WELCOME!

I know your choice to begin this journey is based on your commitment to optimizing your physical, emotional, and spiritual health. My goal is to join you on this path of self-discovery, personal growth, and empowerment. This is a limitless process and I look forward to a long-lasting partnership with you.

The forms in this packet are extensive and will require time to fill out. ***Please know that I will spend an equal amount of time reviewing them.*** I developed these forms over many years and take them seriously. My goal is to see your how your life history relates to whatever struggle you are currently facing.

BEFORE WE MEET:

1. **Complete New Patient Forms:** Please be sure to fill them out with as much detail as possible. Really feel into the questions and spend some time with it. The more information you provide me, the better I will be able to help you.

2. **Medical Records:** If you're working through any sort of chronic physical disease please include your most recent blood/lab work, and any reports from MRI, CT Scans, Dexa Scans, etc. ***If possible, it is very helpful to include all lab work from the time of your initial diagnosis, as well as lab work from your last general physical six-months to one-year before your diagnosis.*** This information can be very helpful in understanding the progression or regression of a disease.

3. **Prepare Your Questions:** It's always good to come prepared. Spend some time by yourself and really get in touch with what it is you'd like to figure out. Make a priority list. I find that clients who have really spent time feeling into what they want always get more out of our journey together. You deserve this.

WHAT TO EXPECT WITH OUR FIRST CALL:

We'll spend about 60 minutes going over your health history and current concerns. I'll ask any questions I have and you can do the same. We're going to look at the three main areas of your life – your physical health, your mental health, and your spiritual health. We'll be trying to see how they are connected to each other so that you can make sense of what's going on and find a way to move forward.

AFTER THE CALL:

1. Following our initial talk, I'll send you an email that highlights our assessment and your plan going forward. For me the path to cultivation must include all aspects of your life (physical, mental or emotional, and spiritual). In my email, I'll outline methods ranging from physical treatments like acupuncture to meditation or visualization practices to dietary strategies and to various physical exercises.

One way to look at it is that rather than exercising to stay in shape, taking supplements to support your immune system, energy levels, or brain function, or meditating to calm your mind, I'll have all of these focus on your unique cultivational journey? Most people use body, mind, and spirit as separate paths of cultivation. ***We'll tie them all together to keep your focus and give you the best chance of having a deep breakthrough.***

GENERAL OFFICE POLICIES:

Please initial where indicated to signify agreement with our policies:

Pre-Treatment Considerations: Please eat an adequate amount of food before your treatment. You should not receive acupuncture with an empty or overly full stomach. As with any medical procedure, you should not consume alcohol or any other intoxicating substance before your treatment.

Post-Treatment Care: If you receive treatments for pain, avoid aggravation of the painful area between treatments. It is recommended to "baby" that area and avoid strenuous or aggravating activity as much as possible in order to receive maximum benefits. If the area is constantly aggravated, it will take more treatments to achieve satisfactory results.

Timing: I encourage my patients to arrive early so that you can use the restroom, have a drink of water and relax for a few minutes before your treatment. I do my best to be on time for all of our appointments. If circumstances cause you to be late for your appointment, please be advised that your visit will need to be shortened so that other patients are not kept waiting. Please allow about one hour for acupuncture treatments.

Emails: Open communication is essential to this unique process. It is very important to me that you feel completely supported in your journey. I'm here to help. If you have any questions come up please feel free to email me for feedback. I will always try to respond within 24 hours and often less than that.

Payment: Full payment for in-person services is due at the time of your visit. Telephone/Skype appointments should be paid for prior to your appointment. I will forward you an invoice when we make your appointment. _____ ***(initial)***

Cancellations: Your scheduled appointment time reserves exclusive time with me. Missed appointments and late cancellations are wasted time that cannot be spent with another client. I understand that circumstances arise which may require you to change your appointment time. *If you need to reschedule, please notify me at least 24 hours in advance to avoid being charged the full rate of your scheduled visit.* _____ ***(initial)***

New Patient Information

Name: _____ Date: _____

Age: _____ M / F Date of birth: _____ Birthplace: _____

Height: _____ Weight: _____

Address: _____

_____

Phone # (home)_____ (work) _____ (mobile) _____
(Please circle the best phone number to reach you)

Email address: _____ SSN: _____

Occupation: _____ Hours per week: _____

Marital status: _____ Number of Children: _____

Emergency contact: _____ Phone #: _____

Primary Care Physician: _____

Other Treating Physicians: _____

Health Insurance and ID/Group Numbers: _____

Referred by: _____

Have you been treated by an acupuncturist before? _____

If so, name of acupuncturist and conditions treated: _____

Primary concerns and goals:

_____

_____

_____

_____

_____

Other concerns (list as many as you like, in order of importance to you):

_____

_____

_____

_____

In your opinion, what are the primary factors that cause your symptoms? Do you feel there is anything in your life that is keeping you from healing?

