inland acupuncture

PATIENT: Today's date _____

First Name:_____MI_____Last:_____

Called Name:_____

Home Address:_____

City: _____State:_____Zip:_____

Home Phone:_____ Work:_____Cell:_____

Email:_____ Marital Status: S M D W

Date of Birth:_____ Gender: M F T

Mailing Address (if different than above):_____

PATIENT'S EMPLOYER: (if applicable)

Employer Name:_____ Phone:_____

Employer Address:_____ Ins Contact:_____

Occupation:_____

SPOUSE OR GUARDIAN:

Name:_____Date of Birth:_____

Employer:_____Contact Phone:_____

INSURANCE:

Insurance Company: _____Plan:_____

Insured's First Name:_____MI_____Last_____

Date of Birth:_____Group#_____Policy#_____

RESPONSIBLE PARTY: Complete this section if the patient or spouse is not responsible for the bill.

Responsible Party: _____Contact Phone:_____

Address:_____ Work Phone:_____

Relationship to Patient:_____

Signature_____ **Date:**_____

Patient, Parent or Guardian

602 W Lincoln Ave, Yakima, WA 98902 mailing: P.O.Box 941, 98907 phone: 509.457.2499 fax: 509.823.4357

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MAIN CONCERN: _____

_____

_____

How long ago did this problem begin (be specific)? _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, etc.)? _____

_____

Have you been given a diagnosis for this problem? If so what? _____

What other treatments have you tried? _____

PAST MEDICAL HISTORY: (please include dates):

Cancer _____ Diabetes _____ Hepatitis _____ High Blood Pressure _____

Seizures _____ Heart Disease _____ Asthma _____ Thyroid Disease _____

Bleeding/Clotting issues _____ Allergies (list) _____

Other _____

Surgeries (type & date) _____

Significant Trauma (auto accidents, falls, etc.) _____

FAMILY MEDICAL HISTORY (circle)**:**

Diabetes High Blood Pressure Heart Disease Stroke Seizures Asthma

Allergies _____

Other _____

Do you have a **regular exercise program**? Yes No

Please Describe: _____

Are you currently or have you recently followed a **restricted diet**? Yes No

Please Describe: _____

Do you **smoke cigarettes** or have you smoked regularly in the past? Yes No

How much **coffee, tea, cola, or other caffeinated beverages** do you drink per day? _____

How much **alcohol** do you drink per week? _____

Signature_____ **Date:**_____

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General
- ❑ Fevers
- ❑ Chills
- ❑ Bleed or bruise easily
- ❑ Poor Sleep
- ❑ Fatigue
- ❑ Sweat Easily
- ❑ Night Sweats
- ❑ Weight Gain or Loss

Musculoskeletal
- ❑ Stiff or Painful Joints
- ❑ Joint Popping/Cracking
- ❑ Neck Pain
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Hand/Wrist Pain
- ❑ Shoulder Pain
- ❑ Knee Pain
- ❑ Foot/Ankle Pain
- ❑ Hip Pain
- ❑ Arthritis
- ❑ Scoliosis
- ❑ Disc Problems
- ❑ Osteoporosis
- ❑ Spasms or Cramps
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Other _____

Cardiovascular/Respiratory
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Fainting
- ❑ Cold Hands or Feet
- ❑ Difficulty in Breathing
- ❑ Other _____

Gastrointestinal
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Peculiar Tastes, smells or cravings
- ❑ Strong Thirst
- ❑ Nausea/Vomiting
- ❑ Acid Reflux / Ulcer
- ❑ Gas
- ❑ Belching
- ❑ Diarrhea / Constipation (circle)
- ❑ Hemorrhoids
- ❑ Other _____

Genito-urinary
- ❑ Pain with urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Incontinence
- ❑ Prostate Problems
- ❑ Kidney stones
- ❑ Genital sores
- ❑ Getting up at night to urinate
- ❑ Other _____

Neuropsychological
- ❑ Seizures
- ❑ Tremors
- ❑ Lack of coordination
- ❑ Loss of balance
- ❑ Areas of numbness
- ❑ Pin & Needles sensation
- ❑ Poor memory
- ❑ Bad temper
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Other _____

