Ginger Michels, L.Ac., Dipl. O.M., MSTOM,
Board Certified Herbalist
3535 E. New York Street, Suite 120, Aurora, IL 60504
acupuncture@atouchofginger.com
www.atouchofginger.com
630 - 299 - 3464

WELCOME TO A TOUCH OF GINGER!

Thank you for choosing A Touch of Ginger LLC. I look forward to working with you soon. I want to reassure you that acupuncture and herbal medicine are safe, comfortable, and help your body and mind heal naturally and with little to no concern for side effects. If you have not booked a treatment yet you may schedule an appointment by calling (630) 299-3464.

HELPFUL GUIDELINES:

- Please eat at least a light snack 1 to 2 hours before your appointment.
- Try not to drink coffee, caffeinated tea, smoke cigarettes or be under chemical influence up to 1 to 2 hours before treatment unless necessary for your health.
- Please fill out the online INTAKE (www.atouchofginger.com) form and bring it with you for your first treatment. This will save time during the initial visit.
- Please wear loose-fitting clothes if possible. You can change at the office if needed.

Your initial visit will last approximately 60-90 minutes. Return visits are typically 45-60 minutes. This time will be spent discussing your medical history and primary complaint, conducting a physical examination based on Traditional Chinese Medicine (TCM), and treatment.

If you are unable to keep your scheduled appointment please contact Ginger at (630) 299-3464 at least 24 hours prior to your appointment time. All appointments canceled with less than 24 hour notice will be assessed a $25.00 fee.

PAYMENT OPTIONS

I accept payment by cash, check, or credit/debit card. Upon request, a Superbill can be provided once a month for your submission to your insurance provider. There is a $40.00 fee for a bounced check and only one occurrence is permitted. If a second check bounces, I will require cash-only payment from then on.

I am pleased to have you as a client and hope you will soon share my enthusiasm for the health-enhancing benefits of acupuncture, herbs and nutrition. My goal is to support your body's natural healing process and assist you in improving your overall health and vitality.

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Acupuncture - New Client

Name _____ Today's Date _____
Address _____ City _____
State _____ Zip _____ E-mail address _____
Phone: Home _____ Work _____ Cell _____
Birth Day _____ Age ____ Ht ____ Wt ____ Sex ☐ M ☐ F ☐ Trans ☐ MTF ☐ FTM
Marital Status _____ No. of Children ____ Occupation _____
Emergency Contact: Name _____ Phone _____
Primary Care Practitioner _____
How did you hear about us? _____
Is this your first time getting acupuncture? ☐ Y ☐ N
What are the main health problems for which you are seeking treatment? _____
_____
When did the problem begin? (Be Specific) _____
_____
Have you been given a diagnosis for the problem? If so, what?_____
Does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? Describe._____
_____
What other forms of treatment have you sought? _____
Do you have any other health complaints or issues you'd like to address?☐ Y ☐ N
If yes, please list and prioritize if possible. _____
_____
_____

Medical History

Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

Cancer (Type) _____ HIV _____
Diabetes (Type 1 or 2) _____ Mental/Emotional Illness _____
Heart Disease _____ Seizures _____
Hepatitis (Type)_____ Stroke _____
High Blood Pressure _____ Thyroid Disease _____
High Cholesterol _____ Tuberculosis _____
Sexually Transmitted Disease: ☐ Gonorrhea ☐ Syphilis ☐ HPV ☐ Chlamydia
☐ Herpes Date _____
Infectious Disease (Type) _____Other _____

PLEASE CHECK ALL THAT APPLY.

Energy and Immunity
- ☐ Fatigue
- ☐ Allergies (Specify) _____
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ Tendency to Catch Colds

Head, Eye, Ear, Nose, and Throat
- ☐ Eye Dryness
- ☐ Blurry Vision
- ☐ Poor Night Vision
- ☐ Ear Ringing
- ☐ Hearing Difficulties
- ☐ Headaches / Migraines
- ☐ Teeth Grinding / TMJ
- ☐ Sore Throat
- ☐ Chronic Sinus Congestion
- ☐ Dry Mouth
- ☐ Bad Breath
- ☐ Mouth Sores / Bleeding Gums
- ☐ Increase in Thirst

Emotions / Sleep
- ☐ Mood Swings
- ☐ Anxious / Worried
- ☐ Depressed
- ☐ Irritable
- ☐ Difficulty Making Decisions
- ☐ Stressed
- ☐ Insomnia
- ☐ Nightmares
- ☐ Difficulty Falling or Staying Asleep

Respiratory / Cardiovascular
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Chest Pin
- ☐ Palpitation / Fluttering
- ☐ Poor Circulation (Cold hands/feet)
- ☐ Chronic Cough
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Hot/Cold Intolerance

Gastrointestinal
- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Bloating / Pain
- ☐ Gas
- ☐ Heartburn / Acid Reflux
- ☐ Belching
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Constipation
- ☐ Sudden Weight Change

Kidney / Urinary
- ☐ Painful Urination
- ☐ Frequent Urinary Tract Infections
- ☐ Frequent / Urgent Urination
- ☐ Edema / Swelling

