PATIENT DOCUMENTS

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Naomi Rabinowitz, LAc
1318 North Vivian Street Longmont, Colorado 80501

Disclosure Statement

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. The practice of acupuncture is regulated by the Department of Regulatory Agencies. Inquiries should be made to: Director of Registrations, Acupuncturists Licensure, 1560 Broadway, Suite 1350, Denver, CO 80202, (303)894-7800.

Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies

Practitioner Education, Certification, and Experience

Naomi Rabinowitz MD, LAc
SUNY-Downstate Medical School (MD 1976).
Post graduate training: Beth Israel Hospital, New York.
Training in Traditional Chinese Medicine was acquired by apprenticeship.
Licensed to practice Medicine and Surgery in New York and Colorado
Certified to practice Acupuncture in New York
Licensed to practice Acupuncture in Colorado
NCCAOM Diplomate certification issued 1985

Fees:

Payment is expected at time of treatment.
Credit cards are not accepted.
No insurance is accepted. No receipts for medical services will be provided.
A bill for acupuncture services is available for flex-spending.

Patients are requested to give 24 hours notice in advance of an appointment if it is necessary to cancel/reschedule.
All appointments that are cancelled/rescheduled with less than 24 hours notice and appointments missed without notice may be charged $40.00 for that appointment.

I have read and understand the Disclosure information.

Name: ________________________________

Date: _________________________________

Naomi Rabinowitz, LAc
1318 North Vivian Street Longmont, Colorado 80501

ACUPUNCTURE CONSENT FORM

Only sterile, disposable needles are used in our practice. Chinese herbs and other supplements will be prescribed when appropriate.

Acupuncture has been practiced for thousands of years and is a very safe procedure. If you've never experienced acupuncture you should be aware that you may experience some of the following:

> Minor, transient discomfort can occur as the needles penetrate the skin. Numbness, tingling or a sensation of heat or pulling may occur during the treatment.
> All of these sensations are normal.

It is extremely rare for a serious medical incident to result from acupuncture.

The most common untoward effects of the treatment include, but are not limited to, these:

- Occasionally, the acupoint will bleed slightly when the needle is withdrawn.
- "Black and blue" marks from minor bleeding under the skin are infrequent, but do happen.
- Transient lightheadedness can occur as the body's energy (Qi) changes, but passes rapidly.

With regard to treatment outcome, usually the person's symptoms are ameliorated after the treatment. If they are unchanged, more or different treatment is needed. Uncommonly, a symptom will get worse after the treatment as energy moves through an area of blockage. Thereafter, once the energy moves freely, the relief is usually significant.

Please let the doctor know if you are pregnant, or trying to get pregnant, as this will influence the placement of the needles.

I hereby request and consent to the performance of acupuncture procedures by Dr. Rabinowitz.

I have discussed the nature and purpose of my treatment with the acupuncturist named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time.

Signed consent for treatment

I have read the above information, agree to the terms therein and agree to treatment.

Name:____

Date:____

Patient Information & Consent Form

About the Treatment

Only sterile, disposable needles are used in our practice. Chinese herbs and other supplements will be prescribed when appropriate.

Acupuncture has been practiced for thousands of years and is a very safe procedure. If you've never experienced acupuncture you should be aware that you may experience some of the following: Minor, transient discomfort can occur as the needles penetrate the skin. Numbness, tingling or a sensation of heat or pulling may occur during the treatment.
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Please let the practitioner know if you are pregnant, or trying to get pregnant, as this will influence the placement of the needles.

Appointments:

Schedule your appointment carefully, at a time convenient for you. A credit card will be necessary to secure your INITIAL appointment time.

Cancellation Fee Policy:
If it is necessary for you to cancel, please give us 24 HOURS NOTICE, as it is difficult to fill appointment slots on short notice. If you cancel with less notice, you will be charged 1/3 of the service fee ($70 for the initial/ $30 for a follow up visit). If you fail to show up for your scheduled appointment without notifying us, you will be charged full fee for the visit. Your full cooperation is appreciated.

Fees and Billing for Acupuncture Services:

Initial visit = $85
Ongoing visits = $75

Payment is expected at time of service (check or cash only).
No insurance is accepted.
No receipts for medical services will be provided.
A bill for acupuncture services is available for flex-spending.

Signed consent for treatment:
I have read the above information and agree to treatment.

