Desert ridge Acupuncture

Chinese Medicine

5820 S. Pecos Rd. Ste.#100 Las Vegas, NV 89120 : (702) 704-1567

Patient Information Form

Name_____ Date_____
First MI Last

Social Security Number:_____

Phone (Home) (____)_____(Cell)(_____)_____

Email:_____

Contact me at: ( ) Home ( ) Cell ( ) Do Not Contact Initial_____

DOB _____ Age_____ Height _____Weight _____ Sex _____

Street_____ City_____ State_____ Zip_____

Occupation_____ Employer Name_____

Marital Status_____ Number of Children _____

Personal Physician _____

Date of Last Physical Exam _____

Referred by:_____

Emergency Contact and Relation_____ Phone (_____)_____

Do you have a allergy to latex exam gloves? _____Yes _____No

Have you ever had acupuncture before? _____Yes _____No

Are you willing to take Chinese herbs if needed? _____Yes _____No

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Notice of Privacy

Dear Valued Patient,

This notice describes our office's 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.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.
Other instances of shared information:

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to the public health authorities for purposes related: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file and/or are stored in HIPPA Compliant and password protected software and data bases and filing systems.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- 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 part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

Acknowledgement of Receipt of Notice of Privacy Form

Name_____Date_____
DOB _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I understand and have been provided with a *Notice of Privacy Form* that provides a more complete description of the privacy practices of Desert Ridge Acupuncture LLC.

I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the many healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and health information to my bill.
A means by which a third-party payer can verify that services billed were actually provided.
A tool for routine health care operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

To object to the use of my health information for directory purposes.
To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that Desert Ridge Acupuncture LLC is not required to agree to the restrictions requested.
To revoke this consent in writing, except to the extent that Desert Ridge Acupuncture LLC has already taken action in reliance thereupon.
The right to review the Notice of Privacy Form prior to signing this document

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____

_____

Patient or Guardian Signature
Date

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Nevada Disclosure Form

Education and Experience

Dr. Joel Rios OMD. received a Masters of Science in Traditional Chinese Medicine degree from Colorado School of Traditional Chinese Medicine, in Denver Co, In April 2012. This program consisted of a total of 2,850 hours.

Dr. Rios was certified as a Diplomate in Oriental by the National Certification Commission for Acupuncture and Oriental Medicine in May, 2012. This includes the certification in Chinese Herbology and Clean Needle Technique.

Dr. Rios is a member of American Association of Acupuncture and Oriental Medicine, and Nevada Coalition for Acupuncture. Dr. Rios is a licensed Doctor of Oriental Medicine in the state of Nevada and this license has never been suspended or revoked.

Dr. Rios's training include adjunctive therapies such as but not limited to Moxabustion, Cupping, Gua Sha (scraping), Tui Na, Electrical Stimulation, TDP and Far Infra-Red heating lamps, Bleeding (blood letting), and dietary and lifestyle recommendations.

This clinic complies with the rules and regulations enforced by the Nevada Board of Oriental Medicine, including the proper cleaning and sterilization of acupuncture needles and the sanitation of acupuncture offices. Only single use, disposable factory-sterilized needles are used.

Fee Schedule:

$120 Initial Treatment
$80 Subsequent Follow Up Treatment

*(Payment is required at time of services)

*(Price of herbs not included in treatment price)

*(All prices are subject to change at anytime for any reason)

*(Appointments may be cancelled or rescheduled at anytime for any reason)

Patient's Rights

The patient is entitled to receive information about the methods of therapy, the techniques used, duration of therapy, if known.

The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

In a professional relationship, sexual intimacy, is never appropriate and should be reported to the Executive Director of the Nevada Board of Oriental Medicine.

The practice of acupuncture and Acupuncture regulated by the Nevada State Board of Oriental Medicine. If you have comments, questions, or complaints, contact the Nevada Board of Oriental Medicine, 3191 E. Warm Springs Road Las Vegas, NV 89120 (702) 675-5326

$25 Fee will be charged for missed appointments and late cancellations (less than 24 hours notice), or returned checks.

I have fully read and understand this document.

_____ _____

Patient or Guardian Signature Date

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CONSENT TO TREATMENT

I, the undersigned, understand and voluntarily consent to methods of treatment used by licensed acupuncturists at Desert Ridge Acupuncture LLC and may include, but are not limited to, acupuncture, moxabustion, auricular therapy, cupping, electrical stimulation, heat therapy, herbal therapy, tui-na massage, and nutritional counseling. I understand that acupuncturists practicing in the state of Colorado are not primary care providers, and the above methods of treatment are not a substitute for western medical care. We recommend that you **Consult Your Physician** and get at least two medical opinions.

