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. $145 for the first visit and $105 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):_____
_____

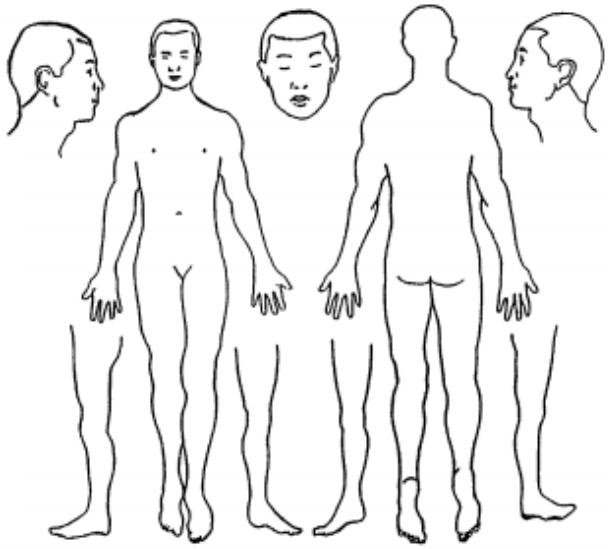
On the images to the right, indicate areas of concern (pain, weakness, numbness, rash etc). Describe these sensations.

_____

_____

_____

_____



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

❑ Poor Appetite
❑ Fevers
❑ Chills
❑ Sweat Easily
❑ Localized Weakness
❑ Bleed or Bruise Easily
❑ Peculiar Tastes or Smells
❑ Strong Thirst (cold or hot drinks)
❑ Sudden Energy Drop: Time? _____
❑ Fatigue
❑ Poor Sleeping
❑ Night Sweats
❑ Cravings: for _____
❑ Change in Appetite
❑ Weight Gain
❑ Weight Loss

Other? _____

Musculoskeletal

❑ Neck Pain
❑ Shoulder Pain
❑ Hand/Wrist Pain
❑ Back Pain
❑ Hip Pain
❑ Knee Pain
❑ Foot/Ankle Pain
❑ Muscle Weakness
❑ Muscle Pains

Other?_____

Gastrointestinal

❑ Nausea
❑ Vomiting
❑ Constipation
❑ Gas
❑ Black Stools
❑ Blood in Stools
❑ Bad Breath
❑ Rectal Pain
❑ Chronic Laxative Use
❑ Hemorrhoid
❑ Diarrhea
❑ Belching
❑ Indigestion
❑ Abdominal Pain or Cramping

Psychological

❑ Depression
❑ Anxiety
❑ Bipolar
❑ Anger/Bad Temper
❑ Addiction Issues
❑ Easily Susceptible to Stress
❑ Panic Attacks
❑ Attempted or considered suicide

Any known history of abuse (physical or emotional) or neglect? ❑ yes ❑

Head, Eyes, Ears, Nose and Throat

❑ Dizziness
❑ Glasses
❑ Poor Vision
❑ Spot in Front of Eyes
❑ Eye Pain
❑ Blurry Vision
❑ Ringing in Ears
❑ Sinus Problems
❑ Nose Bleeds
❑ Grinding Teeth or Jaw Pain
❑ Facial Pain
❑ Teeth Problems
❑ Concussions
❑ Migraines
❑ Earaches
❑ Lip or Tongue Sores
❑ Headaches

Other?_____

Cardiovascular

❑ High Blood Pressure
❑ Low Blood Pressure
❑ Chest Pain
❑ Cold Hands or Feet
❑ Blood Clots
❑ Phlebitis
❑ Fainting
❑ Swelling of Hands
❑ Difficulty in Breathing
❑ Dizziness
❑ Swelling of Feet

Other? _____

Respiratory

❑ Cough
❑ Coughing Blood
❑ Bronchitis
❑ Pneumonia
❑ Difficulty Breathing Lying Down
❑ Pain with Deep Breathing
❑ Production of Phlegm
Other? _____

Neurological

❑ Seizures
❑ Paraesthesia (abnormal sensation)
❑ Areas of Numbness
❑ Lack of Coordination
❑ Poor Memory
❑ Concussion
❑ Stroke
❑ Tremors
❑ Loss of Balance
❑ Dizziness
Other? _____

Skin and Hair

❑ Rashes
❑ Itching
❑ Loss of Hair
❑ Change in hair or skin texture
❑ Psoriasis
Other?_____

Genito-urinary

❑ Pain When Urinating
❑ Frequent Urination
❑ Urgency to Urinate
❑ Unable to Hold Urine
❑ Decrease in Flow
❑ Halting Urination
❑ Blood in Urine
❑ Kidney Stones
❑ Sores on Genitals
❑ 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 _____
# of Births _____
Miscarriages _____
Abortions _____
Age at first menses _____
First date of last menses _____
Period between menses _____

❑ Irregular Periods
❑ Unusual Character (Heavy or Light, spotting, intermittent)
❑ Painful Periods
❑ Clots
❑ Vaginal Discharge
❑ Vaginal Sores
❑ Breast Lumps

❑ Breast Lumps
Changes in Body/Psche
❑ Prior to menses
❑ Post menses
Do you use birth control?
❑ yes ❑ no
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

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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 t 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