This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

New Patient Intake Form, the office of Bruce Pendleberry, OMD, LAc, Dipl. O.M. (NCCAOM)® Date:_____

Patient Name:_____Date of Birth:_____Referred by:_____

Your Address:_____City:_____State:____ Zip:_____

Phone. Cell:_____Home:_____Work:_____

Occupation:_____ Married Divorced Widowed Single

Date of last physical exam:_____Weight:_____Height:_____Blood Pressure:_____

Email:_____Receive email communications from this office only Yes No

Emergency Contact:_____Relationship:_____Phone:_____

Have you had Acupuncture or Herbs before Yes No_____

What was your experience? Very good Good No Change_____

Family Physician or current Physician:_____Phone:_____

Are there any other therapies which you are involved in? Yes No Who and what for?_____

_____

_____

What is the primary reason for seeking care at our office?_____

What was the initial cause?_____

When did it begin?_____

What makes it worse?_____

What makes it better?_____

How does this problem interfere with your daily activities? Work Sleep Walking Sitting Standing Emotional Social Life Relationships Sexually Recreation Bending/Stretching Other_____

What have you done about this?_____

Are you interested in: Acupuncture Pain Relief Preventative Care Oriental Nutrition Stretching Maintenance Care Stress Relief Herbal Therapy Other_____

What are your health goals?_____

List any past or future surgeries_____

_____

List any significant trauma & when it occurred (ex: auto accident, falls, emotional, sexual, etc)_____

_____

List exercise and sport activities you have been or are currently involved in:_____

_____

Medical History

Do you have any allergies? Yes No If so to what?

Do you take medication? Yes No If so, what types and how often?

Do you take supplements? Yes No If so, what types and how often?

Please indicate if you ⟳ circle or any family (underline) members have or had any of the following conditions:

Pneumonia Drug reaction Mental breakdown Gonorrhea/Herpes Mental illness Tuberculosis

Heart attack/Disease Jaundice HIV/AIDS Hepatitis Hypo/Hyper Thyroid Blood Transfusion Parasites

Premature Graying Parasites Hyper or Hypo Tension Cancer Diabetes Anemia Measles Seizures

Epilepsy Arthritis Mumps Gout Multiple Sclerosis Kidney Stones Obesity Syphilis

Other not listed:_____Who in family:_____

Do you have a high point during the day? No Yes When?_____Related to food?_____

Do you have a low point during the day? No Yes When?_____Related to food?_____

What are your indulgences?_____What are your hobbies/pleasures?_____

Pain: Use the pain key below to indicate areas and type of pain.

Circle pain intensity and limitations

Pain intensity levels

Pain: No Problem Moderate Severe Terrible

Sleeping: No Problem Disturbed Very No sleep

Work: Usual work 50% of work 25% of work No work

Frequency: 25% of time 50% 75% 100%

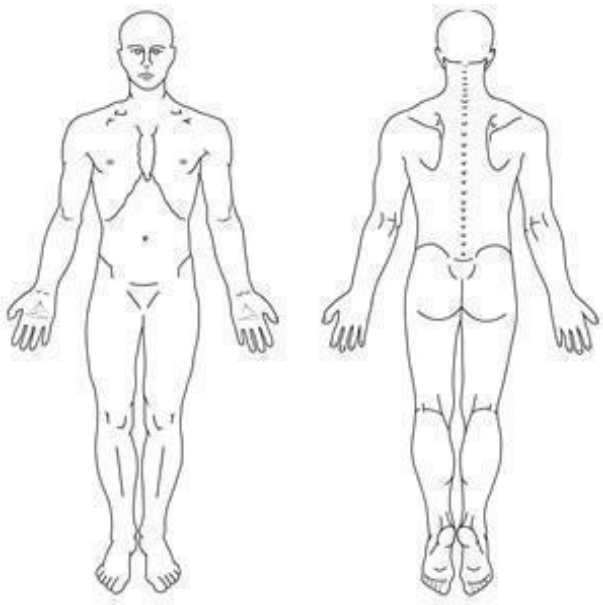
Travel: No Problem Mild Pain Moderate Severe

Recreation: No limitations Some Severe pain No activities

Walking: No pain After 10 min Hard to walk Cannot Walk

Sitting: No pain Some pain Much pain Cannot sit

Other:_____



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^^	--------	oooooo	xxxx	////////

Commitment: On a scale from 1 - 10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Please circle all that apply

Sweating: Night sweats Rarely sweat Excess sweating Odor Hands Feet Other_____

Circulation: Poor Good Hot Cold What areas_____Bleed easily_____

Sleep: Restful Restless Not rested when you wake up How many hours do you sleep a night_____

Is that enough? Yes No Trouble falling asleep Active mind Worry Fear Other Trouble staying asleep

Dreams: Good Bad Often Rarely Recurring General themes_____

Bowels: Painful Diarrhea Constipation Bloody Black Mucus Hemorrhoids Gas Foul odor Colitis.