I understand that these are all safe methods of treatment. Potential risks include temporary pain, discomfort, hematoma, swelling, bleeding, numbness, tingling, dizziness, weakness, aggravation of present symptoms and soreness at the needling site that may last a few days. Unusual risks include , hyperventilating, fainting, nerve damage or pneumothorax. Although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment, infection is possible. Potential risks of moxibustion include burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. Potential risks of heat therapy include burns or blistering. Potential risks electrical stimulation include pain, discomfort, nervous system stimulation, dizziness, electrical shock. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the practitioner should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could cause complications, or miscarriage during pregnancy.

I will notify my practitioner of any and all western physician prescribed medications I am currently taking, or changes of thereof medication or doses as to avoid and possible drug/herb interactions. I will only take the recommended doses of nutritional and herbal supplements recommended to me by my practitioner. Doses of herbs taken without my practitioner's recommendation may be toxic and may be inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my practitioner as soon as I experience any discomfort or adverse reactions.

The Practice of acupuncture means the insertion and removal of acupuncture needles, the application of heat therapies to specific areas of the human body, and traditional oriental adjunctive therapies. Traditional oriental adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical and electromagnetic treatment, the recommendation of oriental therapeutic exercises, and subject to federal law, the recommendation of herbs and dietary guidelines." The "Practice of Oriental Medicine" shall defined by the scope of practice as set forth Nevada Administration Code NAC634A "Practice of Acupuncture" does not mean: Osteopathic medicine and manipulative treatments; Chiropractic medicine or Chiropractic medicine or adjustments; or Physical therapy.

In signing this form, I have read and understand all of the above information. I acknowledge any inherent risks and understand I may ask my practitioner for more detailed explanation of any of the above. I give permissions and consent to treatment; payment and healthcare operations received, incurred or carried out at this practice.

_____ _____

Patient / Guardian Signature Date

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Patient Health History

Date_____

Name_____Age_____

Chief Complaint (e.g. allergies)_____

Complaint History (e.g. started 3 weeks ago, worse in a.m.)_____
_____

Past/Current Medical History (e.g. pneumonia @ 38 y.o, surgery @ 16 y.o.)_____
_____

Herbs/ Vitamins/ Supplements Taking (e.g. daily vitamin, calcium)_____
_____

Family Medical History (e.g. diabetes on fathers side)_____
_____

Do you have any allergies? ☐ Food _____ ☐ Medication _____
☐ Environmental _____

Do you smoke/ drink/ rec. drugs? How often? ☐ Cigarette/Marijuana_____ ☐Alcohol_____

☐ Recreation/ other drugs_____ ☐ Caffeine _____

Do you exercise? ☐ Yes How often/ type?_____ ☐No_____

Describe your appetite: ☐ Strong, always hungry_____ ☐ Normal, hungry appropriately_____

☐ Weak, not very hungry _____ How many times do you eat in a day (including snacks)? _____

Give example of daily meals: Breakfast _____Lunch _____

Dinner _____ Snacks _____

Do you crave any foods/ flavors? (e.g. sweets, chocolate) _____

Any predominant emotions? (e.g. anger, sadness, depression) _____

Rate your energy today: ☐ 10 High ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2
☐ 1 ☐ 0 No Energy _____

Describe your core body temperature: ☐ Hot to warm(never needs jacket) ☐ Warm to normal (not too hot or too cool)
☐ Normal to cool (needs jacket normally) ☐ Cold (always need jacket or blanket) _____
_____

Do you sweat easily? ☐ Always, quick to sweat ☐ Normal, when its hot outside or on exertion ☐ Never
Any night sweating or hot flashes? ☐ Yes ☐ No _____

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Describe your digestion: ☐ Strong; no gas, no bloating, no stomach aches ☐ Normal; occasional gas, bloating
☐ Weak; always have gas, bloating, stomach ache or heart burn _____
_____

How many times per day or week do you have a bowel movement? _____

Any undigested food in stool? Yes ☐ No ☐ _____

What is the consistency of the bowels? ☐ Solid, well formed ☐ Well formed, sometimes slightly loose
☐ More loose than solid ☐ Always loose or diarrhea, never solid ☐ Alternating diarrhea and constipation
☐ Dry, constipated, hard to pass ☐ Incomplete

What is the color of the bowels? ☐ Black ☐ Dark Brown ☐ Medium Brown ☐ Light Brown ☐ Green ☐ Grey
☐ Other _____ Any blood/ mucus? Yes ☐ No ☐

What is the smell of the bowels? ☐ Strong and offensive ☐ Some smell, not strong ☐ No smell
☐ Other _____

Any urination problems? ☐ Burning ☐ Blood ☐ UTI ☐ Frequent urination ☐ Incomplete flow ☐ Dribbling
☐ Pain ☐ Discharge ☐Stones ☐Incontinence ☐ None ☐ Other_____
_____

