



Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ ft. in. Weight: \_\_\_\_\_ lbs.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: Cell ( \_\_\_\_\_ ) - \_\_\_\_\_ Home ( \_\_\_\_\_ ) - \_\_\_\_\_ (Parent/Guardian if a minor)

Email: \_\_\_\_\_ (Parent/Guardian if a minor)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed Spouse's Name: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Were you referred in? Name: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) - \_\_\_\_\_

Are you a part of a team or club in need of sponsorship? Yes No

If yes, Team/Organization Name: \_\_\_\_\_

**INSURANCE INFORMATION:**

Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**HEALTH HISTORY & CURRENT CONDITION:**

Primary Care Physician: \_\_\_\_\_

Name of Clinic/Group: \_\_\_\_\_ Clinic Phone #: ( \_\_\_\_\_ ) - \_\_\_\_\_

Have you ever received Acupuncture Therapy? Yes No If yes, when & with whom? \_\_\_\_\_

What are the main health problems you are seeking acupuncture treatment for?

\_\_\_\_\_

What other forms of treatment have you tried? What were the results?

\_\_\_\_\_

Other current health problems or concerns?

\_\_\_\_\_

Please list any medications and/or supplements you are currently taking

Medication/Supplement	Dose	Reason	How long?	Prescribed by	Last Checkup

Please check the box if any of the following statements are true:

- I have known allergies       I have a pacemaker       I am taking Coumadin/Warfarin       I am taking Lithium

**FEMALE OB/GYN HISTORY**

Have you ever had/been diagnosed with:

- Fibroids  Fibrocystic Breasts
- Endometriosis  Ovarian  Cysts
- PID

Other diagnoses: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you pregnant?  Yes  No  Trying to get pregnant

Number of live births: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_  
 Number of abortions: \_\_\_\_\_

Date of last gynecologic exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date of last pap smear: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date of last mammogram: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date of last bone density scan: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Results of the above procedures: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Age of 1<sup>st</sup> period (menarche): \_\_\_\_\_  
 Age of last period (menopause): \_\_\_\_\_  
 Color of flow: \_\_\_\_\_  
 Clots:  Yes  No Color: \_\_\_\_\_  
 Number of days between periods: \_\_\_\_\_  
 Number of days of flow: \_\_\_\_\_  
 Average number of pads/tampons per day(s):  
 1<sup>st</sup>: \_\_\_\_\_ 2<sup>nd</sup>: \_\_\_\_\_ 3<sup>rd</sup>: \_\_\_\_\_ 4<sup>th</sup>: \_\_\_\_\_ 5<sup>th</sup>: \_\_\_\_\_  
 6+: \_\_\_\_\_

Location of menstrual pain:  Lower abdomen  Lower back  Thighs  
 Other: \_\_\_\_\_

Nature of menstrual pain (please indicate if before, during, or after):  
 Cramping: \_\_\_\_\_ Stabbing: \_\_\_\_\_ Burning: \_\_\_\_\_  
 Aching: \_\_\_\_\_ Dull: \_\_\_\_\_ Bloating: \_\_\_\_\_  
 Bearing down sensation: \_\_\_\_\_  
 Generally, is this pain:  Consistent  Frequent  Intermittent

Other symptoms related to menses (please check all that apply):

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Headache     |
| <input type="checkbox"/> Poor appetite     | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Mood swings  |
| <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Swollen breasts | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Increased libido  | <input type="checkbox"/> Hot flashes     | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Decreased libido  | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Discharge    |
| <input type="checkbox"/> Other: _____      |  |                                       |

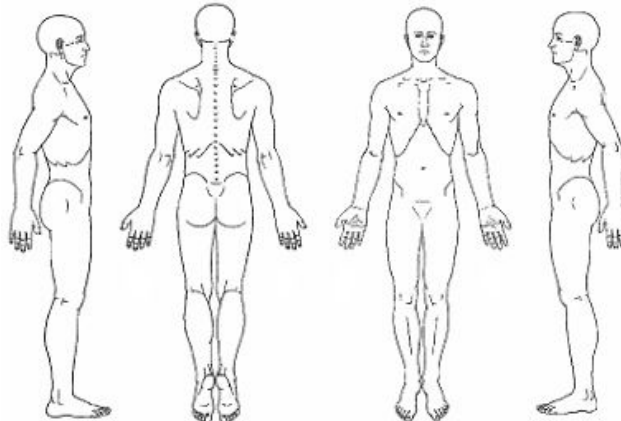
**MALE UROGENITAL HISTORY**

Date of last prostate exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Manual prostate exam results: \_\_\_\_\_  
 PSA results: \_\_\_\_\_  
 Lab results: \_\_\_\_\_  
 Frequency of urination: \_\_\_\_\_ day \_\_\_\_\_ night  
 Color of urine:  Clear  Cloudy  Odor: \_\_\_\_\_

