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Blue Jasmin Acupuncture & Herbs  
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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

### I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

### II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
  - g) Coroners, medical examiners and funeral directors
  - h) Organ or tissue donation facilities if you are an organ donor
  - i) To avert a threat to an individual or to public health safety

### III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

### V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
  - c) Right to know to whom we have disclosed your health information
  - d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
  - f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

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Signature of Patient or Representative

Date

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Print Patient Name

Patient Birth Date

1. Name \_\_\_\_\_  
 First Middle Last

2. Address \_\_\_\_\_  
 Street City State Zip

3. Home Phone \_\_\_\_\_ 4. Business Phone \_\_\_\_\_

5. Cell Phone \_\_\_\_\_ 6. Email \_\_\_\_\_  
 Preferred # to be contacted @? \_\_\_\_\_  
 Do you want to be added to an email list for special promotions and discounts? Y N

7. Age \_\_\_\_\_ 8. Date of Birth \_\_\_\_\_ 9. Sex M F 10. Marital: M S D W

13. Occupation \_\_\_\_\_ 14. Employer \_\_\_\_\_

14. Employer's Address \_\_\_\_\_  
 Street City St. Zip

**CASE HISTORY**

15. Chief Complaint \_\_\_\_\_

16. Complaint result of:  Auto Accident  Injury  Job Related  Other

17. Date of accident/Injury/Other \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

18. Have you seen any other doctor about this condition? \_\_\_\_\_ If yes, when? \_\_\_\_\_  
 Doctor's Name \_\_\_\_\_ Address \_\_\_\_\_

19. Have you had recent X-Rays? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Area X-Rayed \_\_\_\_\_

21. Nearest relative not living with you: \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Street City State Zip

22. In case of emergency, call: \_\_\_\_\_  
 Name Relationship to you Street City Phone

FOR FEMALES: Are you pregnant? \_\_\_\_\_ IF YES, HOW LONG? \_\_\_\_\_

FOR MINORS: List both parents' names and addresses: \_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

How do you plan to handle your account? (Check one)  Cash  Check  Master Card  Visa

**INSURANCE INFORMATION**

Do you have a personal, group health or accident insurance? \_\_\_\_\_ If yes, give: \_\_\_\_\_  
 Company Name \_\_\_\_\_ Address \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Group Number \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED \_\_\_\_\_ PATIENT'S SIGNATURE \_\_\_\_\_  
 (parent's signature if patient is minor)

How did you hear about the office? \_\_\_\_\_

# Patient Health History

Name: \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) Gender: M/F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

\*Is it okay to send coupons, birthday cards, etc. to your home address? Y N

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Have you had acupuncture before? Y N

3. Please identify the health concerns that have brought you to the acupuncture clinic in order of importance below:

<u>Condition</u>	<u>Past Treatment</u>
a. _____ How does this condition affect you? _____	_____
b. _____ How does this condition affect you? _____	_____
c. _____ How does this condition affect you? _____	_____
d. _____ How does this condition affect you? _____	_____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

\_\_\_\_\_  
\_\_\_\_\_

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. (Females) Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

<b>8. Family History:</b>	<b><u>Father</u></b>	<b><u>Mother</u></b>	<b><u>Brothers</u></b>	<b><u>Sisters</u></b>	<b><u>Spouse</u></b>	<b><u>Children</u></b>
<b>Check those applicable:</b>						
<b>Age (if living)</b>	_____	_____	_____	_____	_____	_____
<b>Health (G=Good, P=Poor)</b>	_____	_____	_____	_____	_____	_____
<b>Cancer</b>	_____	_____	_____	_____	_____	_____
<b>Diabetes</b>	_____	_____	_____	_____	_____	_____
<b>Heart Disease</b>	_____	_____	_____	_____	_____	_____
<b>High Blood Pressure</b>	_____	_____	_____	_____	_____	_____
<b>Stroke</b>	_____	_____	_____	_____	_____	_____
<b>Mental Illness</b>	_____	_____	_____	_____	_____	_____
<b>Asthma/Hay fever/Hives</b>	_____	_____	_____	_____	_____	_____
<b>Kidney Disease</b>	_____	_____	_____	_____	_____	_____
<b>Age (at death)</b>	_____	_____	_____	_____	_____	_____
<b>Cause of Death</b>	_____	_____	_____	_____	_____	_____

