Welcome to Auburn Community Acupuncture

Auburn Community Acupuncture (ACA) is one of many community acupuncture clinics established in the country who are members of the People's Organization of Community Acupuncture (POCA). POCA is a multi-stakeholder cooperative whose mission is to make acupuncture affordable for nearly everyone, while promoting a sustainable business model that works for patients and practitioners. To jump on board, learn more about the cooperative and to find POCA member clinics near you, visit www.pocacoop.com.

We Have a Sliding Scale

We offer treatments on a sliding scale of $25-$55, New Patients are a flat $60.00. You decide what you can afford. There is never any need to prove your income. Our only goal is for you to be able to find out how useful acupuncture can be for you. Acupuncture is most effective for current health concerns when it is done frequently and regularly. We've found this to be especially true at the beginning of a course of treatment.

Acupuncture is a PROCESS. It is very rare for any person to be able to resolve a problem completely with one treatment. Frequent treatment is much more likely to lead to relief. Your acupuncturist will suggest a course of treatment based on the intensity and duration of your health concern. Twice a week is usually the minimum needed to get some momentum moving ahead with a health issue – though more frequent visits are common for short periods of time if the problem is quite intense. If you don't come in often enough or for enough treatments, acupuncture may not work as well for you.

We Treat in a Community Room

We believe a group setting has many benefits: it's easier for friends and family to come in together and it allows patients to keep their needles in as long as they want. Most people learn after a few treatments when they feel 'done'. This can take anywhere from twenty minutes to an hour or two.

The treatment room is meant to remain a quiet space for you and others to rest, sleep and sort it all out. Its atmosphere exists through our patients relaxing together. We appreciate everyone's presence...we find this kind of collective stillness a rare and valuable thing in our rushed and isolating society. Maintaining this reservoir of calm requires very little talking in the clinic space – including us. If you would like to speak to your acupuncturist one-on-one at great length, please let us know. We can arrange for time in the office.

Our Commitment to You

We want our community to be welcoming to all different kinds of people. We want to give you the tools to take care of your own health in a safe environment with skilled, experienced practitioners. We will always be available to listen to any advice and/or feedback you may have about ACA. We will do all of this with a sense of humor and help from you as well.

Please enjoy the space and time to do your work. We're happy you're here.

- The ACA Family

How Our Clinic Works

On your first treatment we ask that you remain in the waiting room until we are ready to receive you.

For the remainder of your treatments we ask that you use the following format:

Checking In:

~Find the envelope with your first name on it in the black box

~Put payment (cash or check) into envelope and deposit into wood box

~Reschedule yourself with **pencil** on the schedule provided on your left, you may pre-schedule as many treatments as you like, you may also schedule online

~ Take off your socks and shoes, and put your belongings in bin provided, take this in and sit it by your chair

Please turn off your cell phone before entering the treatment room

~ Enter the treatment space, find a chair, recline as much as you like, start relaxing until we come to start your treatment

Treatment:

~We will give you your treatment

~ We encourage you to stay as long as you like – until you feel "done" - this may be as short as 10 minutes or as long as 2 hours, often people will fall asleep, this is your time out enjoy it!

~As long as your eyes are closed we will leave you be, when you are ready to leave open your eyes and we will come check on you and pull out your needles. If you need to be done at a certain time please let us know beforehand.

~Sit up, grab your stuff and you're done!

Financial Policy

ACA is a low-cost, high volume Community Acupuncture Clinic. Our fees are $25-$55 per treatment, New Patients are a flat $60. You decide what you can pay at each visit. We will never ask for income verification and trust that you know best what you can afford to pay for your treatment. We make every attempt to make acupuncture available to as many people as possible at the most affordable rates. This is our mission.

Payment is expected at the time of your visit. We accept checks made out to ACA, cash, Visa & Mastercard. We ask that you be prepared to pay for your treatment each time you come in. At any time you may change the amount that you pay on the sliding scale up or down.

We reserve an appointment time for you and ask that you call us if you cannot keep your appointment. In consideration of other folks who may be on a waiting list for appointments, we ask that you give us at least 24 hours notice in advance of an appointment that you'll not be able to keep.

All appointments that are canceled on the day of, or are missed altogether, without letting our front desk know, will be charged a $25.00 fee payable at the next visit.

We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, of course. Thanks for understanding and in doing so, helping us to keep our fees as low as possible.

I agree to the above policy:

Print Name ____

Signature __________________________ Date _______________

As always, in order to keep our rates low, we rely on your referrals to our clinic.

Please share our vision with anyone who may need help with a health issue.

Informed Consent

Acupuncture involves the insertion of special needles into particular points on the body. The purpose of this treatment is to prevent or reduce pain and to help your body function better. There are some risks to treatment, including bruising of the skin and/or slight bleeding, weakness, fainting and aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection when all needles are sterile. **ACA only uses one-time use, sterile, disposable needles. We do not reuse needles, ever.**

We do not provide emergency care, nor Western (allopathic) medical care. Please see your medical doctor for those services and for routine check-ups. If you are pregnant, have a bleeding disorder, pacemaker, local infection or have been prescribed anticoagulant medications like Coumadin, by signing below you state that you have informed your acupuncturist of such conditions and we will modify treatments as needed.