Are you ever thirsty? ☐ Always, drinks a lot of liquids ☐ Normal, drink regular amount ☐ Hardly any, just not thirsty

How much liquids in ounces do you drink in a day? (1 cup is 8 ounces)_____

Do you prefer hot/ cold / room temperature liquids?_____

Any sleep problems? ☐ Hard to fall asleep ☐ Hard to stay asleep/ wakes easy ☐ Insomnia, can't sleep ☐ None
☐ Other _____ How many hours do you sleep a night? _____ Do you wake rested? Yes ☐ No ☐

Any Headaches/ Dizziness/ Migraines? Yes ☐ No☐ How many times per week/month?_____

Describe headache or migraine: (e.g. dull/achy or sharp and piercing) _____
_____

Any problems with Skin/ Hair/ Nails? ☐ Dryness ☐ Brittleness ☐ Rashes/ Eczema ☐ Sores ☐ Falling out ☐ Ridges
☐ None
☐ Other _____

Any problems with Mouth/ Throat? ☐ Dryness ☐ Sores ☐ Mucus ☐ Pain ☐ Loose teeth ☐ Sore throat ☐ Bad Breath
☐ None
☐ Other _____

Any problems with your eyes? ☐ Dryness ☐ Discharge ☐ Light Sensitivity ☐ Night Blindness ☐ Failing Vision
☐ Itchy /Redness ☐ Floaters ☐ None ☐ Other _____Wear Glasses/ Contacts ☐ Yes ☐ No

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Any problems with your ears? ☐ Dryness ☐ Discharge ☐ Sores ☐ Excess Wax ☐ Loss of Hearing ☐ Itchy ☐ Ringing
☐ None ☐ Other _____ Wear Hearing Aid? ☐ Yes ☐ No

Any problems with your nose? ☐ Dryness ☐ Discharge ☐ Sores ☐ Excess Mucus ☐ Nosebleeds ☐ Itchy ☐ Sneezing
☐ Obstruction ☐ None ☐ Other _____Allergy/Cold symptoms right now? ☐ Yes ☐ No

Any Respiratory Problems? ☐ Shortness of breath ☐ Asthma ☐ Cough ☐ Mucus ☐ Blood ☐ Wheezing ☐ Chest pain
☐ None ☐ Other
_____

Any Cardiovascular problems? ☐ Palpitations ☐ Irregular heart beat ☐ Fast heart beat ☐ Slow heart beat ☐ HBP ☐ CVD
☐ Bipass surgery ☐ Chest pain ☐ Stroke ☐ None ☐ Other _____

Do you have a pace maker? ☐ Yes ☐ No Since what year?_____

Any Circulatory problems? ☐ Cold hands ☐ Cold feet ☐ Numbness/ tingling ☐ Loss of feeling ☐ None
☐ Other _____

Any muscle or joint pain? ☐ Back pain ☐ Osteo-Arthritis ☐ Rheumatoid Arthritis ☐ Swollen Joints ☐ Stiff joints ☐ Sciatica
☐ Hernia ☐ Muscle pain/ weakness ☐ None ☐ Other _____

Explain about muscle/joint or any pain? _____
_____

For Men Only:

Any Men's Health issues? ☐ Penile discharge ☐ Excess Libido ☐ Decreased Libido ☐ Penis/Testicle pain ☐ Prostate problems ☐ Impotence ☐ None ☐ Other _____

For Women Only:

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No If pregnant, how far along are you?_____

Have you experienced menopause yet? ☐ Yes ☐ No ☐ N/A

What day in your cycle are you on? (e.g. day 15) _____

How many days do you normally go between periods? (e.g. 28days) _____

Do you ever skip a period? ☐ Yes ☐ No ☐N/A _____

Describe your last period:
How many days did your period last for? (e.g. 6 days) _____
How heavy or light was the flow? ☐ Very Heavy ☐ Heavy to Normal ☐ Normal ☐ Normal to Light
☐ Light/Scanty
☐ Other _____

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What was the color of the flow? ☐ Dark Brown to Purple ☐ Purple ☐ Red to Dark Red ☐ Red ☐ Red to Pink ☐ Pink ☐ Other _____

Did you experience any PMS or emotional symptoms before, during, or after your period? ☐ Yes ☐ No _____

Did you experience and cramps or pain before, during, or after your period? ☐ Yes ☐ No _____

Did you experience any breast tenderness before, during, or after your period? ☐ Yes ☐ No _____

Did you have any Clots? ☐ Yes ☐ No, What size were the Clots? ☐ Dime size ☐ Nickel size ☐ Quarter size ☐ Other_____

Any Women's Health issues? ☐ Discharge ☐ Excess Libido ☐ Decreased Libido ☐ Yeast Infection ☐ Foul Odor ☐ None ☐ Other _____

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Please place a "X" next to any symptoms/diseases you have experienced in the past. Circle any symptoms/ diseases you currently experience.