9. Height: \_\_\_\_\_ Weight: **Currently:** \_\_\_\_\_ **Past Maximum:** \_\_\_\_\_ **When?** \_\_\_\_\_

10. Blood Pressure: **What is your most recent blood pressure reading?** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **When was this reading taken?** \_\_\_\_\_

11. Childhood Illness (please circle any that you have had):

**Scarlet Fever      Diphtheria      Rheumatic Fever      Mumps      Measles      German Measles      Chicken Pox**

12. Hospitalizations and Surgeries:

<b><u>Reason</u></b>	<b><u>When</u></b>	<b><u>Reason</u></b>	<b><u>When</u></b>
_____	_____	_____	_____
_____	_____	_____	_____

13. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

<b><u>Reason</u></b>	<b><u>When</u></b>	<b><u>Reason</u></b>	<b><u>When</u></b>
_____	_____	_____	_____
_____	_____	_____	_____

14. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

**Mood Swings      Nervousness      Mental Tension      Depression      Bipolar      Eating Disorder**

15. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

**Fatigue      Slow Wound Healing      Chronic Infections      Chronic Fatigue Syndrome**

16. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

<b>Impaired Vision</b>	<b>Eye Pain/Strain</b>	<b>Glaucoma</b>	<b>Glasses/Contacts</b>	<b>Tearing/Dryness/Redness</b>
<b>Impaired Hearing</b>	<b>Ear Ringing</b>	<b>Earaches</b>	<b>Headaches</b>	<b>Sinus Problems</b>
<b>Nose Bleeds</b>	<b>Frequent Sore Throats</b>	<b>Teeth Grinding</b>	<b>TMJ/Jaw Problems</b>	<b>Hay Fever</b>

17. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

<b>Pneumonia</b>	<b>Frequent Common Colds</b>	<b>Difficulty Breathing</b>	<b>Emphysema</b>
<b>Persistent Cough</b>	<b>Pleurisy</b>	<b>Asthma</b>	<b>Tuberculosis</b>
<b>Shortness of Breath</b>	<b>Other Respiratory Problems: _____</b>		

18. Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

<b>Heart Disease</b>	<b>Chest Pain</b>	<b>Swelling of Ankles</b>	<b>High Blood Pressure</b>	<b>Pacemaker</b>
<b>Palpitations/Fluttering</b>	<b>Stroke</b>	<b>Heart Murmurs</b>	<b>Rheumatic Fever</b>	<b>Varicose Veins</b>

19. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

<b>Ulcers</b>	<b>Changes in Appetite</b>	<b>Nausea/Vomiting</b>	<b>Abdominal Pain</b>	<b>Passing Gas</b>	<b>Heartburn</b>
<b>Belching</b>	<b>Gall Bladder Disease</b>	<b>Liver Disease</b>	<b>Hepatitis B or C</b>	<b>Hemorrhoids</b>	<b>IBS</b>

20. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

<b>Kidney Disease</b>	<b>Painful Urination</b>	<b>Frequent UTI</b>	<b>Frequent Urination</b>	<b>Heavy Flow</b>
<b>Kidney Stones</b>	<b>Impaired Urination</b>	<b>Blood in Urine</b>	<b>Frequent Urination at Night</b>	<b>STDs</b>

21a. Female Reproductive (please circle any that you experience now and underline any that you have experienced in the past)

<b>Irregular Cycles</b>	<b>Breast Lumps/Tenderness</b>	<b>Nipple Discharge</b>	<b>Heavy Flow</b>
<b>Vaginal Discharge</b>	<b>Premenstrual Problems</b>	<b>Clotting</b>	<b>Bleeding Between Cycles</b>
<b>Menopausal Symptoms</b>	<b>Difficulty Conceiving</b>	<b>Painful Periods</b>	<b>Morning Sickness</b>