Name:____ **Date:** _______________

Patient Profile

Please Print

Name (Last, First):		
Street Address:		
City, State, Zip:		
Email Address: This information will permit Dr. Rabinowitz to communicate with you by email.		
Home Phone :	Work Phone:	Cell Phone:
Current age:____________ Birth date: Place of Birth (City, State, Country): Time (include AM or PM):		
Social Security Number:		
Emergency Contact (Name and Phone Number):		
Referred by___________________________ Referrer's Address:		

This questionnaire is an essential component for successful diagnosis and treatment. Please answer all questions carefully.

Name ____________________________ Date ____________ Age ____________ Gender ___________

List your five main complaints below, in order of importance: Number of Years

1. ____ ______________

2. ____ ______________

3. ____ ______________

4. ____ ______________

5. ____ ______________

Check if you have taken frequent:

____ Antibiotics
____ Antihistamines
____ Sedatives
____ Hormones
____ Birth Control Pills
____ Bronchial Inhalers
____ Cortisone
____ Nose Drops or Sprays
____ Skin Ointments
____ Vitamins
____ Antidepressants

List any drugs, vitamins, herbs or homeopathics you are currently taking: (use back of sheet if necessary)

Is there a family history of:
Diabetes ___ Cardio-Vascular Disease____ Allergies_____ Asthma____ Cancer____

Are you allergic to any foods or medications? If so, which? ________________________

Have you ever been hospitalized for a:
Medical problem no_________ yes_________
Surgical procedure no_________ yes_________
Psychiatric reason no_________ yes_________

If yes, list reasons for hospitalization, treatment & date of stay: (use back of sheet if necessary)

Name ________________________________

Body Systems Review (please check all that apply):

0 = never   1 = rarely   2 = occasionally   3 = frequently   4 = always

Scale	Symptom	Scale	Symptom
0 1 2 3 4	low appetite	0 1 2 3 4	ravenous appetite
0 1 2 3 4	loose stools	0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	mouth sores	0 1 2 3 4	fatigue after eating
0 1 2 3 4	abdominal gas/bloating after food	0 1 2 3 4	bruise easily
0 1 2 3 4	gums (bleeding/swollen)	0 1 2 3 4	thirst
0 1 2 3 4	organ prolapsed (diagnosed)	0 1 2 3 4	belching or vomiting

---

Scale	Symptom	Scale	Symptom
0 1 2 3 4	spontaneous sweat	0 1 2 3 4	fatigue
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	shortness of breath
0 1 2 3 4	general weakness	0 1 2 3 4	cough
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	nasal discharge
0 1 2 3 4	feel worse after exercise	0 1 2 3 4	sinus congestion

---

Scale	Symptom	Scale	Symptom
0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feel cold
0 1 2 3 4	low back pain	0 1 2 3 4	edema
0 1 2 3 4	frequent urination	0 1 2 3 4	urinary incontinence
0 1 2 3 4	early morning diarrhea	0 1 2 3 4	ear problems
yes no	impaired memory	yes no	hair loss
yes no	infertility	high normal low	libido

Scale	Symptom	Scale	Symptom
0 1 2 3 4	muscle spasms/twitches	0 1 2 3 4	irritable
0 1 2 3 4	feel better after exercise	0 1 2 3 4	numb extremities
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes
0 1 2 3 4	alternating diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	red eyes

Scale	Symptom	Scale	Symptom
0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	headaches
0 1 2 3 4	anxiety	0 1 2 3 4	restlessness
0 1 2 3 4	chest pain traveling to shoulder		

high	normal	low	overall body temperature
high	normal	low	overall energy level

Scale	Symptom	Scale	Symptom
0 1 2 3 4	see floaters in eyes	0 1 2 3 4	foggy thinking
0 1 2 3 4	heat in palms or soles	0 1 2 3 4	dizzy upon standing
0 1 2 3 4	feeling of heaviness	0 1 2 3 4	nausea
0 1 2 3 4	afternoon fever	0 1 2 3 4	night sweats
0 1 2 3 4	enlarged lymph nodes	0 1 2 3 4	cloudy urine
0 1 2 3 4	face flushes		

Name _______________________________

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty

Profuse Dribbling Greater than 1x a night

Bowel Movements: Frequency: _______ When? _____________ Feels complete? □ Yes □ No

Please circle any of the following symptoms you are currently experiencing:

Stools: Undigested food Blood Mucus

Consistency: Well-formed Hard Loose Alternates

****

Men Only:

Have you been diagnosed with prostate problems? □ Yes □ No

Do you experience premature ejaculation? □ Yes □ No

Do you have problems with Impotence? □ Yes □ No

Have you been diagnosed with Infertility? □ Yes □ No

Diseases/ Disorders:

____

____

****

Women Only:

Fertility History

Are you pregnant now? □ Yes □ No

Have you been pregnant in the past? □ Yes □ No

Number of live births ____ Miscarriage ___ Abortion____

Infertility work-up (if pertinent)

Doctor or clinic ______________________________ When? _______________________

Do we have your permission to correspond with your reproductive specialist? ?