# of bowel movements a day_____Other_____

Urine: Color_____ Infrequent Frequent Retention Pain Burning Strong odor Cloudy Dribbling

Blood Frequent infections Retention Urge to go but can't. # times per Day_____ Night_____

Other:_____

Skin: Dry Itchy Moist/clammy Burning Changing Moles or Lumps (cysts/tumors) Boils Rashes

Acne Dry scalp Hair loss / thinning Skin puffy/wrinkled Bruise easily Hives Other_____

Head: Headaches What areas:_____When do they occur_____

Dizziness Memory loss Loss of balance Fainted Other_____

Eyes: Pain Dry Red Discharges Blurred vision Darkness under eyes Watery Nearsighted / Farsighted

Other_____

Ears: Poor hearing Earaches Discharges / Infections Ringing / buzzing Other_____

Nose: Frequent nosebleeds Sinus problems Frequent colds Runny Dry Itchy Sores Sneezing

Other _____

Throat: Sore Hoarseness Difficulty swallowing Teeth/gum problems Swollen tongue Jaw problems Teeth

sensitive to cold / hot Other_____

Female Concerns: Date of last menstruation_____Days between cycle_____Days of flow_____

Form of birth control Yes No Pill Other_____If yes, to Regulate period / Birth control Other_____

Age started period?_____Stopped?_____Do you have: Menstrual cramps or pain Low backache Clotting

Heavy bleeding Light scanty bleeding Water retention Mood changes Cravings Painful breast Hot flashes

Skip periods Low sex drive Color of blood throughout period_____

Discharges: Yellow White Clear Thick Copious Odor Itching Other_____

GYN Operations_____

Male Concerns: Testicular pain Penis pain Penis sores Discharge Premature ejaculation Impotence

Nocturnal emission ED Prostatitis Other_____

Appetite: Excessive Poor Changing Feel tired/weak if a meal is missed Eat quickly Never satisfied

Never thirsty Excessive thirst Eat when nervous or working Eat frequently Eat late in evening

Prefer: Sweet Spicy Salty Sour Bitter Bland Fried Raw Well Cooked Other_____

Specific foods you crave or dislike_____

Food allergies or sensitivities_____

Digestion: Stomach discomfort Gas Heartburn Burping/Belching Pain Cramps Nausea/Vomiting

Bad Breath Sores in mouth Taste in mouth: Bitter Sour Salty Bland Other_____

Weight gain Weight loss Bloating How long after eating?_____Other_____

Eating Habits: How many meals a day do you eat _____When is your biggest meal_____

How many glasses of water do you drink a day_____Is it Tap Filtered Bottled Other_____

Do You: Eat when you are worried or rushed: Yes No If yes how often and when:_____

Use Alcohol: Amount per day/week____ Tobacco Packs per day_____ How many years_____

Eat or drink dairy products every day Eat until you feel full Eat late in the evening or have late night snacks

Eat frequently between meals Eat the same foods almost every day Eat protein at least one time a day

Eat green or yellow vegetables at least: Once Twice a day Chew your food thoroughly before swallowing

Go on "diets" often Eat or drink cold beverages or food often: Yes No

Eat out often If yes How many times a day, and what meal(s)

Eat at regular intervals (ex: 7am 1pm 6pm) Yes No If no, when do you normally eat_____

Give a typical Breakfast, Lunch, Dinner and Snacks_____

_____

_____

Anything else you want to tell me that was not on this form_____

_____

_____

Bruce Pendleberry, OMD, LAc, Dipl. O.M. (NCCAOM)®

1325 E. Thousand Oaks Blvd, #104 Thousand Oaks, CA 91362

805 380-5742

Financial Agreement as of 1/1/2024

Cash Payment Checks Credit Cards

We would like to take a moment to welcome you to our office and familiarize you with our financial policy.

Payment Arrangements: Charges for herbal consultations, treatment(s) and herbs /supplies are due at the time of service and when picking up herbal/supplement refills.

Initial Visit which includes initial consultation, initial herbal/nutritional consultation (if needed), and/or acupuncture procedure if needed: $175.00.
Follow up **Acupuncture alone**: $ 85.00.
Acupuncture with Red & NIR LED Light Therapy and/or PEMF Therapy**: $100.00, 1 side only.
Follow up **Acupuncture with Herbal/Nutritional Consultation**: $95.00.
Follow up **Acupuncture with Herbal/Nutritional Consultation** and **Red & NIR and/or PEMF Therapy**: $110.00
Follow up **herbal/nutritional consultation**: $65.00.
Phone Consultation: $65.00
LED Red & NIR Treatment Alone**: $ 55.00. 15 minute treatment front and back for a total of 30 minutes
Cupping or Gua Sha with Acupuncture: Additional $15.00 - $25.00 depending on the extent of the procedure.
Cupping or Gua Sha treatment alone: $55.00
Facial Acupuncture: $125.00 (This includes body Acupuncture)
PEMF Treatment Alone: $55.00. Pulsed Electromagnetic field treatment to specific body parts that are of concern.
Electro-Stim/Microcurrent with Acupuncture: $95.00
Herbal Formula: Prices typically range from $55.00 - $125.00+. Nutritional supplement prices vary.
Facial/Hair MicroNeedling Rejuvenation 3 Treatment Package: $900.00 or **Individual Treatments**: $350.00
Facial/Hair NANO Needling Rejuvenation Individual Treatments: $350.00
****Note: The more skin exposed the better with Red and NIR light. Treatments last for 25 minutes, so wearing a 2 piece bathing suit, or a sports bra, with shorts also works. For men, shorts.**