General Symptoms

- Tremors
- Headache
- Migraines
- Fever
- Chills
- Cold Hands/Feet
- Sweating
- Fainting/ Dizziness/ Vertigo
- Motion Sickness
- Convulsions
- Loss of sleep/ Insomnia
- Fatigue
- Nervousness
- Depression
- Loss of Weight
- Forgetfulness
- Numbness or pain in shoulders or hips or extremities
- Confusion
- Paralysis
- Other

Eyes, Ears, Nose, Throat

- Failing Vision
- Eye pain or Sensitivity
- Eye Strain
- Blurry Vision
- Cross Eyed
- Eye Inflammation
- Glaucoma
- Cataracts
- Color Blindness
- Spots/ Lines in Vision
- Deafness
- Earache
- Loss of Hearing
- Ear Discharge
- Ear Noise, Ringing
- Nose Bleeds
- Nasal Obstruction
- Nasal Drainage
- Loss of Smell
- Sinus Infection
- Hay Fever
- Allergies
- Sore Throat
- Hoarseness
- Difficult Speech
- Difficult swallowing
- Loss of Taste or Change in Taste
- Dental Decay
- Gum Problems
- Tonsillitis
- Asthma/ Bronchitis / Pneumonia
- Frequent Colds/ Flu
- Thyroid Problems
- Enlarged Swollen Glands
- Other

Skin, Hair, Nails

- Skin Eruptions
- Itching
- Clammy Skin
- Dryness
- Bruise Easily
- Cuts Heal Slowly
- Boils
- Rashes
- Moles/ Warts
- Sensitive Skin
- Hives or Allergy
- Hair Problems
- Finger Toenail Problems
- Other

Respiratory

- Chronic Cough
- Spitting up Phlegm
- Spitting up Blood
- Chest Pain
- Difficulty Breathing
- Wheezing
- Other

Cardio-Vascular

- Rapid Beating Heart
- Slow Beating Heart
- Irregular Heart Beat
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Previous Stroke
- Hardening of Arteries
- Swelling of Ankles
- Poor Circulation
- Paralytic Stroke
- Varicose Veins
- High Cholesterol
- Low Cholesterol
- Anemia
- Other

Muscle / Joints

- Stiff Neck or Neck Pain
- Pain Between Shoulders
- Backache
- Painful Tailbone
- Foot, Toes, Heel problems
- Hand, Wrist, Finger Problems
- Hernia
- Spinal Curvature
- Faulty Posture
- Swollen Joints
- Stiff Joints
- Painful Joints
- Arthritis
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sciatica

Genitourinary

- Frequent Urination
- Scanty Urination
- Painful Urination
- Blood In Urine
- Pus In Urine
- Kidney Infection Or Stones
- Bed Wetting
- Inability to Control Urine
- Bladder Problems
- Foul Smelling Urine
- Discolored / Cloudy Urine
- Urinary Tract Infections
- Other

Gastrointestinal

- Eating Disorder
- Poor Appetite
- Excessive Hunger
- Difficult Chewing
- Belching
- Bad Breath
- Nausea
- Gas
- Indigestion
- Heartburn
- Vomiting
- Vomiting of Blood
- Pain in the Abdominal Area
- Distension in Abdomen/ Bloating
- Constipation
- Diarrhea
- Undigested Food in Stool
- Black Stool
- Blood in Stool
- Mucous in Stool
- Colon Problems
- Anal Problems
- Hemorrhoids (Piles)
- Intestinal Worms
- Liver Problems
- Gallbladder Problems / Stones
- Jaundice
- Colitis
- Weight Problems
- Other

Female

- PMS
- Painful Menstrual Periods
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Period Cramps or backache
- Previous Miscarriage
- Vaginal Discharge
- Vaginal Pain
- Breast Pain
- Lumps in Breast
- Menopausal Symptoms

Female

- Abnormal Bleeding
- Reduced Sex Drive
- Pregnancy
- Pregnancy Complications
- Abnormal Paps Smear
- Other

Male

- Prostate Problems
- Genital Pain or Problems
- Reduced Sex Drive
- Premature Ejaculation
- Seminal Emission
- Impotence
- Discharge
- Other

Other

- Edema Hepatitis
- Herpes
- Cancer
- Diabetes
- TB/ Epilepsy
- Alcoholism/Substance Abuse
- Depression
- Mental/ Emotional Disorder
- HIV+/Aids
- Venereal Disease
- Other

_____

_____

_____

_____

_____

_____

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Practitioner Notes:

_____
_____
_____
_____
_____

Tongue

_____
_____

Pulse L_____R_____

_____
_____

Diagnosis/ Differentiation: _____

_____

Treatment Principle: _____

Treatment Plan: _____

_____

_____

Practitioner Signature