With this knowledge, I voluntarily consent to the above procedures.

Print Name ______________________________

Signature ____________________ Date __________

Pledge and Responsibilities Regarding Your Protected Health Information

Medical information about you and your health is personal. We are committed to protecting health information about you.

ACA is required by law to: To protect the privacy of the medical information that identifies you & to provide you this notice.

Uses and Disclosures of Your Protected Health Information: ACA may use and disclose your protected health information in many ways related to your treatment, payment for your care, and our health care operations.

We may also use or disclose your protected health information in the following miscellaneous circumstances: Appointment Reminders, Health-Related Benefits & Services, Individuals Involved in Your Care, As Required By Law, Workers' Compensation, Public Health & Safety, Lawsuits & Disputes, Law Enforcement, Military Activity & National Security.

You Have a Right To:

Request to inspect and/or copy certain protected health information that may be used to make decisions about your care * Ask us to amend certain protected health information * Request an accounting of certain disclosures * Request restrictions * Request confidential communications * Receive a paper copy of this notice.

I, ______________ have reviewed and understand the information provided to me in the Notice of Privacy Practices.
Name

Print Name ______________________________

Signature ____________________ Date __________

HEALTH HISTORY

Date: ____ / ____ / ______

Name:			Sex:	Age:
Address:	City:		State:	Zip Code:
Phone # that you prefer to be contacted at::	Other Phone #: Work Cell Other	Email:		
Date of Birth:	Employer:	Occupation:		

Health Care Providers:

Relationship Status: ❐ Single ❐ Married ❐ Separated ❐ Divorced ❐ Widowed ❐ Living w/partner ❐ Other: ___________

Height:

Usual Blood Pressure:

Do you have a history of passing out?

Weight:

Weight One Year Ago:

How did you hear of our clinic? € Friend__________________________ € ACA Website € Health Provider_____________________________ € Flyer € Article € Drive By/Sign € Other

Are you or may you be currently pregnant?

Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when _____/_____/_____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________________

When did this start? _________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |———————|———————| 10

2 ______________________________

When did this start? _________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |———————|———————| 10

3 ______________________________

When did this start? _________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |———————|———————| 10

HEALTH HISTORY

Check the ❐ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? ____________	❐	_______	❍
Diabetes	❐	_______	❍
Hepatitis	❐	_______	❍
High Blood Pressure	❐	_______	❍
Heart Disease	❐	_______	❍
Stroke	❐	_______	❍
Seizure Disorder	❐	_______	❍
Thyroid Disease	❐	_______	❍
Asthma	❐	_______	❍
Pacemaker	❐	_______	❍

	YOU	Year	FAMILY
Osteoporosis	❐	_______	❍
Herpes	❐	_______	❍
AIDS / HIV	❐	_______	❍
Other STD	❐	_______	❍
Rheumatic Fever	❐	_______	❍
Alcoholism	❐	_______	❍
Allergies type(s)? ____________	❐	_______	❍
Mental Illness	❐	_______	❍
Kidney Disease	❐	_______	❍
Anemia	❐	_______	❍

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	______________	_______
Soda	______________	_______
Tobacco	______________	_______
Alcohol	______________	_______
Drugs	______________	_______

EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No

If so, what and how often:

____

____

____

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

____

____

____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

____

____

____

HEALTH HISTORY for WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD |———|———| HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks
- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats

When______ am / pm
Where on body ________ _

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |———|———| OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?
- ❒ Edema / Swelling _____________
- ❒ Rashes ______________________
- ❒ Itching _______________________
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

DIGESTION

DIARRHEA |———|———| CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ❒ Y ❒ N
- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

ENERGY

LOW |———|———| HIGH

- ❒ Sudden energy drop

Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

SLEEP

Hours per night ______
- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate: How often? _______
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness
- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

EYES, EARS, NOSE, THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color_______)
- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

MENSES

MENOPAUSE

Age at last menses: ________
Year changes began: ________
- ❒ Hot flashes _____x / day
- ❒ Night sweats _____x / week
- ❒ Vaginal dryness
- ❒ Loss of sex drive

Age at first menses: ______
Length of full cycle: ______ days (i.e. 28)
Length of menses: ____ days (i.e. 3-4)
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: _______ premature ______
# of abortions / miscarriages: _________

- ❒ Heavy periods
- ❒ Light periods
- ❒ Painful periods
- ❒ Irregular periods
- ❒ Changes in body/ psyche prior to menstruation (PMS)

- ❒ Cramps
  - ❒ Before bleeding
  - ❒ First day
  - ❒ During period
- ❒ Clots
- ❒ Breast tenderness

- ❒ Mood changes
- ❒ Fatigue w/ menses
- ❒ Digestive changes w/ menses
- ❒ Mid-cycle spotting
- ❒ Yeast infections
- ❒ Birth control pill (hormonal)