The Om Flow LLC
Confidential Patient Information

Date_____

First Name_____ M.I._____ Last Name_____

Address_____ City_____ State_____ Zip_____

PHONE – Home_____ Work_____ Cell _____
Preferred contact number? Home ☐ Work ☐ Cell ☐ Other ☐
_____

Email_____

Emergency Contact _____ Relationship_____

Emergency Contact Phone _____

D.O.B._____ Age_____ Gender _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner/Significant Other ☐
Live with: Spouse ☐ Partner ☐ Children ☐ Parents ☐ Friend(s) ☐ Alone ☐ Pet(s) ☐

Occupation _____
Employed ☐ Self- Employed ☐ Unemployed ☐ Retired ☐ Full-time Student ☐ Part-time Student ☐

Who may I thank for your referral? _____

Who is your primary physician? _____ Date of last visit _____

Are you seeing any other health care practitioners? Yes ☐ No ☐
If yes, please list: ___ _____

Have you ever had acupuncture? Yes ☐ No ☐ If yes, from who and when?_____

Did you have any sensitivity or reactions to the treatment? Yes ☐ No ☐
If yes, please share your experience: _____

HIPAA Policy

Please [check] your preferred methods of contact.

Detailed message at: Home ☐ Work ☐ Cell ☐ Other ☐
Message with call back number only at Home ☐ Work ☐ Cell ☐ Other ☐
Mail to Home Address Yes ☐ No ☐
Email ☐
Would you like an email reminder of your scheduled appointments? Yes ☐ No ☐

Symptoms

Please list in order of importance the main symptoms that are of concern to you.

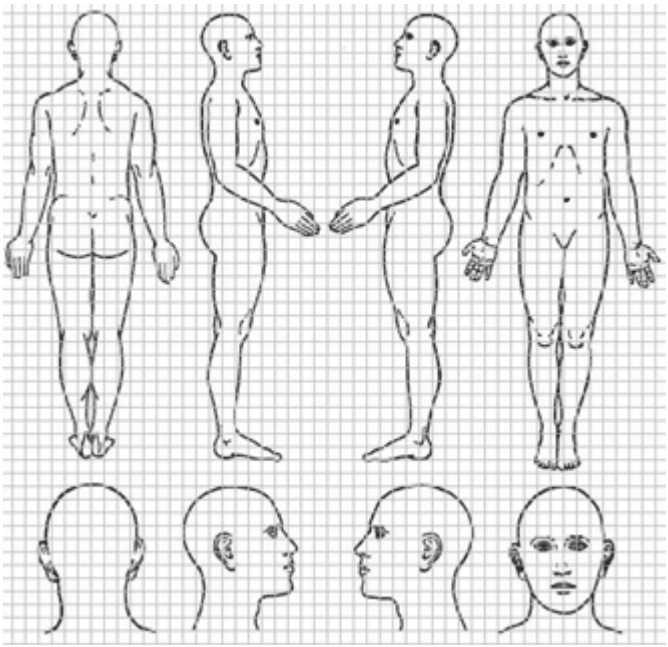
1. _____
2. _____
3. _____
4. _____
5. _____

Goals

What would you like to achieve through your sessions at The Om Flow?

1. _____
2. _____
3. _____
4. _____
5. _____

Are you experiencing any pain or discomfort in any area(s) of your body? Yes ☐ No ☐



If yes, please use the illustration to indicate painful or distressed areas. Use the following symbols on any area(s) of the illustration where you are experiencing the following feelings:

XXX = Sharp or stabbing pain

PPP = Pins and Needles

DDD = Dull Aching

NNN = Numbness

WWW = Weakness

Medical History

Please check all that apply.

	Date diagnosed		Date diagnosed
☐ Diabetes	_____	☐ High Cholesterol	_____
☐ High Blood Pressure	_____	☐ Thyroid Disease	_____
☐ Seizures	_____	☐ Cancer	_____
☐ Hepatitis	_____	☐ HIV	_____
☐ Other	_____		

Please specify _____

Please list any medications you are currently taking on a regular basis, including prescription medicine, vitamin or herbal supplements, and over the counter medications along with dosages and brands if known.