_____

_____

_____

_____

_____

What do you feel will help you reach your goals? How long do you expect the process to take?

_____

_____

_____

_____

Is there anything in your life that you would not be willing to change? _____

_____

_____

_____

_____

WORK:

Type of Work/Profession: _____ Hours Worked Daily? _____

I spend much of the day: ☐ Sitting ☐ Standing ☐ Lifting ☐ On the phone ☐ Heavy Labor

I find my work: □ Boring □ Challenging □ Enjoyable □ Exhausting
□ Frustrating □ Fulfilling □ Pressured □ Stressful □ Other _____

STRESS/EMOTIONS:

What are the sources of stress in your life now? How do you normally cope with stress? _____

_____

_____

_____

My ability to cope with stress is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I am under the care of a: ☐Psychotherapist ☐Psychiatrist

I am taking medications for: ☐Mood ☐ Sleep ☐ Pain

Are there areas in your life where you feel disempowered, trapped, or a victim? Why? Please include the past.

_____

_____

_____

_____

Do you have frequent mood changes? If so, please indicate the specific moods and if you know the reasons why:

_____

_____

_____

_____

FAMILY HISTORY	Self	Mother	Father	Brothers	Sisters	Grandparents	Comments
Alive? Yes/No?		Y N	Y N	Y N	Y N	Y N	
In Good Health?	Y N	Y N	Y N	Y N	Y N	Y N	
Arthritis/Gout?							
Asthma							
Allergies							
Bleeding Disorders							
Cancer							
Diabetes							
Eating Disorders							
Emotional Disorders							
Epilepsy							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Stroke							
Thyroid Disease							
Tuberculosis							
Ulcers							
Weight Problems							
Other Significant Illnesses							

Please check any other illnesses you have had and note the years you had them:

- □ Anemia
- □ Bronchitis
- □ Chicken Pox
- □ Chronic Fatigue Syndrome
- □ Colitis
- □ Diverticulitis
- □ Eczema
- □ Emphysema
- □ Epstein Barr Virus
- □ Eye Disease
- □ Gall Stones
- □ Hemorrhoids
- □ Hepatitis
- □ Hernia
- □ Jaundice
- □ Liver Disease
- □ Lyme Disease
- □ Malaria
- □ Measles
- □ Migraines
- □ Mononucleosis
- □ Mumps
- □ Neuralgia
- □ Pancreatitis
- □ Parasites
- □ Polio
- □ Rheumatic Fever
- □ Tropical Infectious Disease
- □ Typhoid Fever
- □ Yeast Infection

Sexually Transmitted Disease
- □ Herpes
- □ Gonorrhea
- □ Syphilis
- □ HIV
- □ Genital Warts (HPV)
- □ Other _____

Vaccines & Immunizations (Please note the year/date if known):

- □ Chicken Pox
- □ Cholera
- □ Flu
- □ Hepatitis (A / B)
- □ Meningitis
- □ HPV
- □ Malaria Pills
- □ Pneumonia
- □ Polio
- □ Rotavirus
- □ Shingles
- □ Smallpox
- □ Typhoid
- □ Yellow Fever
- □ Tdap (Tetanus, Diphtheria, Pertussis)
- □ MMR (Measles, Mumps, Rubella)
- □ Other: _____

List any significant hospitalizations, or surgeries:

_____

_____

Current Medications - include dosages, reason for taking, and all side effects:
(please list all prescription, non-prescription, herbal and dietary supplements – attach a separate sheet if necessary)

_____

_____

_____

_____

Past use of antibiotics or steroids (prednisone, cortisone, etc., including dates)

_____

_____

Indicate medications you have ever taken, including dates:

☐ Allergy Shots ☐ Anti-Depressants ☐ Chemotherapy ☐ Pain Medications
☐ Antacids ☐ Antihistamines ☐ Estrogen/Progesterone ☐ Radiation Therapy
☐ Anti-Anxiety Meds ☐ Birth Control Pill ☐ Immunosuppressive Drugs ☐ Thyroid Medication
☐ Other: _____

