

OUR WORK

East Asian Medicine is a holistic modality based on hundreds of years of paying close attention to how and why human systems swing out of balance. Acupuncture and adjunctive techniques are powerful tools for interrupting imbalance and supporting your body's natural ability to heal. In addition, it is possible you may choose to incorporate suggestions of movement work, relaxation techniques, dietary adjustments and/or herbs.

FIRST VISIT PREPARATION

Please bring your completed Health Profile and Consent forms with you and allow up to an hour and a half for the visit. Plan to wear or bring loose, comfortable clothing as I may need to assess and/or treat limbs, abdomen, back and neck. Women may want to bring shorts and a tank top or sports bra. Men may want to bring a pair of gym shorts.

Parking in Ballard is variable so please allow a bit of extra time. If you arrive early, please take a few minutes to relax in the waiting room before your appointment begins.

PAYMENT AND INSURANCE

Payment in full is due at the time of your visit. \$155 for the first visit (90 minutes) and \$115 (1 hour) for follow-up visits. I will supply a Receipt of Payment (including appropriate diagnostic and procedure codes) for you to submit to your insurance company for possible reimbursement or application toward your deductible. If you have specific acupuncture insurance questions, I suggest you refer to your policy document or call the number on the back of your insurance card.

I look forward to meeting you and beginning our work together. -Michelle

PATIENT NAME: _____

_____/_____/_____
Date of first visit

PRIMARY CONCERN

What primary concern brings you here today? _____

When did this problem begin? _____

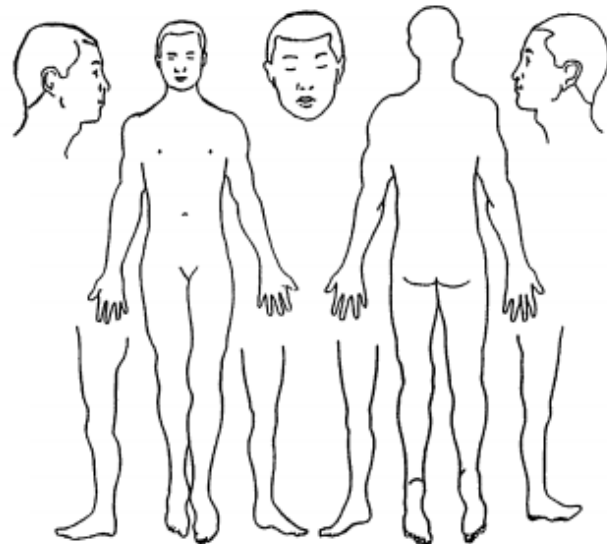
To what extent does this interfere with your daily life? _____

What treatments/interventions have you tried? _____

Have you been given a diagnosis for this problem? If yes, what is it? _____

Are there additional concerns you would like to address? If yes, please list (in order of importance to you): _____

On the images to the right,
indicate areas of concern
(pain, weakness, numbness, rash etc).
Describe these sensations.



General Lifestyle and Activities of Daily Living

What do you enjoy most about your life? _____

What do you consider the strong point(s) in your health or your life? _____

What are the major stressors in your life? _____

Movement

How many hours screen time (computer/smart phone/TV/etc.) per day? _____

Do you consider yourself an active person? () y () n If yes:
 type of activity _____ times per week _____ duration of activity _____

What other types of activities do you do? (housework, yard work, volunteering, employment related)

Rest and relaxation:

How many hours sleep per night? _____

How many **days per week** do you: feel rested upon waking? _____ have difficulty waking up? ____
 have difficulty falling asleep? _____ have difficulty staying asleep? ____

Do you take regular time for yourself? () y () n If yes, what form does it take? _____

Average Daily Food and Beverage Intake Including Snacks (please describe).

Morning: _____

Afternoon: _____

Evening: _____

Average number of fresh fruits and vegetable servings per day: _____

Please describe any special dietary practices or dietary restrictions: _____

Current Medications: (Include all vitamins, supplements, herbs and pharmaceutical medications.)
 item _____ dosage _____ for what condition _____ prescribed by _____

Other Intake: Indicate use per week. If you have quit any of the following, how long ago?

Alcohol _____ Caffeine _____

Tobacco _____ Marijuana _____

MEDICAL HISTORY

Please indicate date and other information as appropriate.

General

- | | | |
|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Cravings: for _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Strong Thirst (cold or hot drinks) | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sudden Energy Drop: Time? _____ | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Sleeping | |
| <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Night Sweats | Other? _____ |

Musculoskeletal

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Muscle Pains |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain | |
| <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Foot/Ankle Pain | |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | Other? _____ |

Gastrointestinal

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Abdominal Pain or |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Cramping |

Psychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anger/Bad Temper | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Addiction Issues | <input type="checkbox"/> Attempted or |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Easily Susceptible to Stress | considered suicide |
| Any known history of abuse (physical or emotional) or neglect? <input type="checkbox"/> yes <input type="checkbox"/> | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Spot in Front of Eyes | <input type="checkbox"/> Grinding Teeth or Jaw Pain | <input type="checkbox"/> Lip or Tongue Sores |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Teeth Problems | Other? _____ |

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of Feet |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of Hands | Other? _____ |

Respiratory

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Production of Phlegm |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Difficulty Breathing Lying Down | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pain with Deep Breathing | Other? _____ |