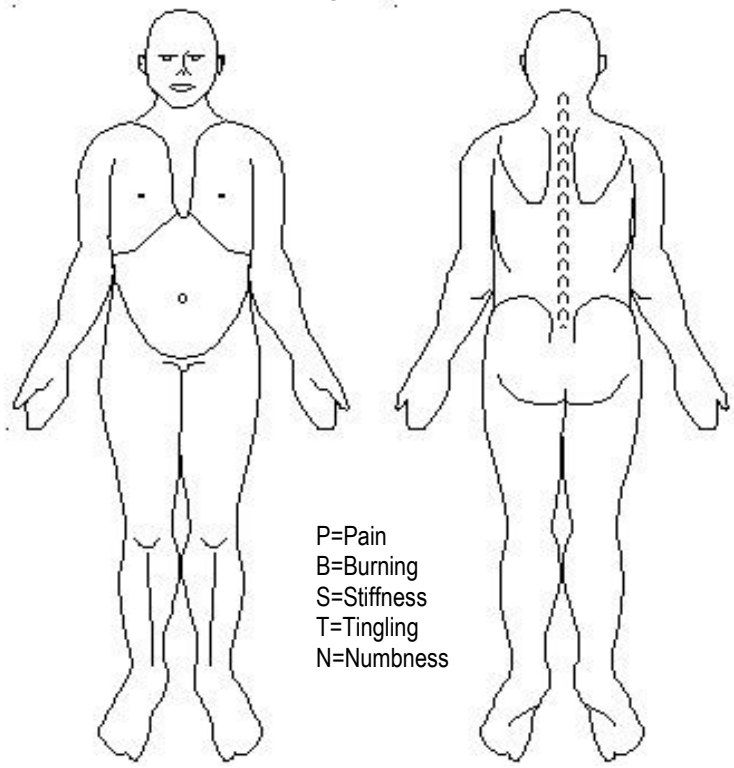
Head, Eyes, Ears, Nose & Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Poor vision
- ❑ Eye redness or dryness
- ❑ Spots in vision
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Sinus problems
- ❑ Nose bleeds
- ❑ Grinding teeth
- ❑ Dental problems
- ❑ TMJ problems
- ❑ TMJ pain
- ❑ Sore throat
- ❑ Sores on lips or tongue
- ❑ Other _____

Skin and Hair
- ❑ Rashes
- ❑ Itching
- ❑ Dandruff
- ❑ Eczema / Psoriasis (circle)
- ❑ Hair loss
- ❑ Acne
- ❑ Other _____

Pregnancy & Gynecology
_____ Number of Pregnancies
_____ Number of Births
_____ 1st Day of Last Menses
_____ Days between Menses
_____ Duration of cycle
- ❑ Heavy Menses
- ❑ Light Menses
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ PMS
- ❑ Clots
- ❑ Vaginal Sores
- ❑ Irregular periods
- ❑ Other _____

Meds taken this last year
- ❑ Antacids
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Antifungals
- ❑ Pain relievers
- ❑ Ibuprofen / Motrin
- ❑ Asthma Inhalers
- ❑ Blood Pressure Meds
- ❑ Blood Thinners
- ❑ Chemotherapy
- ❑ Cholesterol Meds
- ❑ Cortisone / Prednisone
- ❑ Diabetic medications
- ❑ Diuretics / Water pills
- ❑ Headache Medication
- ❑ Heart Medications
- ❑ Heartburn Meds
- ❑ Hormone Therapy
- ❑ Laxatives
- ❑ Insulin
- ❑ Oral contraceptives
- ❑ Implant contraceptives
- ❑ Recreational drugs
- ❑ Relaxants/Sleeping Pills
- ❑ Thyroid Medication
- ❑ Tylenol / acetaminophen
- ❑ Ulcer medications

Please draw in your areas of concern



P=Pain
B=Burning
S=Stiffness
T=Tingling
N=Numbness

Additional Herbs, Vitamins or Meds

_____

_____

_____

_____

_____

_____

_____

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Welcome to Inland Acupuncture

We are pleased to have you as a client and hope you will soon share our enthusiasm for the health-enhancing benefits of Acupuncture and Oriental Medicine. Our goal is to support your body's natural healing process and assist you in improving your overall health and vitality. In order to best serve you we've listed our guidelines and office policies.

Appointments and Fee Information:

If you choose to pay privately and in full at the time of service, we offer a **discounted rate** of $90 for the initial visit and $70 for return visits. Inland Acupuncture will bill contracted insurances as a courtesy to our patients. **If you are using insurance, you are responsible for knowing your benefits, co-payments and deductibles.** Co-payments are due at the time of service whereas your patient portion is due upon receipt. Inland Acupuncture bills monthly.

Payment Method:

We accept both credit cards (Visa, MasterCard, American Express) and checks. We are a no cash facility. Returned checks will result in an additional $40 fee.