TOXIC EXPOSURES:

□ Asbestos □ Coal □ Lead □ Tobacco
□ Chemical Fumes □ Fertilizers □ Mercury (including fillings) □ Uranium
□ Chemotherapy □ Herbicides □ Other _____

Smoking? Yes ___ No ___ How much/How long: _____ Do you want to quit? _____

Drink Alcohol? Yes _____ No _____ How much per week: _____ Type: _____

Recreational Drugs? Yes _____ No ____ How often: _____Type: _____

Drink Coffee? Yes ____ No ____ How much per day: _____

Please list what activities you do for exercise and how often: _____

_____

Hours Spent Daily	Exercise	TV	Computer	Yoga	Meditation	Outside	Inside

TYPICAL DIET:

Cravings (sweet, salty, sour, bitter, spicy, other) _____

Thirst: ☐ Normal ☐ Rare ☐ Excessive Drink Preference: ☐ Hot ☐ Cold ☐ Iced ☐ Room Temp

How many ounces of water do you drink per day: _____

List any drug allergies and food sensitivities/allergies. Please include reaction when consumed.

_____

_____

_____

_____

How often do you:

Cook for yourself _____ Eat Out _____ Use artificial sweeteners _____

Carbonated Beverages _____ Diet Beverages _____

Are you on a special diet? (if yes, why and please describe): _____

_____

_____

_____

_____

CLIMATIC FACTORS/TIME: *Please indicate "**B**" for best and "**W**" for worst.*

What time of day do you feel your best? __Upon Waking __Daytime __Late Afternoon __Evening __Night

What season do you feel your best/worst? ___Spring ___ Summer ___ Fall ___ Winter

Where do you feel best/worst? ___ At Home ___ At Work ___ Indoors ___ Outdoors (where) _____

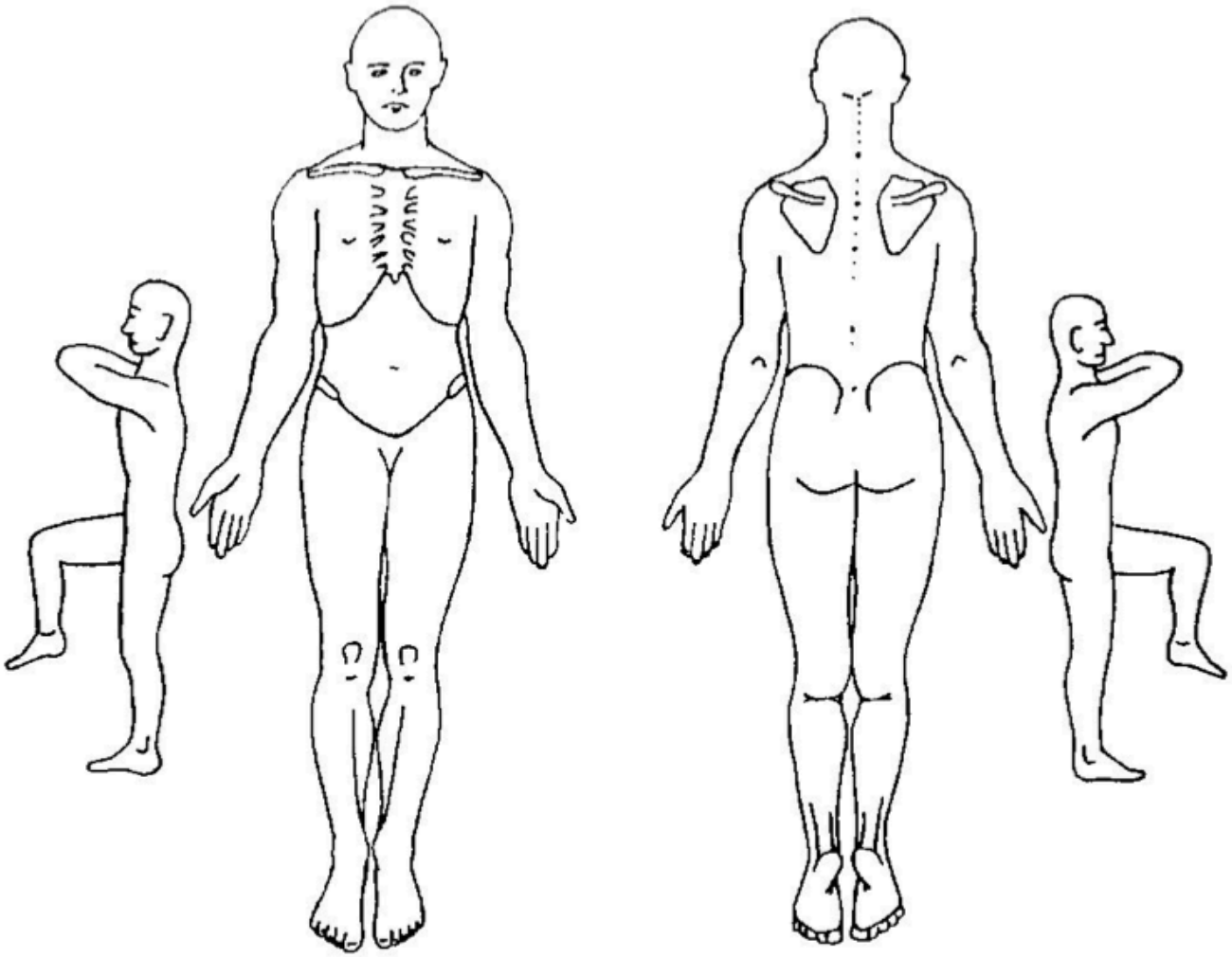
What weather makes you feel your best/worst?