_____

_____

_____

_____

Please list any surgeries, broken bones, or traumas Date

1. _____
2. _____
3. _____
4. _____
5. _____

How many times have you been hospitalized? _____

Please list and briefly describe the most significant events in your life (can be any event, happy, sad, etc.)

1. _____
2. _____
3. _____
4. _____

Have you been treated for emotional issues? Yes ☐ No ☐
Have you ever considered or attempted suicide? Yes ☐ No ☐
Who would you describe as your source of primary social support? _____
What is their relation to you?_____

Do you exercise? Yes ☐ No ☐ If yes, ____days per week. What type? _____
Do you follow a special diet (i.e. vegetarian, vegan, low carb, gluten-free)? Yes ☐ No ☐
If yes, please describe _____

Do you have any known allergies or hypersensitivities? Yes ☐ No ☐ Any history of anaphylaxis? Yes ☐ No ☐
If yes, Please list_____

_____

_____

Social History

Do you consume or use any of the following? If yes, how much?

1. Coffee - Yes ☐ No ☐ Regular ☐ Decaf ☐ ____ cups per day
2. Tea - Yes ☐ No ☐ Black ☐ Green ☐ Herbal ☐ ____cups per day
3. Soft Drinks - Yes ☐ No ☐ Regular ☐ Diet ☐ ____glasses per day
4. Water - ____glasses per day
5. Alcohol - Daily ☐ Occasionally ☐ No ☐ ____Drinks per day _____
6. Cigarettes - Yes ☐ No ☐ ____Packs per day
7. Cigars - Yes ☐ No ☐ ____ Cigars per day
8. Other Drugs - Yes ☐ No ☐ _____

Have you ever had a problem with alcohol or alcoholism? Yes ☐ No ☐
Have you ever had a problem with dependency on any drugs? Yes ☐ No ☐
If yes, which and when? _____
Do you have a history of any exposure to any toxic substances? Yes ☐ No ☐
If yes, which, what symptoms did you notice and when? _____

Family History

Please check all that apply and how you are related to the family member with that condition.

Condition	Mother	Father	Sibling(s)	Maternal Grandparent	Paternal Grandparent
Heart Disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other Mental Illness					
Substance Abuse					
Osteoporosis					
Diabetes					
Alzheimer's Disease/Dementia					

Is there anything else you would like to share about your family history? _____

_____

Health

Please check all that apply

General

Past	Currently	Condition
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Changes in appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night sweats
☐	☐	Sweat easily
☐	☐	Chills
☐	☐	Localized weakness
☐	☐	Bleed or bruise easily
☐	☐	Excessive thirst
☐	☐	No thirst
☐	☐	Other_____

Skin & Hair

Past	Currently	Condition
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Boils
☐	☐	Dryness
☐	☐	Tumors/Lumps
☐	☐	Hair loss
☐	☐	Other _____

Head & Neck

Past	Currently	Condition
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Concussions
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Neck stiffness
☐	☐	Enlarged lymph glands
☐	☐	Goiter
☐	☐	Other_____

Ears

Past	Currently	Condition
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other_____

Eyes

Past	Currently	Condition
☐	☐	Blurred Vision
☐	☐	Visual Changes
☐	☐	Poor night vision
☐	☐	See spots/floaters
☐	☐	Cataracts
☐	☐	Glasses/contacts
☐	☐	Eye inflammation
☐	☐	Other_____

Nose, Throat & Mouth

Past	Currently	Condition
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Hay fever
☐	☐	Allergies
☐	☐	Teeth Grinding
☐	☐	Jaw clenching
☐	☐	Dry mouth/throat
☐	☐	Recurring sore throat
☐	☐	Difficulty swallowing
☐	☐	Other_____

Cardiovascular

Past	Currently	Condition
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	High Cholesterol
☐	☐	Blood clots
☐	☐	Phlebitis
☐	☐	Chest pains
☐	☐	Palpitations
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Other_____

