Acupuncture For Wellness
2100 SE Lake Road Suite 3 Milwaukie, Oregon 97222 503.786.0771

FINANCIAL POLICY

Our goal at the Acupuncture For Wellness clinic is to make acupuncture and Chinese medicine available to as many people as possible, at the most affordable rates.

In respect for our intention to offer high quality health care at affordable rates, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged **$15** for that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number or remaining appointments in that package.

Thank you for your understanding.

Print name ___________________________________ Date _______________________

Signature ____________________________________

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Welcome to our office. The purpose of the Acupuncture For Wellness clinic is to assist each individual in achieving and maintaining their optimum health and wellness. Traditional Chinese Medicine includes Acupuncture, Chinese Herbs and Nutrition, and may differ from most medical approaches, but it is viewed as complimentary.

Please print and answer all questions completely. All information will be strictly confidential.

Name ____ Date ____________________

Address ____

City/State/Zip ____

Home Phone ________________ Work Phone ____________ Cell Phone ________________

Email ____

Date of Birth ________________ Age ________________

Occupation ______________________ Company Name ____________________________

Emergency Contact ________________ Relation ______________ Phone ________________

How did you hear about us? ____

Have you received acupuncture before? Y N Chinese herbal medicine? Y N

CONSENT:

I voluntarily consent to be treated with Acupuncture and/or Chinese Herbs at the Acupuncture For Wellness clinic, and/or my residence. I understand that acupuncturists practicing in the state of Oregon are not primary care providers, and that regular primary care by a licensed physician is an important choice that is strongly recommended.

I understand that acupuncture is performed by the insertion of needles. This occurs through the skin, and/or by the application of heat to the skin, at certain points on or near the surface of the body. The effect of acupuncture is to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions. I have been informed that only disposable needles will be used during each treatment.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to the acupuncture treatment. Possible adverse side effects from taking Chinese herbs include, but are not limited to, changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment.

I am aware that acupuncture is licensed in Oregon and many other states, has been safely practiced for centuries, and that the FDA classifies the procedure as a medical procedure. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatments at any time.

PAYMENT OF SERVICES:

Payment is due at the time of services unless arrangements are made in advance. Payment can be made with cash, personal check, or visa/debit card. A fee will be charged for all returned checks.

I have carefully read, understand, and agree to all of the above information, and I am fully aware of what I am signing. I give my permission and consent to treatment.

______________________________________ ____________________

Signature (Patient/Parent/Guardian) Date

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HEALTH HISTORY QUESTIONNAIRE

Name: ____ Date: ______________________________

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

1. Please identify the health concerns that have brought you to the Acupuncture For Wellness clinic below (list in order of importance):

Condition	How does this affect you?
1). ______________________	______________________
2). ______________________	______________________
3). ______________________	______________________

2. Are you currently under the care of a physician for the conditions listed above? Y N
3. Do you have any chronic infectious diseases? Y N If yes, please explain ______________________
4. Please list any prescription medications, over the counter medications, vitamins, and/or supplements you are currently taking:

   1). ______________________ 3). ______________________

   2). ______________________ 4). ______________________
5. Please list any serious illness, accidents or surgeries you may have had: ______________________

   ____
6. Check any conditions that have occurred in your blood relatives:

   ◻ Cancer ◻ Diabetes ◻ Heart Disease ◻ High Blood Pressure ◻ Kidney Disease ◻ Mental Illness ◻ Stroke

Symptom Profile: For the following, please check **YES** for a condition you have currently or have had in the past year.

Emotional/Mental	**■Yes**
Mood Swings	◻
Poor Memory or Concentration	◻
Easily Stressed	◻
Anxiety	◻
Depression	◻
Excessive Anger	◻
Excessive Fear	◻
Excessive Worry	◻
Nervousness/Irritability	◻
Overwhelmed by Life	◻

Energy and Immunity	**■Yes**
Slow Wound Healing	◻
Chronic Infections	◻
Easily Tired/Fatigued	◻
Body Heaviness	◻

Skin and Hair Disorders	**■Yes**
Rash	◻
Acne/Boils	◻
Eczema/Hives	◻
Sensitive Skin	◻
Psoriasis	◻
Itchy or Dry Skin	◻
Bleed or Bruise Easily	◻
Day/Night Sweats	◻
Acute Hair Loss	◻