___ Cool ___ Cold ___ Damp ___ Dry ___ Fog ___ Hot ___ Rain ___ Snow ___ Warm

CURRENT PAIN SYMPTOMS

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates/spreads with a ↑, ↓, ←, → to indicate the direction of the radiating pain.

A = Ache	**D = Dull Pain**	**O = Other, please describe**	**R = Radiating Pain**
B = Burning Pain	**N = Numbness**	**P = Pins & Needles**	**S = Stabbing Pain**



Please indicate how you would rate your pain in each area on a 1-10 scale.

Is there any more information about your pain or injury that you feel I should know? _____

_____

_____

Please check any symptoms that apply to you now or were significant health concerns **in the past six months**.
Please comment about the frequency, time of last occurrence, duration, etc. when appropriate.

HEAD & NECK
□ Dizziness
□ Enlarged Lymph Glands
□ Fainting
□ Hair Loss
□ Headaches Type/Location _____

EYES
□ Blurred Vision
□ Contact Lenses
□ Dark Circles
□ Double Vision
□ Dry Eyes
□ Excessive Tearing
□ Eye Inflammation/Redness
□ Eye Surgery
□ Light Sensitivity
□ Pain/Swelling
□ Spots/Floaters

EARS
□ Congestion/Wax Build Up
□ Deafness/Decreased Hearing
□ Discharge
□ Infection
□ Pain
□ Ringing/Tinnitus

NOSE
□ Allergies/Hay Fever
□ Bleeding
□ Congestion
□ Infection
□ Loss of Sense of Smell
□ Pain
□ Post Nasal Drip
□ Runny Nose

MOUTH
□ Bleeding Gums
□ Cavities
□ Change in Sense of Taste
□ Dentures
□ Difficulty Swallowing
□ Dry Mouth/Lips
□ Gum Disease/Loss
□ Oral Herpes (cold sores)
□ TMJ/Jaw Pain
□ Ulcers/Sores in Mouth

MEN ONLY
□ Burning or Discharge from Penis
□ Difficulty with Erection
□ Leakage of Semen
□ Low Sperm Count
□ Pain in Genital Region (hot/cold)
□ Premature Ejaculation
□ Prostate Infections
□ Prostate Surgery/Biopsy
□ Prostate Swelling/Enlargement
□ Swelling or Lumps in Testicles

Method of Birth Control _____

Date of Last Prostate Exam _____

PSA Blood Test Results_____

RESPIRATORY
□ Bronchitis
□ Chronic Cough (dry/productive/color)
□ Coughing Blood
□ Chest Pain (with breathing)
□ Loss of Voice
□ Sensation of something stuck in throat
□ Shortness of Breath
□ Sore Throat
□ Tonsillitis
□ Wheezing/Asthma