Respiratory

Past	Currently	Condition
☐	☐	Asthma
☐	☐	Anaphylaxis
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	COPD
☐	☐	Pneumonia
☐	☐	Recurrent Cough
☐	☐	Coughing blood
☐	☐	Phlegm
☐	☐	Other_____

Gastro-Intestinal

Past	Currently	Condition
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Belching
☐	☐	Bad breath
☐	☐	Acid Reflux
☐	☐	Blood in stool
☐	☐	Black stool
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Pain or cramping
☐	☐	Gas
☐	☐	Gallbladder Disorder
☐	☐	Rectal Pain
☐	☐	Hemorrhoids
☐	☐	Other_____

Urinary

Past	Currently	Condition
☐	☐	Kidney stones
☐	☐	Pain with urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other_____

Neurological

Past	Currently	Condition
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness/tingling limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other_____

Psychological

Past	Currently	Condition
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Panic Attacks
☐	☐	Irritability
☐	☐	PTSD
☐	☐	Emotional problems
☐	☐	Other_____

Muscular-Skeletal

Past	Currently	Condition
☐	☐	Stiff neck/shoulders
☐	☐	Low back pain
☐	☐	Upper back pain
☐	☐	Muscle spasms/twitching
☐	☐	Muscle cramping
☐	☐	Knee pain
☐	☐	Weak knees
☐	☐	Joint pain
☐	☐	Osteoporosis
☐	☐	Other_____

Male

Past	Currently	Condition
☐	☐	Pain/Itching genitals
☐	☐	Genital lesions/discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Other_____

Female

Past	Currently	Condition
☐	☐	Urinary tract infections
☐	☐	Vaginal infections
☐	☐	Pain/itching genitals
☐	☐	Genital lesions/discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal pap smears
☐	☐	Irregular menstrual periods
☐	☐	Painful menstrual periods
☐	☐	PMS
☐	☐	Abnormal bleeding
☐	☐	Menopause
☐	☐	Breast Tenderness
☐	☐	Breast Lumps
☐	☐	Hot flashes
☐	☐	Other_____

Infection Screening, Positive Results

Past	Currently	Condition
☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphilis
☐	☐	Genital Warts
☐	☐	Herpes - oral
☐	☐	Herpes – genital

The Om Flow LLC

Informed Consent to Treatments

I, _____, hereby request and consent to acupuncture and related treatments and therapies from The Om Flow LLC By my signature below, I acknowledge and agree that I have read and understood the following:

I have been advised by The Om Flow LLC to consult a licensed physician or mental health care professional regarding the condition or conditions for which I am seeking acupuncture treatments. I understand that there may be other treatment alternatives.

Initial: _____

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to balance bodily energies, dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, minor burns with the use of Moxa, swelling, infection, bruising from cupping techniques, needle sickness (dizziness, fainting, nausea), pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment, or a broken needle (very rare with the use of disposable needles).

Initial: _____

I understand that the use or ingestion of certain herbal and other non-pharmaceutical substances may be recommended to me. I understand that I must follow my acupuncturist's instructions for use or ingestion of these substances if I agree to their use. I am aware that any substance recommended to me may cause certain adverse side effects, including but not limited to: changes in bowel movement, abdominal pain or discomfort, allergic reaction, and the possible aggravation of pre-existing symptoms. I understand that if I experience any such side effects, I must discontinue use, consult a physician, and notify The Om Flow LLC prior to further acupuncture or related treatments.

Initial: _____

I understand that I may discontinue acupuncture treatment and related therapies at any time.

Initial: _____

No guarantees have been given to me by The Om Flow LLC regarding cure or improvement of any condition.