Cancellation and Late Policy:

Your appointment time is reserved for you. 24 hour notice is required to avoid being billed. Patients arriving more than 15 minutes late will also be charged for a missed appointment. If you arrive late for an appointment, we reserve the right to reschedule.

Patient Privacy / HIPAA:

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medial information and to provide you with notice describing:

How medical information about you may be used and disclosed and how you can access this information. We are required by law to have your written consent before we use or disclose to others your medical information for the purpose of the following: providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and/or related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and or disclose your medical information for other purposes with out your consent or authorization. We are required to inform you that your insurance claims may be sent via electronic billing services. We have available to you a detailed notice of privacy policies that fully explains your rights and my obligations under the law. You have the right to obtain a copy of the most current notice by asking for one.

Client Acknowledgment:

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered as well as missed appointments. I authorize Inland Acupuncture to release to my insurance company or companies any and all information necessary to process any claim. I further authorize that insurance payment(s) be made directly to Joa Crowder EAMP and/or Inland Acupuncture. I understand the contents of this disclosure and agree to abide by these policies.

Signature_____ **Date:**_____

Patient, Parent or Guardian

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Patient Notification of Qualifications and Scope of Practice

East Asian Medicine (EAM) means that a health care service is using EAM diagnosis and treatment to promote health and treat organic or functional disorders. East Asian Medicine was formerly known as Traditional Chinese Medicine in the State of Washington.

- Joa Crowder EAMP, LMP is Licensed by the State of Washington in Acupuncture and East Asian Medicine. License # AC00002037 since September 2002.
- Joa is a graduate of the Northwest Institute of Acupuncture and Oriental Medicine in Seattle with a four year Master Degree in Traditional Chinese Medicine.
- Joa is Nationally Accredited as a Diplomat in Acupuncture and has a BA from the University of Washington.
- Joa attended Brenneke Massage School's Intensive Massage Program and is licensed by the State of Washington for Massage Therapy. License # MA00016131

State of Washington Scope of Practice for East Asian Medicine includes the following procedures:

- Acupuncture - includes the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians.
- Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians.
- Moxibustion, acupressure, cupping, dermal friction techniques, infrared therapy, sonopuncture, laserpuncture, point injection therapy, superficial hot and cold therapy and qi gong
- Breathing, relaxation, and East Asian exercise techniques.
- Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements.
- East Asian massage may be performed with the use of tools common to the practice including us of: superficial heat, cold water, lubricants, salts, minerals, liniments, poultices, and herbs.
- East Asian massage does not include attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force.
- Tuina is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking and stretching of the body (does not include spinal manipulation).

Side effects may include, but are not limited to:

Pain following treatment, minor bruising, infection , needle sickness, broken needle

You are required to inform the practitioner of any bleeding disorder or if you have a pacemaker prior to any treatment.

Client Acknowledgment:

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Joa Crowder EAMP, LMP regarding the cure or improvement of my condition. I hereby release Joa Crowder EAMP, LMP from any and all liability which may occur in the connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participating in these procedures at any time.

Signature_____ **Date:**_____

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Written Waiver for EAMP Care:

The State of Washington requires that a waiver be signed to continue care for all individuals with the following Medical disorders. These disorders should be brought to the attention of your East Asian Medicine Provider in order to provide appropriate and adequate care.

I, _____, acknowledge I may have a potentially serious disorder.

Potentially serious disorders include, but are not limited to:

- Cardiac conditions, including uncontrolled hypertension
- Acute abdominal symptoms
- Acute undiagnosed neurological changes
- Unexplained weight loss or gain in excess of fifteen percent body weight within a three month period
- Suspected fracture or dislocation
- Suspected systemic infection
- Any serious undiagnosed hemorrhagic disorder
- Acute respiratory distress without previous history or diagnosis

Joa Crowder EAMP, LMP requested a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder.

I acknowledge that failure to pursue treatment from my primary health care provider may involve risks that such a condition can worsen without further warning and even become life threatening.

I also acknowledge the fact that the treatment Joa Crowder EAMP LMP is authorized to provide will not resolve any underlying potentially serious disorder.

I have been supplied a list of my practitioners Qualifications and Scope of Practice.

I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue care.

Client Acknowledgment:

With this knowledge, I, _____, voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Joa Crowder EAMP, LMP regarding the cure or improvement of my condition.

I hereby release Joa Crowder EAMP, LMP and Inland Acupuncrture from any and all liability which may occur in the connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participating in these procedures at any time.

Signature_____ **Date:**_____

Patient, Parent or Guardian

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