CARDIOVASCULAR
□ Ankle Swelling
□ Atrial Fibrillations
□ Bruise or Bleed Easily
□ Chest Pain/Angina
□ Cold Hands/Feet
□ Heart Attack
□ Heart Murmur
□ High Cholesterol
□ Irregular Heart Beat
□ Leg Cramps at Night
□ Mitral Valve Prolapse
□ Palpitations (feel your heart beating)
□ Stroke
□ Tightness in Chest
□ Varicose Veins

GASTROINTESTINAL
□ Appetite Changes (increase/decrease)
□ Belching
□ Black/Tarry Stools
□ Bloating/Gas (Upper or Lower)
□ Constipation
□ Diarrhea
□ Dry/Hard Stools
□ Gall Bladder Problems
□ Hernia
□ Heartburn/Acid Reflux
□ Hemorrhoids
□ Hypoglycemia (low blood sugar)
□ Inflammatory Bowel Disease
□ Mucous in Stool
□ Nausea/Vomiting
□ Stomach Pain
□ Stools Painful to Pass
□ Ulcers
□ Undigested Food in Stool
□ Use of Laxatives
□ Watery Stools

How often do you have a bowel movement?
_____

URINARY
□ Blood in Urine
□ Change in Quantity of Urine
□ Difficulty in Urination
□ Dribbling after Urination
□ Frequent Bladder Infections
  □ with Intercourse
  □ with Stress
□ Frequent Urination
□ Incontinence
□ Kidney Stones
□ Loss of Force of Urination
□ Nighttime Urination
□ Pain/Burning with Urination
□ Pus in Urine
□ Sand/Gravel in Urine
□ Strong Smell to Urine
□ Urination with cough/sneeze

Color of Urine:
□ Clear □ Straw □ Yellow □ Cloudy

REPRODUCTIVE
□ Decreased Sexual Desire
□ Increased Sexual Desire
□ Pain with Sex
□ Infertility

WOMEN ONLY
□ Breast Lumps/Cysts
□ Breast Tenderness
□ Discharge from Nipples
□ Endometriosis
□ Infertility
□ Ovarian Cysts
□ Pelvic Infection
□ Uterine Fibroids
□ Vaginal Discharge
□ Vaginal Dryness

□ Vaginal Infections
□ Vaginal Itching
□ Vaginal Pain
□ Vaginal Sores
Regular Self-Breast Exam? _____
Date of last mammogram _____
Date of last PAP test/Pelvic Exam _____
(Note irregular results)

MENSTRUATION & PREGNANCY

Age of First Period _____
How many days between periods _____
How many days of flow _____
□ Clots with Flow
□ Cramps/Pain (Before/During/After)
Feel Better Before/After Period
□ Heavy Blood Flow
□ Irregular Periods
□ Light Blood Flow
□ No Menstrual Period
□ Premenstrual Bloating
□ Spotting Between Periods
Premenstrual Syndrome Symptoms?
Describe: _____
_____
_____
Are You or Might You Be Pregnant? ____
Number of Pregnancies _____
Number of Abortions _____
Number of Live Births _____
Number of Miscarriages _____
Number of Caesarian Sections _____
Complications with pregnancy, labor or delivery _____
_____
_____
Fertility Treatments? Describe _____
_____
_____
Method of Birth Control:
Current _____
Past _____

PERIMENOPAUSE/MENOPAUSE

Age when Cycle began to change? _____
Age when Menses Stopped _____
Hormone Replacement Therapy? _____
□ Drugs _____
□ Herbs _____
□ Hot Flashes
□ Night Sweats
□ Change in Mood
□ Change in Sex Drive
□ Change in Sleep
Other _____

ENDOCRINE/IMMUNOLOGIC

□ Abnormal Weight Gain
□ Depression
□ Diabetes
□ Dry Skin
□ Fatigue
□ Frequent Low Grade Fever
□ Hair or Nail Changes
□ Intolerance to
□ Cold □ Heat □ Wind
□ Loss of Feeling of Wellbeing
□ Night Sweats
□ Perspiration
□ Diminished □ Excessive
□ Swollen Lymph Glands
□ Unexplained Fever or Chills

NEUROLOGIC

□ Changes in Handwriting
□ Dizziness
□ Drowsiness
□ Fainting
□ Loss of Coordination
□ Loss of Sensation
□ Memory Changes
□ Muscular Weakness
□ Nerve Pain _____
□ Nervousness
□ Numbness _____
□ Paralysis _____
□ Seizures – Type _____
□ Tremors