Respiratory Disorders	**■Yes**
Frequent Colds	◻
Chronic Cough	◻
Asthma/Wheezing	◻
Difficulty or Painful Breathing	◻
Pneumonia	◻
Emphysema	◻

Head, Eye, Ear, Nose, Throat	**■Yes**
Blurred or failing Vision	◻
Eye Pain or Strain	◻
Tearing or Dryness	◻
Spots In Front of Eyes	◻
Loss of Hearing	◻
Ear Ringing	◻
Earache	◻
Headaches/Migraines	◻
Sinus Problems	◻
Nose Bleeds	◻
Hay Fever/Allergies	◻
Frequent Sore Throats	◻
Swollen Glands	◻
Bleeding Gums	◻
Dry Mouth	◻
Hoarseness	◻
Trouble Swallowing	◻
Teeth Grinding	◻
TMJ/Jaw Problems	◻

Turn over

Cardiovascular Disorders ■Yes
- Heart Disease ☐
- Chest Pain ☐
- Blood Clots ☐
- High or Low Blood Pressure ☐
- Heart Attack ☐
- Rapid/Irregular Heart Beat ☐
- Hardening of Arteries ☐
- Poor Circulation ☐
- Ankle Swelling ☐

Digestive System Disorders ■Yes
- Nausea or Vomiting ☐
- Change in Appetite ☐
- Ulcer ☐
- Heartburn/Indigestion ☐
- Stomach Pain or Cramping ☐
- Belching, Gas or Bloating ☐
- Hemorrhoids ☐
- Diarrhea ☐
- Constipation ☐

Urinary Tract Disorders ■Yes
- Kidney Infection/Stones ☐
- Burning or Painful Urination ☐
- Urgent Urination ☐
- Frequent Infections ☐
- Frequent Urination ☐
- Frequent Night Urination ☐

FOR WOMEN ONLY ■Yes
- Breast Lumps ☐
- Breast Pain or Tenderness ☐
- Irregular Cycle ☐
- Excessive Menstrual Flow ☐
- Scanty Menstrual Flow ☐
- Clotting During Menses ☐
- Painful Periods ☐
- Bleeding Between Periods ☐
- PMS ☐
- Endometriosis ☐
- Menopausal Symptoms ☐
- Previous Miscarriage ☐

Could you be pregnant now? ______________________

FOR MEN ONLY ■Yes
- Testicular Masses/Swelling ☐
- Testicular Pain ☐
- Impotence ☐
- Sexual Difficulties ☐
- Prostrate Disease ☐

Musculoskeletal Disorders ■Yes
- Muscle Weakness ☐
- Muscle Spasms or Cramps ☐
- Neck or Shoulder Pain ☐
- Arm Pain ☐
- Back Pain ☐
- Leg Pain ☐
- Sciatica ☐
- Fibromyalgia ☐
- Osteoarthritis ☐
- Rheumatoid Arthritis ☐
- Joint Pain, Stiffness or Swelling ☐
- Other ______________________

Neurological Disorders ■Yes
- Vertigo/Dizziness ☐
- Paralysis ☐
- Numbness or Tingling ☐
- Seizures/Epilepsy ☐

Endocrine Disorders ■Yes
- Hyperthyroid/Hypothyroid ☐
- Diabetes ☐
- Excessive Thirst ☐
- Excessive Hunger ☐

Miscellaneous ■Yes
- Anemia ☐
- Cold Hands or Feet ☐
- Fainting ☐
- Jaundice ☐
- Hepatitis A, B or C ☐
- HIV/AIDS ☐
- Stroke ☐
- Cancer ☐
- Lymph Nodes Removed ☐

Lifestyle:

1). Do you eat a balanced diet? Y N

Do you eat at least 3 meals per day? Y N

2). How much water do you drink? ______________________

Do you drink alcohol? Y N

If yes, how much? ______________________

3). Do you smoke or use tobacco? Y N

If yes, how much? ______________________

Have you smoked previously? Y N

If yes, for how long? ______________________

4). Do you exercise? Y N

If yes, what kind? ______________________

How often? ______________________

5). Do you sleep well? Y N

Do you wake rested? Y N

Do you average 6-8 hours of sleep? Y N

6). Occupation ______________________

Hours/Week ______________________

Do you enjoy work? Y N

7). Have you experienced any traumas? Y N

Explain ______________________

____

8). History of abuse? Y N

Psychological Physical Sexual

9). How long has it been since you have had a complete medical exam? ______________________

10). Is there anything else we should know? ______________________

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