- Prostate Related Symptoms (please check all that apply):
- |  |  |
|--|--|
| <input type="checkbox"/> Prostate problems         | <input type="checkbox"/> Increased libido      |
| <input type="checkbox"/> Retention of urine        | <input type="checkbox"/> Decreased libido      |
| <input type="checkbox"/> Delayed stream            | <input type="checkbox"/> Erectile Dysfunction  |
| <input type="checkbox"/> Decreased force of stream | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Post void dribble/leaking | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Incontinence              | <input type="checkbox"/> Testicular pain       |
| <input type="checkbox"/> BPH/Enlarged Prostate     | <input type="checkbox"/> Back pain             |
|  | <input type="checkbox"/> Groin pain            |

Please circle the severity of pain (current, best, & worse): 0 1 2 3 4 5 6 7 8 9 10

Using the diagram provided, mark the areas of concern:



**SYMPTOM SURVEY**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Lack of appetite          | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Eye issues              | <input type="checkbox"/> Fatigue                           |
| <input type="checkbox"/> Excessive appetite        | <input type="checkbox"/> Chest pains              | <input type="checkbox"/> Allergies               | <input type="checkbox"/> Edema                             |
| <input type="checkbox"/> Loose stool/diarrhea      | <input type="checkbox"/> Sciatic pain             | <input type="checkbox"/> Blurry vision           | <input type="checkbox"/> Blood in stool                    |
| <input type="checkbox"/> Digestive issues          | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Gall stones             | <input type="checkbox"/> Black tarry stool                 |
| <input type="checkbox"/> Vomiting/nausea           | <input type="checkbox"/> Cough                    | <input type="checkbox"/> Floaters in the eye     | <input type="checkbox"/> Easily bruised                    |
| <input type="checkbox"/> Belching                  | <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Soft/brittle nails      | <input type="checkbox"/> Incontinence                      |
| <input type="checkbox"/> Heartburn/reflux          | <input type="checkbox"/> Decreased sense of smell | <input type="checkbox"/> Easily angered/agitated | <input type="checkbox"/> Asthma                            |
| <input type="checkbox"/> Feeling of food retention | <input type="checkbox"/> Nasal issues             | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Tendency to catch colds           |
| <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Skin issues              | <input type="checkbox"/> Muscle spasms           | <input type="checkbox"/> Intolerance to changes in weather |
| <input type="checkbox"/> Heart palpitations        | <input type="checkbox"/> Loss of hearing          | <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Jaundice (yellowish skin/eyes)    |
| <input type="checkbox"/> Cold hands/feet           | <input type="checkbox"/> Swollen/painful joints   | <input type="checkbox"/> Knee pain               | <input type="checkbox"/> Difficulty making plans/decisions |
| <input type="checkbox"/> Nightmares                | <input type="checkbox"/> Stress or nervousness    | <input type="checkbox"/> Hearing impairment      | <input type="checkbox"/> Hay fever                         |
| <input type="checkbox"/> Ear ringing               | <input type="checkbox"/> Night sweats             | <input type="checkbox"/> Mentally restless       | <input type="checkbox"/> Hemorrhoids                       |
| <input type="checkbox"/> Kidney stones             | <input type="checkbox"/> Sudden weight loss       | <input type="checkbox"/> Extreme thirst          |  |
| <input type="checkbox"/> Hair loss                 | <input type="checkbox"/> Urinary problems         | <input type="checkbox"/> Lumps/swelling          |  |
| <input type="checkbox"/> Decreased sex drive       | <input type="checkbox"/> Spontaneous sweating     | <input type="checkbox"/> Constipation            |  |
| <input type="checkbox"/> Rib/side pain             | <input type="checkbox"/> Recent antibiotic use    |  |  |

Other: \_\_\_\_\_

Please indicate the USE and FREQUENCY of the following:

	Yes	No	How much/often
Coffee/Black Tea			
Non-Medicinal Drug			
Tobacco/Vape			

	Yes	No	How much/often
Alcohol			
Soda			
Water intake			

Please indicate any significant illnesses you or a blood relative (grandparent, parent, sibling) have had:

	Who/Relation	Approx. Date
Cancer		
Hepatitis		
High Blood Pressure		
Rheumatic Fever		
Infectious Disease		

	Who/Relation	Approx. Date
Diabetes		
Heart Disease		
Seizure		
Emotional Disorders		
Tuberculosis		

Sexually Transmitted Infections (please check all that apply):