Musculoskeletal
- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps / Weakness
- ☐ Arm Pain
- ☐ Finger Pain / Tingling / Numbness
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg / Knee Pain
- ☐ Foot / Ankle Pain
- ☐ Hip / Pelvic Pain
- ☐ Arthritis

Neurological
- ☐ Vertigo / Dizziness
- ☐ Numbness / Tingling
- ☐ Difficulty Concentrating / Poor Memory

Skin
- ☐ Rashes / Eczema / Hives / Psoriasis
- ☐ Dry Hair or Hair Loss
- ☐ Changes in Skin Color
- ☐ Easy Bruising
- ☐ Acne
- ☐ Dry / Itchy Skin

Female Health
- ☐ Irregular Cycle
- ☐ Heavy / light Flow
- ☐ Clots in Menstrual Blood
- ☐ Menstrual Related Moodiness
- ☐ Menstrual Related Breast Tenderness
- ☐ Menstrual Related Bloating
- ☐ Bleeding Between Cycles
- ☐ Painful Periods (before, during and/or after)
- ☐ Hot Flashes
- ☐ Vaginal Dryness
- ☐ Breast Lumps / Cysts
- ☐ Uterine Fibroids
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Unusual Vaginal Discharge Odor
- ☐ Frequent Yeast Infections
- ☐ Decreased Libido

Male Health
- ☐ Prostate Enlargement
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Decreased Libido
- ☐ Groin Pain

Please list any surgeries or major injuries with dates.

_____

_____

_____

Please list any significant emotional traumas/Events with dates.

_____

_____

List any medications or supplement you have taken in the last 2 months.

_____

_____

_____

Do you have a pacemaker or any metal device in your body? ☐ Y ☐ N

FAMILY HISTORY

Indicate close family members with any of the following.

Cancer (Type) _____ High Cholesterol _____

Diabetes (Type 1 or 2) _____ Mental Illness _____

Heart Disease _____ Stroke _____

High Blood Pressure _____ Alcoholism _____

LIFESTYLE HABITS

Do you have an exercise routine? Please describe. _____

_____

How many hours per night do you sleep on average?_____

Do you wake rested? ☐ Y ☐ N

Nicotine Use _____

Alcohol Use (#drinks per week and type)_____

Caffeine Use (#drinks per week and type) _____

Water Intake (how much per day) _____

Marijuana Use ☐ Y ☐ N

Drug Use ☐ Y ☐ N

Occupational Hazards ☐ Y ☐ N

Briefly describe your dietary habits (#meals per day and type of food).

_____

_____

_____

Is there anything else you would like to share that you feel might be helpful in some way? _____

_____

_____

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NOTICE OF PRIVACY POLICIES - 9/1/2011

Our office is dedicated to providing services with respect for human dignity. Protecting your privacy and healthcare information is fundamental to our relationship with you. This notice will remain in effect until it is replaced or amended by changes in the law.

We gather personal information and health information in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

Protected Health Information is any information that includes demographic information; information gathered by this office as it relates to your past, present, and future physical or mental health or condition; or past, present, or future payments for healthcare services.

You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for the treatment, payment, and healthcare operations performed.

Without your consent or authorization, this office may disclose information about you only to the following groups for the specified purposes:

- to a public health agency, for a purpose such as controlling disease.
- in case of suspected child abuse, to the appropriate governmental authority.
- in other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- to health oversight authorities, for regulatory, licensing, and other legal purposes.
- in litigation, subject to certain requirements controlling the terms of the disclosure.
- to law enforcement agencies, subject to applicable legal requirements and limitations.
- for medical research purposes, subject to your authorization or approval by an institutional review board.
- if you are in the United States military, national security, or intelligence for Foreign Service, to your authorized superiors or other authorized federal officials.

We may not use or disclose information about you for any other purpose without your authorization, provided separately from your written consent. You may submit written authorization to disclose Protected Health Information to a person or group specified by you.

Marketing

This office will not use your health information for marketing communications without your written authorization. Marketing communications may include birthday cards, newsletters, and appointment reminders, by calls, postcards, or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

Upon written request, you have the right to access, review, or receive copies of your healthcare records.

Upon written request, unless prohibited by law, you have the right to receive a list of items this office disclosed about your healthcare information.

You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

You have the right to request restrictions on the use and disclosure of your Protected Health Information for the purposes of treatment or payment for healthcare operations, but A Touch of Ginger LLC is not required to agree to these restrictions. However, if A Touch of Ginger LLC agrees to a restriction that you request, the restriction is binding to A Touch of Ginger LLC.

You have the right to receive all notices in writing.

More Information

If you have any questions or complaints, or would like to receive more information, contact Ginger Michels, L.Ac. at 630-712-4997, or at the address above.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed to our Privacy Officer by calling our office or directing a letter to her attention.

If you are not satisfied with how our office handles your complaint, you may submit a formal complaint to:

DDHS (Office of Civil Rights)
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

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Acknowledgment of Receipt of NOTICE OF PRIVACY POLICIES - 9/1/2011

I, the undersigned, have received a copy of, read, reviewed, understand, and agree to the "Notice of Privacy Policies" for healthcare services at A Touch of Ginger LLC.

Client Signature: _____

Date: _____