Initial: _____

I have carefully read all of the above information and I understand it entirely. I have asked any questions necessary to complete my understanding. Having done so, I voluntarily consent to any of the above treatments or therapies.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

The Om Flow LLC
Informed Consent to Supplemental Treatments

I, _____, hereby request and consent to the following treatments and therapies from The Om Flow LLC By my signature below, I acknowledge and agree that I have read and understood the following:

I have been advised by The Om Flow LLC to consult a licensed physician or mental health care professional regarding the condition or conditions for which I am seeking the following treatments or therapies. I understand that there may be other treatment alternatives.

Initial: _____

Accunect/BodyTalk: I request and consent to the application of **Accunect/BodyTalk** techniques, which I understand are intended to enhance relaxation, increase communication within the areas of the body, and to educate me to possible energetic or emotional blocks that may create pain and disease. I understand that these techniques are not intended to diagnose or treat disease or other infirmity. I understand that I may refuse or discontinue these techniques at any time.

Initial: _____

Electro-Acupuncture: I request and consent to **electro-acupuncture**, which I understand involves the use of electrical currents applied to the skin or attached to acupuncture needles which have been inserted into my body. I understand that mild electric charge may occur, as well as mild discomfort. I understand that intense discomfort or pain is not a normal side-effect of **electro-acupuncture** and I will advise the practitioner of any such sensations. I understand that I may refuse or discontinue **electro-acupuncture** at any time.

Initial: _____

No guarantees have been given to me by the acupuncturists at The Om Flow LLC regarding cure or improvement of any condition.

Initial: _____

Aromatherapy: I request and consent to the application of Essential Oils directly on my skin in pure form and/or in a facial mask and/or indirect inhalation through a diffuser. I have no known allergies and will advise the practitioner immediately of any skin irritation sensation.

Initial: _____

I have carefully read all of the above information and I understand it entirely. I have asked any questions necessary to complete my understanding. Having done so, I voluntarily consent to any of the treatments or therapies that I have initialed above.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

The Om Flow LLC
1040 S. Gaylord St., Suite 204
Denver, CO 80209
303-859-8644

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2010

I keep medical records of the health care services I provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give me written permission to release them or I am required to do so by law. I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. You may see your records or get more information about them by contacting my office.
For more information about our privacy practices please inquire with me.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Signature of patient or legal representative Date

The Om Flow LLC
1040 S. Gaylord St., Suite 204
Denver, CO 80209
303-859-8644

FINANCIAL POLICY

The Om Flow LLC is a preferred provider for numerous insurance companies, and will directly bill your insurance if your policy covers acupuncture treatments. If you are not sure if you are eligible for insurance coverage, please check with your workplace benefits coordinator or directly with your insurance company. It would be helpful if you can find out if you have already met your deductible, and what your office co-payment is.

Co-payments and unmet deductibles are due at the time of the visit, unless you would prefer to pay for a series of payments at once at a discounted rate. If you are waiting for a referral that has not yet been confirmed, you will need to pay out of pocket until the referral is finalized.
If your insurance coverage is declined due to ineligibility or other reasons, you must pay for services rendered. Balances are due upon receipt of statement.

If your insurance does not cover our services, payment is due at time of visit. We accept cash, personal checks, Discover, Visa, or Mastercard. For any returned checks, a $35 fee will be charged to you. If you have other medical insurance that will reimburse you, we will provide you with a billing statement that you can submit.

If you do have health insurance that is accepted by our office, missed appointments are not billable to your insurance company. If you need to cancel your appointment, we kindly request a 24-hour notice. Less than 24-hour cancellation will be charged 50% of the service price. A "no-show" or same day cancellation for appointments will be charged at the full service price.

As a courtesy to all our clients, please be prompt for your appointment. We suggest you arrive 10 minutes prior to your service in order to begin your relaxing Om Flow experience.

For all our customer's comfort, please turn off or silence cell phones and pagers during your service. This is a chance for you to turn off the outside world and enjoy the peace and tranquility of the The Om Flow experience. Everything at The Om Flow has been designed to enhance your wellness, healthy way of living, and to help provide balance for your mind, body, and spirit.

I have read and understand the above financial policies and agree to adhere to them in all respects.

Signature _____ Date _____