SKIN

□ Abnormal Sweating
□ Acne (what causes?/Where?) _____
□ Changing Moles or Lumps
□ Dryness
□ Herpes
□ Itching
□ Pigment Changes
□ Psoriasis
□ Rash
□ Warts

MUSCULOSKELETAL

□ Arthritis _____
□ Disc Injury _____
□ Joint Swelling _____
□ Joint Stiffness _____
□ Muscle Spasm _____
□ Sciatica
Location of Pain _____
□ Scoliosis
□ Osteoporosis – How Long _____
Pain:
□ Burning □ Achy □ Intermittent
□ Sharp/Stabbing □ Constant
□ Changes Location
Better With:
□ Rest □ Movement □ Ice
□ Heat □ Touch/Massage
Worse With:
□ Rest □ Movement □ Ice
□ Heat □ Touch/Massage
Has your pain shifted from one side of your body to the other? _____

SLEEP

□ Difficulty Falling Asleep
□ Difficulty Staying Asleep
□ Disturbing Dreams/Nightmares
□ Insomnia
□ Sleep Apnea
□ Snoring
□ Wake to Urinate
Position You Sleep in _____
Type of Pillow _____

LIFE HISTORY

On a separate sheet of paper, please provide a detailed history of life events that have been significant to you. This should include major health problems, life changes, traumas, etc. This should be for all experiences that stand out in your memory of your life so far and will typically include any major health problems or injuries, big changes in your life path (marriage, divorce, careers), significant emotional struggles (anger, depression, fear, anxiety), etc.

Please look at the three sides of your life experiences – ***your physical experiences, your emotional/mental experiences, and your spiritual experiences***. Being able to look at this information is really central to my approach so please take some time with this. It may seem like a lot to go back and review these aspects of your life in detail but the more time you spend with this the more I will be able to help you.

Please include all forms of therapy you have used in your life for this problem (acupuncture, massage, psychotherapy, meditation, shamanic work, etc.). It's important for me to know what you've done, how long you've done it, and how it helped or did not help.

Here is an example of a fictitious life history to give you an idea of what information is helpful. Please use your own wording and group them in five-year blocks. **Thank you for taking the time to do this.**

EXAMPLE – Jane Doe, Life History

Birth to Age 5

Healthy birth. No known complications. Small birth weight (5 lbs. 6 oz.) Not breast-fed - formula only with signs of allergic reaction. Second child of 4. Oldest daughter. Norman vaccinations for the time.
Age 1 – Bad chest cold with diagnosis of bronchitis, put on antibiotics
Age 3 – Sister born
Ages 3 to 5 - Frequent ear infections in both ears.

6 to 10 years

Age 6 - Diagnosis of asthma with intermittent use of meds. Allergic to medications. Sick often. Frequent stomachaches and constipation.
Age 10 - Brother born. Unplanned pregnancy. Mother quite ill with blood disorder afterwards.

11 to 15 years

Age 11 – nearsighted, requiring glasses. Had anxiety around mother's health.
Age 13 - first case of pneumonia (out of school for 1 month, lost weight). Menstruation started - cycle every 23 to 25 days with severe cramps. Very heavy flow requiring double pads.
Age 14 - Mother almost died required hospitalization. I was very angry at her sickness. It didn't seem fair to me to have to deal with all of this. Got Mono – sick for 10 weeks.
Age 15 - Chronic bronchitis. Frequent bladder infections – treated with antibiotics many times.

16 to 20 years

Age 16 - On birth control pills for acne and to try and temper periods. Menstruation was very heavy (sometimes passing out at school). Intense mood swings. Started to gain weight, which has continued through lifetime. Still had a lot of anger towards my mom being sick.
Age 18 - father died age 47. Older brother died in Vietnam. Chronic bronchitis - felt ill all the time. Started working to help support mother and younger siblings.
Age 19 – sexually assaulted, no disease contracted.

21 to 25 years

Age 21 - Beloved grandfather died (only warmth in my life). Had a bad experience drinking alcohol so I quit drinking. Never used recreational drugs
Age 22 - entered psychotherapy "something didn't feel right" - not a very good experience. Started doing Zen meditation and found it difficult but somewhat helpful for some of my mood swings. Continue this practice today, usually meditating for 10 minutes per day.
Age 24 - met husband to be.

26 to 30 years

Age 26 - married, bought first house. Chronic vomiting, no known cause, lasted 2 years then stopped.
Age 28 - Consult with holistic doctor - hypothyroid - Stopped birth control pills. ER on a few occasions due to respiratory distress - asthma still not under control.

