laws and regulations ensuring the privacy and confidentiality of our patients' and clients' personal health information; the staff will make every effort to respect your privacy and keep confidential health information entrusted to us.

Our Duties: We are required by law to maintain the privacy of your health information, to provide you with this notice of our legal duties and our privacy practices, and to abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notice in accordance with federal or state law; any such change will apply to all of your information in our files.

Patients and clients will be asked to consent to the use or disclosure of your protected health information by agreeing to allow Joyanne Kohler Acupuncture staff to:

- Use your health information within the clinic or disclose your health information to another health care provider or facility for the purpose of diagnosis, assessment and treatment of your condition.
- Use your health information within the clinic or disclose your examination, treatment and billing records to another party such as an insurance carrier, HMO or your employer for the purpose of receiving payment for services rendered to you.
- Use your health information, examination, treatment and billing records for quality control or other administrative purposes to efficiently and effectively operate the practice.
- Use your personal health information to contact you by telephone, mail or e-mail with appointment reminders, newsletters, information about treatment alternatives, or other health related information that may be of interest to you as well as sending a thank-you to the person who referred you. If not at home to receive an appointment reminder, a message may be left on your answering machine.

Required or Permitted Use and Disclosures Without Your Consent: Use or disclosure of your health information without your consent may be required or permitted in some circumstances, including but not limited to: 1) The extent that we are required or permitted to do so by applicable federal or state laws; 2) A public health authority for a wide range of public health activities when authorized to collect or receive your health information under federal or state law; 3) An appropriate government authority if there is reason to believe you are the victim of abuse, neglect or domestic violence; 4) Federal or state health care system and government benefit program oversight activities; 5) A response to a court order, or in response to a subpoena, discovery request or other lawful purpose; 6) Law enforcement officials when required to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena or administrative requests; 7) An appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or the public; 8) A correctional institution if we provide health care services to you as an inmate; 9)Emergent care situations; and 10) Providing care to you that is related to a work-place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

The Health Care Information Rights of Our Patients and Clients Include:

Your Right to Revoke Consent: You may revoke your consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

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Your Right to Limit Uses or Disclosures: You have the right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with you restrictions, the restriction is binding on us.

Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services that we provide at a place other than your home.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Wisconsin law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, we are not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without your consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6)Were disclosed for national security or intelligence purposes; or 7) Were made to correctional or law enforcement officers.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.

Your Right to Complain: You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact Joyanne Kohler, L.Ac. at 1622 110th Ave. Hammond, WI 54015.
By signing below, I give consent to Joyanne Kohler Acupuncture staff to disclose my personal health information as noted above.

[ ] I acknowledge receipt of Joyanne Kohler Acupuncture's Notice of Privacy Practices.
Initial above

_____ _____
Printed Name Authorized Provider Representative Signature

_____ _____
Signature Date

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ACUPUNCTURE INFORMED CONSENT

I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named, for whom I am legally responsible) by Joyanne Kohler, L.Ac. or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Joyanne Kohler, L.Ac., including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, KHT, cupping, tui-na (Chinese massage), moxibustion, electrical or magnet stimulation, auricular seeds, and nutritional and lifestyle counseling.

Acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, numbness, tingling or soreness near the needling sites that may last a few days, dizziness or fainting. Bruising is a common side effect of cupping. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture, including lung puncture (pneumothorax), or broken needles. Infection is another possible risk, although the clinic uses sterile disposable one-time use needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion, cupping or heat lamp therapy. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. **I will notify a clinical staff member who is caring for me if I am or become pregnant.**

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed and I may stop treatment at any time.

I understand that it is not within the scope of practice for acupuncturists to offer a Western (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not done so. I understand that if I have cancer, I must maintain regular visits with my primary physician or oncologist.

I **have / have not** *(circle one)* been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the practitioner of the diagnosis.

I **do / do not** *(circle one)* have a pacemaker or bleeding disorder.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 agree to pay the full amount for services received.

Patient Name (printed): _____

Patient Signature (or patient representative) : _____

Patient Representative/ Relationship (printed): _____

Date: _____

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