BREATH OF LIFE ACUPUNCTURE & WELLNESS
JENNIFER ROSEMAN, L.AC, LMT, CYT
2105 DEMERSE AVENUE, PRESCOTT, AZ 86301
PH: (928)713-3833
WWW.BREATHOFLIFEHEALING.COM

Thank you for scheduling with Breath of Life Acupuncture & Wellness. I strive to provide the best possible integrative care for my clients. During your initial session, I will do a thorough evaluation and give you a treatment plan. You can assist me in that by making sure you have fully completed the intake paperwork enclosed.

I ask that all new patient paperwork is filled out prior to your appointment time. If you are unable to fill out paperwork at home, please arrive 20 minutes before your scheduled appointment time to do so.

Please be aware that I ask patients to give me 24 hour notice if they need to reschedule or cancel an appointment. Late cancellation or missed appointments incur the full fee or your appointment, as I am unable to reschedule the appointment with another patient without sufficient notice.

DIRECTIONS:

The easiest way to find my office location is to type the address into Google Maps or a GPS device.

Once you arrive, pull into the half-moon shaped driveway and park in the section closest to the Yin/Yang symbol signs. (A sample of this symbol is at the top of this page).

The signs will be posted at the front of the driveway entrance and leading up the path to the front gate. Open the gate and let yourself into the front yard area. Follow the path to the left and you'll see a door with a red sun-burst design on it. No need to knock, just come on in and make yourself comfortable.

If you get confused, please give me a call and I'll come out and guide you.

HOW DO YOU GET THE MOST OUT OF EACH TREATMENT?

Be sure to eat a balanced meal before coming to treatment. Avoid caffeine in coffee, tea, or sodas during the day of treatment. Avoid intense physical activity, very spicy foods and exposure to extreme heat like a sauna, before or after your scheduled treatment.

Please let me know if you have any questions. It will be a pleasure to support you on your path towards wellness.

Sincerely,

Jennifer Roseman, L.Ac., LMT, CYT

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Confidential Acupuncture Intake Form

Personal Information

Patient Name:_____

Age:_____ Birth Date:____/____/____ Gender:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone (Day):_____Telephone (Mobile):_____

Email Address:_____

Occupation:_____

How did you hear about us?:_____

Who is your primary health care provider/MD?_____

Emergency Contact:_____ Phone:_____

Health Concerns

Please identify your primary health concerns

1._____

_____

How long have you had this problem?_____

2._____

_____

How long have you had this problem?_____

3._____

_____

How long have you had this problem?_____

Have you been given a diagnosis for these problems?_____

What other treatments have you tried and what were the outcomes?_____

_____

_____

Personal Medical History (Please include your childhood history)

Illnesses	
Surgeries	
Significant Trauma (i.e. motor vehicle accidents, fractures, physical/emotional abuse)	
Do you have a history of current or past infectious disease? Please describe	
Medications (please list all medications, herbs, vitamins, and over the counter drugs)	
Allergies/Sensitivities (please list any foods, drugs, medications, or environmental factors which you are sensitive or allergic to)	

General (please check all that apply)

- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Hearing Loss
- ❑ Easy to Bleed or Bruise
- ❑ Strong Thirst
- ❑ Puffiness or Swelling
- ❑ Night Sweats
- ❑ Changes in Appetite
- ❑ Weakness
- ❑ Fevers
- ❑ Sweat Easily
- ❑ Poor Sleep
- ❑ Poor Balance
- ❑ Cravings
- ❑ Sudden Energy Drops
- ❑ Chills
- ❑ Fatigue
- ❑ Tremors
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ History of Drug or Alcohol Abuse
- ❑ Tendency to Feel Hot or Cold
- ❑ Trouble Sleeping (i.e. Insomnia, Sleep Apnea, Difficulty Falling Asleep or Staying Asleep, etc.)
- ❑ Other:

Skin & Hair

- ❑ Rashes
- ❑ Skin Ulcers
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Hair Loss
- ❑ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ❑ Dizziness
- ❑ Cataracts
- ❑ Taste/Smell Problems
- ❑ Eye Strain/Pain
- ❑ Nose Bleeds
- ❑ Migraines
- ❑ Recurrent Sore Throat
- ❑ Toothache
- ❑ Ear Ringing
- ❑ Headaches
- ❑ Night Blindness
- ❑ Facial Pain
- ❑ Ear Aches
- ❑ Lip or Tongue Sores
- ❑ Blurry Vision
- ❑ Sinus Problems
- ❑ Concussions/Head Injury
- ❑ Tooth/Gum Problems
- ❑ TMJ Pain
- ❑ Spots in Front of Eyes
- ❑ Floaters

Cardiovascular

- ❑ High Blood Pressure
- ❑ Cold Hands or Feet
- ❑ Swelling of Hands
- ❑ Phlebitis
- ❑ Low Blood Pressure
- ❑ Blood Clots
- ❑ Swelling of Feet
- ❑ Fainting
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Lightheadedness

Respiratory

- ❑ Cough
- ❑ Phlegm
- ❑ Asthma
- ❑ Bronchitis
- ❑ Coughing Up Blood
- ❑ Painful Breathing
- ❑ Difficulty Breathing
- ❑ Pneumonia
- ❑ Easily Winded

Gastro-Intestinal

- ❑ Nausea
- ❑ Bad Breath
- ❑ Laxative Use
- ❑ Indigestion
- ❑ Blood in Stools
- ❑ Constipation
- ❑ Ulcers
- ❑ Vomiting
- ❑ Rectal Pain
- ❑ Hemorrhoids
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Intestinal Gas
- ❑ Belching
- ❑ Colitis/Diverticulitis

Urology

- ❑ Painful Urination
- ❑ Decrease in Urine Flow
- ❑ Cloudy Urine
- ❑ Pain in Groin Area
- ❑ Urgency to Urinate
- ❑ Frequent Urination
- ❑ Kidney Stones
- ❑ Sexually Transmitted Disease
- ❑ Unable to Hold Urine
- ❑ Blood in Urine
- ❑ Frequent Night Urination

Neuro-Psychological

- ❑ Seizures
- ❑ Twitches
- ❑ Irritability
- ❑ Poor Memory
- ❑ Tremors
- ❑ Areas of Numbness
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Anxiety
- ❑ Concussion
- ❑ Depression
- ❑ Stress
- ❑ Mood Swings

Gynecology

- _____Age of Menses
- _____Duration of Menses
- _____Date of Last Menses
- _____# of Pregnancies
- _____# of Births
- ❑ Irregular Periods
- ❑ Breast Lumps/Pain
- ❑ Spotting
- ❑ Vaginal Discharge
- ❑ Clots
- ❑ PMS
- ❑ Menopausal
- ❑ Yeast Infections
- ❑ Fertility Problems
- ❑ Lack of Sex Drive

Lifestyle

Exercise Routine (how often to you exercise and what type of exercise do you participate in)_____

_____

Spiritual Practices (what spiritual practices do you participate in that help you feel calm and peaceful)_____

_____

Family Life (Do you feel safe, comfortable and happy with your home living situation)_____

_____

Diet: How many of glasses of water do you drink a day? _____
How many alcoholic drinks do you have a day? _____ Do you drink coffee or tea regularly?_____
How much soda/cola/juice/or sweet tea do you drink in a day? _____