□ **Yes** □ **No**

What tests (HSG? Blood work, etc.) and findings_________________________________

____

Current medications (Clomid, Lupron etc.) ____________________________________

____

Menstrual History

At what age did you get your first period: _______ Date of last menstrual cycle? ________

Are you currently on the Pill? ☐ Yes ☐ No

Number of days from the start of one period to the start of the next: ___________________

Are your menstrual cycles spaced regularly? ☐ Yes ☐ No

Average number of days of flow: __________

Maximum Flow Day: Use of tampon or pad is ☐ Light = use one for longer than 4 hours

☐ Normal = change every 3 hours ☐ Heavy = change every hour or less ☐ Heavy with clots

Maximum Flow Day: Color is ☐ Pink ☐ Red ☐ Dark ☐ Bright Red ☐ Brown

Does your period cause you pain or cramping? ☐ No Yes: ☐ Before ☐ During ☐ After Period

Do you get nausea or vomiting with your period? ☐ No Yes: ☐ Before ☐ During ☐ After Period

Do you experience any of the following before your period each month?

☐ Water retention ☐ Breast tenderness or swelling ☐ Mental depression

☐ Irritability

☐ Food cravings ☐ Migraines ☐ Other________________

Do you ever bleed or spot between periods? ☐ Yes ☐ No

Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No

Do you have any vaginal discharge between periods? ☐ Yes ☐ No

Gynecological Problems

Date of last pap smear? ________________Have you ever had an abnormal pap smear?

☐ Yes ☐ No

Any gynecological surgery? ☐ No Yes: __________________

Have you ever had a venereal disease or PID? ☐ No ☐ Yes: __________________

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with ovarian cyst or PCOS? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

Have you been diagnosed pelvic adhesions abnormalities? ☐ Yes ☐ No

Menopause

Have you experienced menopause? ☐ Yes ☐ No When? ______________________

Are you on HRT or herbal aids now? ☐ Yes ☐ No What? ______________________

If you are experiencing menopausal symptoms, please describe: _______________________

____

Lifestyle/Habits

FOOD

List what you typically eat for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you skip meals? Breakfast ______ Lunch ______ Dinner ______

Do you drink caffeinated beverages?
No ______
Yes ______ Coffee ______ (cups/day) Tea ______ Soda ______

Do you eat fish ______ chicken ______ meat ______ eggs ______ dairy products ______

Do you eat fruit? ______

Do you eat vegetables? ______

Which? ____
How often? ____

How much water do you drink? ________________________________

Do you eat sweets (cake candy, ice cream, cookies, etc.)? No _______________
Yes ______ What? _____________________________ How often? ______________________

Do you have or have you had an eating disorder? No ___________________
Yes ______ Anorexia ______ Bulimia ______

EXERCISE

Do you exercise? No ______ Yes ______
How often? ___________________________________
What type of exercise?

SLEEP

How many hours do you typically sleep? _______________
What time do you typically go to bed? ______ Arise? ______
Do you have trouble falling asleep? ______
staying asleep? ______
Do you have nightmares? ______
Do you use sleep medication? No ______
Yes ______ What kind ______________________________________
How often ______________________________________

ALCOHOL, CIGARETTES & DRUGS

Do you drink alcohol? No ______
Yes ______ What? ______________________________ How often? ___________________

Do you ______ smoke marijuana?
______ use cocaine?
______ heroin?
______ other drugs? What kind? ____

Do you smoke cigarettes? No ______
Yes ______ How much? ______ For how long? ______
Have you ever tried to quit before? ______
What means? _________________________
Longest time cigarette free ______________

WORK

What kind of work do you do?

Is the work stressful for you? ______________
Is there stress in other areas of your life (home, family, relationships)?

MEDICAL/PSYCH CARE

Who is your personal physician?

Do you regularly see any specialists? (specify Gyn, GI, ENT, GU, etc.)

Do you get chiropractic, osteopathic, physical therapy or massage treatment? If so, which one(s)? ____

Are you now or have you been in:
______ psychotherapy?
______ group therapy?
______ 12 step program?