- Gonorrhea  Syphilis  HIV  HPV  Chlamydia  Herpes  Other: \_\_\_\_\_

Please list any allergies, food sensitivities and/or food cravings:

\_\_\_\_\_

\_\_\_\_\_

Please list any accidents, surgeries, or hospitalizations (include date):

Approx. Date

_____	_____
_____	_____
_____	_____

Please indicate anything you have been troubled by in the last year in your personal life:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MYSELF/CHILD AS THEY DEEM NECESSARY

PRINT NAME

SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

**ACUPUNCTURISTS USE ONLY**

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

**Your Right to Revoke Consent:** You may revoke 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.

**Your Right to Limit Uses or Disclosures:** You have a 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 your 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 we provide at a place other than your home or if you would like the information in a different form.

**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 Minnesota 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, the clinic is 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 our 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 purpose; 7) Were made to correctional or law enforcement officers; or 8) Were made prior to April 14, 2003.

*We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.*

**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 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 the Compliance/Privacy Officer at:

**PIFF Holdings, PC  
DBA, Northern Life Wellness  
13955 W. Preserve Blvd., Ste. 200  
Burnsville, MN 55337  
(952) 890-0804**



**CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

***OUR PRIVACY PLEDGE: Northern Life Wellness is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us.***

Ways in which the clinic may use or disclose your health care information include, but are not limited to:

- Another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, information about the clinic, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic and will be given to you when you come in for treatment.

**Your Right to Limit Uses or Disclosures:** You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

**Your Right to Revoke Your Authorization:** You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

**YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, NORTHERN LIFE WELLNESS WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.**

[                    ] I acknowledge receipt of Northern Life Wellness's Notice of Privacy Practices  
Initial Here

By signing below, I give consent to Northern Life Wellness clinicians or staff to disclose my personal health information.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN IF MINOR)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE



**INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT**

I have been informed that Jasmine Amberg, L.Ac. is a graduate of Northwestern Health Sciences University and holds a minimum of a Master’s degree in Traditional Chinese Medicine. I have been informed that Jasmine Amberg, L.Ac. is licensed to practice Traditional Chinese Medicine by the Minnesota Board of Medical Practice (MBMP) and is licensed nationally by the National Certification Board for Acupuncture and Herbal Medicine (NCBAHM)

I have been informed that acupuncture needles used in my treatment are sterile, single-use, and disposable.

I understand that acupuncturists do not provide, nor make Western medical (biomedical) diagnoses and that it is my responsibility to seek such evaluation or diagnosis from a licensed medical provider if you have not already done so.

I hereby authorize Jasmine Amberg, L.Ac., to assess and treat me in accordance with the principles and professional standards of Traditional Chinese Medicine. I understand that my treatment may include a variety of modalities, including but not limited to: acupuncture, herbal therapy, tui na (Chinese medical massage), moxibustion, cupping, electrical stimulation, gua sha (dermal friction), acupressure, tuning fork therapy, dietary counseling, breathing techniques, and therapeutic exercises based on Traditional Chinese Medicine principles.

I understand that Traditional Chinese Medicine therapies are generally considered safe; however, I acknowledge that there are potential risks and side effects. These may include, but are not limited to: mild or temporary pain, minor bruising or bleeding at needle insertion sites, fatigue, vasovagal responses (such as dizziness, nausea, or fainting), temporary worsening of symptoms, and a minimal risk of infection. I understand that herbal remedies may cause side effects, including gastrointestinal discomfort. I further understand that moxibustion may result in burns or temporary skin discoloration.

I understand that no guarantees or assurances have been made regarding the outcome of treatment. I acknowledge that reasonable efforts will be made to provide information necessary for me to make informed decisions regarding the duration and appropriateness of my care.

I understand and agree that I am financially responsible for all services rendered. Payment is due at the time services are provided. **I further understand that missed appointments or cancellations made less than 24 hours in advance may result in a fee equal to 50% of the scheduled service.**

\_\_\_\_\_ By initialling here and selecting the the appropriate response, I confirm that I have disclosed, to the best of my knowledge the presence of a pacemaker. **Do you have a pacemaker:**  YES  NO

\_\_\_\_\_ By initialling here and selecting the the appropriate response, I confirm that I have disclosed, to the best of my knowledge the presence of a bleeding disorder. **Do you have a bleeding disorder:**  YES  NO

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE (PARENT/GUARDIAN IF MINOR)

\_\_\_\_\_/\_\_\_\_\_  
DATE

\_\_\_\_\_  
ACUPUNCTURIST SIGNATURE

\_\_\_\_\_/\_\_\_\_\_  
DATE