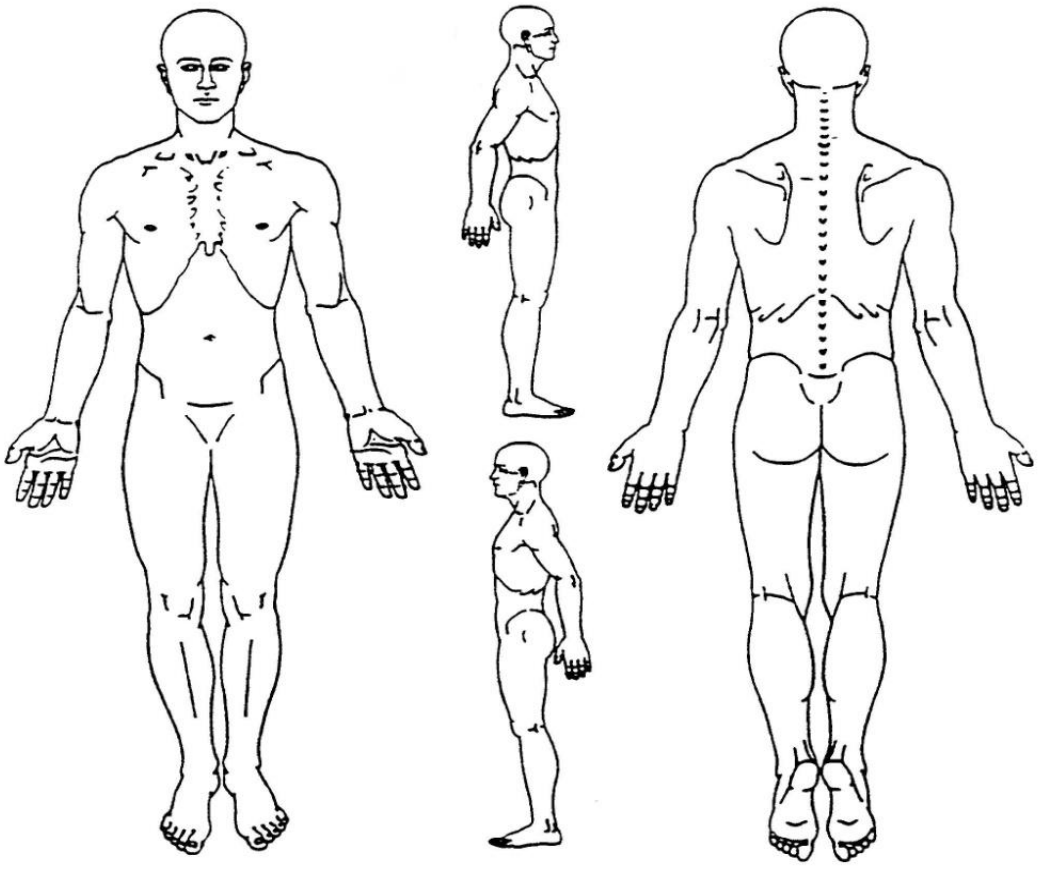
Do you prefer or crave any of the following tastes (circle all that apply): Salty Sweet Sour Spicy Bitter

Muscolo-Skeletal

- ❑ Arthritis
- ❑ Muscle Spasms
- ❑ Pain with Weather Changes
- ❑ Muscle Weakness
- ❑ Scoliosis
- ❑ Pain with Activity
- ❑ Muscle Cramping
- ❑ Weak Joints
- ❑ Pain after Waking

Please indicate any areas of pain, stiffness, numbness or tingling on the body chart below.

P = Pain or Tenderness
S = Joint or Muscle Stiffness
N = Numbness or Tingling



I UNDERSTAND THAT ALL CANCELLATIONS OR APPOINTMENT CHANGES MUST BE MADE AT LEAST 24 HOURS IN ADVANCE TO AVOID A LATE CANCELLATION/APPOINTMENT CHANGE FEE EQUIVALENT TO THE AMOUNT OF YOUR ORIGINALLY SCHEDULED APPOINTMENT.

Your Signature:_____ Today's Date:_____

Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/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 the acupuncturist named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but or not limited to, acupuncture, cupping, gua sha, electrical stimulation, massage, Chinese herbal medicine, nutritional counseling and lifestyle coaching.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling, or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Heat Treatments with Moxa or a TDP Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat. Bruising can last between 1-7 days.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

Acupressure & Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturists of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. 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 conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Jennifer Roseman, L.Ac. is not a primary care physician.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

signature	date
print name	

HIPPA Notice
Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy lows.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. Copies of released records are sent by mail.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Jennifer Roseman, L.Ac, LMT maintain my records confidentially in accordance with the law. I agree to inform Jennifer Roseman, L.AC, if I need any special arrangements pertaining to this issue.

signature	date
print name	