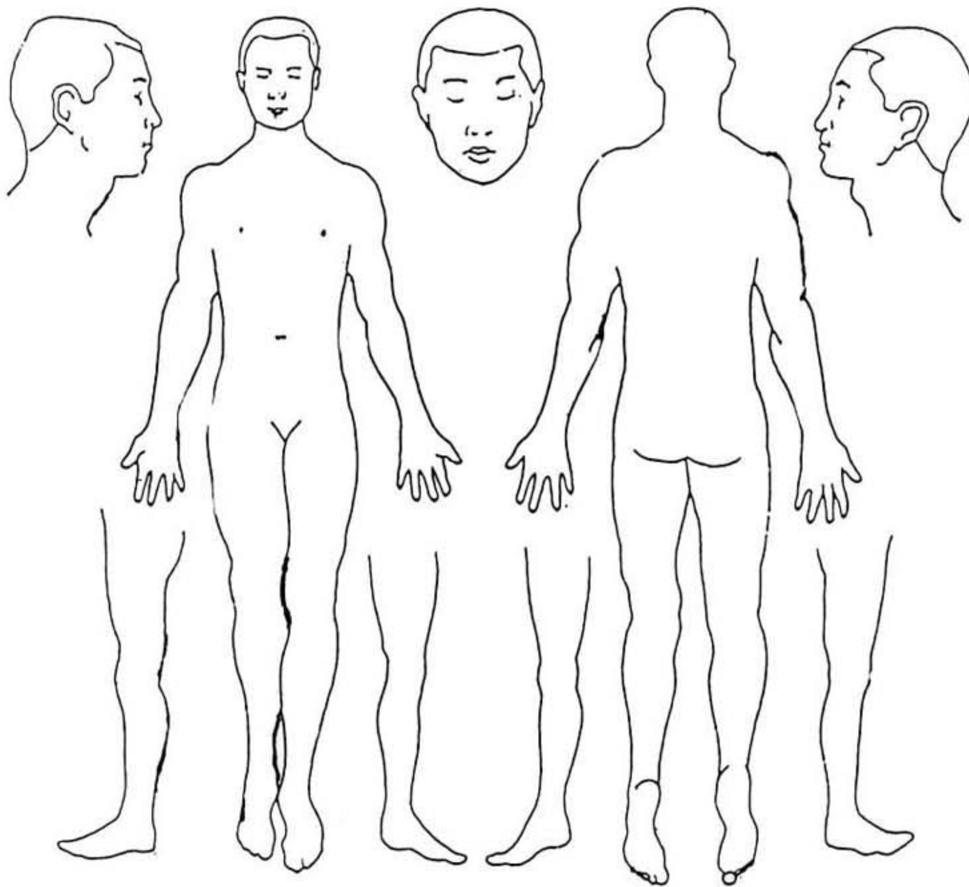
Do you regularly meditate or participate in spiritual practice?
If yes, which_______________________________________

CHINESE MEDICAL EXPEREINCE

Have you ever had acupuncture before? No ______
Yes ______ When and with whom?

Do you have experience with western or Chinese herbal treatment?

Please shade area of pain



Naomi Rabinowitz, LAc
1318 North Vivian Street Longmont, Colorado 80501

Notice of Privacy Policies

Dear Patient,

Patient's privacy of health information is protected by federal law as described by the United States Department of Health and Human Services (HSS). In the spring of 2001 it was established via the Health Insurance Portability and Accountability Act (HIPAA) that all medical facilities were to instruct their patients about their privacy rights.
We are required by law to:

* Maintain the privacy of protected health information
* Give you this notice of our legal duties and privacy practices regarding your health information
* Follow the terms of the notice currently in effect.

Physicians have always protected the confidentiality of health information by locking medical records away in filing cabinets and refusing to reveal your health information.
With the onset of the electronic age, the federal government has recently published regulations designed to further protect the privacy of your health information. This “privacy rule” protects health information that is maintained by physicians, hospitals, other health providers, and health plans. As of April 14, 2003, all health care providers will be required to comply with these privacy standards to protect the confidentiality of your heath information. This includes paper records, oral communications and electronic formats (such as email) and the electronic submission of medical insurance forms.

As specifically concerns privacy at this office, we never release any information about a patient unless permission is first obtained from the patient. This includes phone or written inquiries from insurance companies, law firms or other interested parties. Here we have always taken precautions to ensure confidentially of this sensitive information.

With regard to email, we will use your email address to communicate with you by request, after office hours and for patients in distant locations and for occasional office announcements. Anyone can opt to be removed from that mailing list.

I hope this clarifies my privacy policies. If you have further questions please consult the office manager.

Sincerely,
Naomi Rabinowitz, MD LAc

I have read and understand the Notice of Privacy.

Name: ________________________________

Date: _________________________________