31 to 35 years -

Age 31 – first miscarriage. Continued trying to get pregnant naturally but couldn't. Began to question meaning of life and all the struggles and suffering. Worked with a therapist again but felt it was a waste of time. Quit after 3 months.
Age 33 – Tried three rounds of IVF but was not able to get pregnant. Still having asthma symptoms
Age 34 – referred to acupuncturist to help get pregnant. Finally succeeded!
Age 35 – had daughter. Birth induced and had C-section. Difficult time recovering from birth – very tired, weakened immune system, lots of body aches, low milk production. Bad flares with asthma also had a return of my anxiety. Couldn't understand why it was so bad.

36 to 40 years…

Age 36 – continued to struggle with regaining my energy levels and controlling my asthma. It seemed to get worse the more tired I was. My anxiety continued pretty intensely as well along with some anger about having to deal with all of these chronic problems. Very frustrating and just can't understand why this is happening to me.
Age 37 – referred to you for treatment by…

This is an example - please complete with your own life events

ONE-WEEK FOOD DIARY

Please note all food and drink, including water. Please note approximate serving size of food, and ounces of drink.

It is crucial that you do NOT change your typical diet while doing this diary. I must know what your typical diet looks like even if you plan on changing it.

	Sunday	Monday	Tuesday
Morning Meal			
Afternoon Meal			
Evening Meal			
Snacks			

	Wednesday	Thursday	Friday	Saturday
Morning Meal				
Afternoon Meal				
Evening Meal				
Snacks				

Informed Consent

Justin Ehrlich, L.Ac. is a Licensed Acupuncturist. He does not claim to diagnose, treat, cure or prevent any medical conditions or pathologies, nor prescribe medicines. The services of a Licensed Acupuncturist do not replace those of a medical doctor. For any medical condition, you are advised to seek care from an appropriate licensed medical practitioner. Whether you choose to engage a medical doctor or not is your right and Justin Ehrlich, L.Ac. assumes no responsibility for your decision in this matter.

I, the undersigned, assume any and all responsibility for decisions regarding my health, recognizing that (a) no claims are made that acupuncture, herbal medicines, nutritional supplements, dietary or exercise therapies can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific acupuncture, herbal medicine, nutritional supplement, dietary or exercise therapy recommendations, (d) I am free to act upon or disregard the recommendations of Justin Ehrlich, L.Ac. as I so choose.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named above, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, far-infrared heat, cupping, gua sha, electrical stimulation, tui na (therapeutic massage), internal and topical herbal medicines, nutritional supplements, exercise therapies and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and far-infrared heat. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that people can be allergic to almost any substance and will immediately stop taking any supplements or herbal prescriptions if I feel I have an allergic reaction and will contact Justin Ehrlich, L.Ac. I understand that some herbs may be inappropriate during pregnancy. I will notify the Justin Ehrlich, L.Ac. if I am or become pregnant. I will also immediately notify Justin Ehrlich, L.Ac. if there are any unpleasant effects associated with the consumption of the herbs.

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 the 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 condition and for any future conditions for which I seek treatment with no constraints.

Patient Name (Print) _____

Patient Signature _____ **Date** _____
(or Patient Representative—indicate relationship if signing for patient)

Office Signature _____ **Date** _____
Justin Ehrlich, L.Ac.

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use And Disclosure Of Your Health Information In Certain Special Circumstances
The following circumstances may require us to use or disclose your health information:
1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.
9. Data that is collected by Justin Ehrlich, L.Ac., which does not include the identity of the patient, may be utilized for research purposes.

Your Rights Regarding Your Health Information
1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Justin Ehrlich, L.Ac. 4443 30th St, Suite 210, San Diego, CA 92116 at (619) 535-1876 who will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Justin Ehrlich, L.Ac. 4443 30th St, Suite 210, San Diego, CA 92116 at (619) 535-1876 who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Justin Ehrlich, L.Ac. 4443 30th St, Suite 210, San Diego, CA 92116 at (619) 535-1876. All complaints must be submitted in writing; you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician. I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

General Authorization to Release Health Information
I hereby authorize the release of my personal health information to any health provider approved by my treating physician. I understand that I may cancel this authorization at any time by notifying my treating physician in writing.

Signature: _____ Date: _____

Print Name: _____