1. Age of First Menses: \_\_\_\_\_

4. Birth Control Type: \_\_\_\_\_

7. # of Abortions: \_\_\_\_\_

2. # of Days of Menses: \_\_\_\_\_

5. # of Pregnancies: \_\_\_\_\_

8. # of Live Births: \_\_\_\_\_

3. Length of Cycle: \_\_\_\_\_

6. # of Miscarriages: \_\_\_\_\_

21b. Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

<b>Sexual Difficulties</b>	<b>Prostate Problems</b>	<b>Testicular Pain/Swelling</b>	<b>Penile Discharge</b>
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22. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

<b>Neck/Shoulder Pain</b>	<b>Muscle Spasms/Cramps</b>	<b>Arm Pain</b>	<b>Upper Back Pain</b>	<b>Mid Back Pain</b>
<b>Low Back Pain</b>	<b>Leg Pain</b>	<b>Sciatica</b>	<b>Joint Pain (if so, where?): _____</b>	

23. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

<b>Vertigo/Dizziness</b>	<b>Paralysis</b>	<b>Numbness/Tingling</b>	<b>Loss of Balance</b>	<b>Seizures/Epilepsy</b>
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24. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

<b>Hypothyroid</b>	<b>Hypoglycemia</b>	<b>Hyperthyroid</b>	<b>Diabetes Mellitus</b>	<b>Night Sweats</b>	<b>Feeling Hot or Cold</b>
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25. Other (please circle any that you experience now and underline any that you have experienced in the past):

<b>Anemia</b>	<b>Cancer</b>	<b>Rashes/Eczema/Hives</b>	<b>Cold Hands/Feet</b>	<b>Autoimmune Disorders</b>
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Is there anything else we should know? \_\_\_\_\_

26. Lifestyle:

- a. Do you typically eat at least three meals per day?                      Y        N        If no, how many? \_\_\_\_\_
- b. Exercise routine: \_\_\_\_\_
- c. Spiritual practice: \_\_\_\_\_
- d. How many hours per night on average do you sleep? \_\_\_\_\_ Do you wake feeling rested?        Y        N
- e. Level of education completed:                      High School        Bachelors        Masters        Doctorate        Other
- f. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_
- Do you enjoy work?    Y/N    Why/Why not? \_\_\_\_\_
- g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_
- h. Have you experienced any major physical or emotional traumas?                      Y        N
- Explain: \_\_\_\_\_
- i. How many 8 ounce glasses of water do you drink per day? \_\_\_\_\_
- j. Television habits: \_\_\_\_\_ Reading habits: \_\_\_\_\_
- k. Interests and hobbies: \_\_\_\_\_

**Financial Policy**

The first acupuncture visit is \$100 and generally lasts an hour and a half.

Each following acupuncture visit is \$65 and generally lasts one hour.

Tuning forks are an additional \$15 when added to an acupuncture session.

An herbal consultation with no acupuncture is \$50 plus the cost of the herbs.

Fees are payable by cash, check, or credit card (only Mastercard, Visa & Discover are accepted) at the time that services are rendered.

If a check is returned, you will be charged a \$25 fee.

Please be courteous and respectful of other patients who are waiting for appointments and cancel 24 hours in advance of your scheduled appointment time to avoid charges.

If you miss an appointment without canceling 24 hours in advance you will be charged the usual fee of \$65. Thank you for understanding.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Directions from the 101 Freeway heading Northbound:**

Exit California Street, make a right onto California Street, make another right onto Santa Clara Street. You will past the post office which will be on your left-hand side. You will then come to the 4-way stop sign. You will see the Ventura Executive Suites on the left corner as you are passing through the intersection. Find 2 hour parking on the street. Suite 41 is located in the back corner of the building. Ask receptionist for assistance if needed.