Neurological

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Paraesthesia (abnormal sensation) | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Tremors | Other? _____ |

Skin and Hair

- | | | |
|----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Change in hair or skin texture | Other? _____ |

Genito-urinary

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain When Urinating | <input type="checkbox"/> Halting Urination | |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine | |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Sores on Genitals | |
| <input type="checkbox"/> Decrease in Flow | <input type="checkbox"/> Impotency | |
- Do you wake at night to urinate? yes no How often? _____ Other? _____

Surgeries (type and date): _____

Birth History Was your own or that of your children a prolonged labor? _____

Gynecology and Pregnancy (women only)

- | | | |
|---------------------------------|---|--|
| # of Pregnancies _____ | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Breast Lumps |
| # of Births _____ | <input type="checkbox"/> Unusual Character (Heavy or Light, spotting, intermittent) | Changes in Body/Psche |
| # Miscarriages _____ | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Prior to menses |
| # Abortions _____ | <input type="checkbox"/> Clots | <input type="checkbox"/> Post menses |
| Age at first menses _____ | <input type="checkbox"/> Vaginal Discharge | Do you use birth control? |
| First date of last menses _____ | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Period between menses _____ | <input type="checkbox"/> Breast Lumps | What type and for how long? _____ |

Thank you!

Patient Registration

First Name: _____ MI: ___ Last: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary phone: () _____ -- _____ Secondary phone: () _____ -- _____

Email: _____@_____

Would you like to receive email appointment reminder notices? Y/N

When I need to contact you, which method is preferred? ()primary ()secondary ()email ()no pref.
May I leave confidential health information at: ()primary ()secondary ()email ()no pref.

Date of Birth: ___/___/_____ Age: _____ Gender: () male () female () transgender

Employment: () Employed () Student () Retired () Other

Occupation: _____ Employer: _____

Marital Status: () Single () Married () Partnered () Divorced () Widowed () Dependent () Other

Partner/Spouse's Name: _____

Do you identify as: () straight/heterosexual () lesbian/gay/homosexual () bisexual () something else

Primary Care Provider: _____ Phone: _____

In case of emergency contact: _____ Relationship: _____ Phone: _____

Whom may I thank for referring you: _____

CONSENT FORM FOR ACUPUNCTURE

I, THE UNDERSIGNED, HEREBY AUTHORIZE Michelle Thoreson, LAc, EAMP to perform the following specific procedures related to my health care. Acupuncture procedures involving insertion of sterilized acupuncture needles through the skin into the underlying tissues at specific points on the surface of the body, as well as other techniques specifically described in the Washington State law for Licensed Acupuncturist and East Asian Medicine Practitioner, such as moxibustion, cupping, electromagnetic treatment, as well as the recommendation of dietary guidelines and therapeutic exercises.

I recognize the potential risks and potential benefits regarding the procedure of acupuncture and its related therapies as follows:

POTENTIAL RISKS

Discomfort at the site of insertion of needles which may include swelling, bruising, bleeding, infection and/or pain. Possible systemic responses such as nausea, fainting, dizziness, or weakness. In some cases, there may be aggravation of signs and symptoms that existed prior to the acupuncture treatment.

POTENTIAL BENEFITS

Relief of presenting signs and symptoms and stimulation the body's own self-balancing mechanisms in order to restore health within the body. Acupuncture offers a drugless and non-surgical method of health care which focuses on benefitting overall constitution, as well as health maintenance and preventative medicine.

With this understanding, I recognize that no guarantees or claims are being made to the improvement or cure of my presenting condition and that I am giving my consent on a voluntary basis to the above mentioned acupuncture procedures. I understand that I am free to withdraw my consent and discontinue with the treatment session at any time.

I understand that 24 HOURS NOTICE is needed to avoid being charged for my appointment. If adequate notice is not given, I will be charged the FULL AMOUNT for the missed appointment. I also understand that charges for services rendered are due at the time of service.

Signature of Patient

Date

NOTICE OF PRIVACY PRACTICES

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

Disclosure of Your Protected Health Information (PHI)

Without specific written authorization, I am permitted to use and disclose your health records for the purpose of treatment and payment.

TREATMENT means providing, coordinating, and managing health care and related services by one or more health care providers. For example, I may need to share information with other health care providers involved in the continuation of your care.

PAYMENT means reimbursement for services.

OTHER DISCLOSURES: Unless you request otherwise, I may use or dispose health information of a family, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care.

Example: If another physician referred you to me, I may contact that physician to discuss your care. Likewise, if I refer you to another physician, I may contact that physician to discuss your care or they may contact me. In the event of an emergency or incapacity I will use my professional judgement in disclosing only the protected health information necessary to facilitate needed care. In addition, I may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to subpoena or court order, to military authorities of armed forces personnel, and/or to report suspected abuse, neglect or domestic violence.

Your Protected Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health care information.

You have the right to inspect and copy your health information.

You have the right to request amendments be made by this office to your PHI file.

You have the right to receive an accounting of disclosures of your PHI.

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

If you have any questions about this notice or if you want more information, please contact: Michelle Thoreson, (206) 781-2734

By way of my signature, I consent and authorize Michelle Thoreson to use and disclose my Protected Health Information for the purpose of treatment, payment, and other disclosures as described in the Privacy Notice.

Patient's name (signature)

Patient's name (print)

____/____/____
Date