Cash, Checks, VISA, Master Card, Discover, and American Express are welcome.

Financial arrangements made upon request.

I have read and agree with the above.

Patient's Signature _____ Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Acupuncture, Acupressure, Ear Seeds, Moxibustion, Cupping, Gua Sha, Electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing.
The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally 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 or fainting.
Burns and/or scarring are a potential risk of moxibustion, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 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 condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Bruce Pendleberry, OMD, LAc, Dipl. O.M. (NCCAOM)®

PATIENT SIGNATURE X_____**DATE:**_____
(Or Patient Representative) (Indicate relationship if signing for patient)

HIPAA NOTICE OF PRIVACY PRACTICES

Please read and sign at the bottom of this HIPAA notice.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Bruce Pendleberry, OMD, LAc is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information. Treatment.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

" It is our policy to provide a substitute health care provider, authorized by Bruce Pendleberry, OMD, LAc, to provide assessment and/or treatment to our patients, without advance notice, in the even/ of your primary health care provider's absence due lo vacation, sickness, or other emergency situation. "

Payment.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Workers' Compensation.

If applicable, we may disclose your health information as necessary to comply with state Workers ' Compensation Laws.

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 public health authorities for purposes related to: 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 proceeding.

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.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation & Research.

Though highly unlikely or probable we must inform you that there may be a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing & **Other Communication.**
We may contact you for marketing purposes or fund-raising purposes, as described below: (example)

" As a courtesy to our patients, it is our policy to call or email you on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office

Your Health Information Rights.
You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Bruce Pendleberry, OMD, LAc.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices.
This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints.
Complaints about your privacy rights, or how Bruce Pendleberry, OMD, LAc has handled your health information should be directed to this office at 805 380-5742

Acknowledgment of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of Bruce Pendleberry, OMD, LAc, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed:_____Date:_____
If not signed by the patient, please indicate relationship to patient (ex., mother) and patient's name.

Patient:_____

Relationship:_____

Bruce Pendleberry, OMD, LAc, Dipl. O.M. (NCCAOM)®

1325 E. Thousand Oaks Blvd, #104 Thousand Oaks, CA 91362

805 380-5742

DIRECTIONS

FROM LOS ANGELES

Take the US-101 N to S Rancho Rd in Thousand Oaks.
Take exit 43B (S Rancho Rd)
At the light turn Right onto S Rancho Rd
Then Right onto Thousand Oaks Blvd
In approximately 400ft turn Left into the Northstar Plaza (Tilted Kilt Pub)
Continue straight down the parking lot to the two story building at the end
We are the two Red doors on the left, “Advanced Health and Wellness Center”
Continue straight down the parking lot to the two story building at the end
We are the two Red doors on the left, “Advanced Health and Wellness Center”

FROM VENTURA

Take the US-101 S to S Rancho Rd in Thousand Oaks.
Take exit 43A (S Rancho Rd)
At stop sign turn Left onto S Rancho Rd
Then Right onto Thousand Oaks Blvd
In approximately 400ft turn Left into the Northstar Plaza (Tilted Kilt Pub)
Continue straight down the parking lot to the two story building at the end
We are the two Red doors on the left, “Advanced Health and Wellness Center”

Recommendations To Enhance Your Treatment

Please arrive promptly without being rushed. Avoid coffee, alcohol and other stimulants for 4 hours before treatments, if possible. Do not arrive very hungry. Schedule your exercise program so that your exercise for that day is done before Acupuncture, not afterwards (only if you are receiving Acupuncture). Keep your appointments as a commitment to your recovery and good health.

If you are taking many different supplements, bring them in so I can go over them with you.

If you are receiving Red & NIR Light Therapy: The more skin exposed the better with Red and NIR light. Treatments last for 20 minutes, so wear a 2 piece bathing suit, sports bra, with shorts also works. For men shorts will work well.

Be sure to maintain your appointment schedule. If you must cancel, we request 24 hours' notice so that another person may take that time. This is very important because we are usually booked the whole day and have people waiting for an opening.

Please do your best to be on time. If one person is late it can affect my schedule and all the other patients for the rest of the morning or afternoon.
I will do my best to get you in quickly and give you my full attention for your appointment time. This is very important so that I can give you the best possible care.