MAPLE VALLEY ACUPUNCTURE
AND HERBAL MEDICINE

23745 225th Way SE St. Suite 107 • Maple Valley, WA 98038 • 425-413-3801

Personal Information

Name: _____ Date: _____

Primary Phone: _____ OK to leave messages? Y N Text? Y N

Address:_____

E-mail Address: _____ OK to send e-mails? Y N

Age: _____ Date of Birth: _____ Marital Status: _____

Height: _____ Weight:_____ Gender: _____ Occupation: _____

Primary Care Provider: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about Maple Valley Acupuncture? _____

Health History

Main issue(s) you would like help with:

_____

_____

How long ago did this begin (be specific):

_____

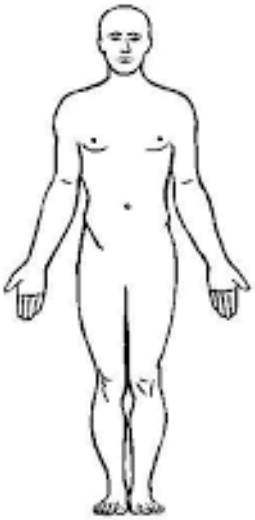
To what extent does this problem interfere with your daily life (sleep, work, exercise, etc.)?

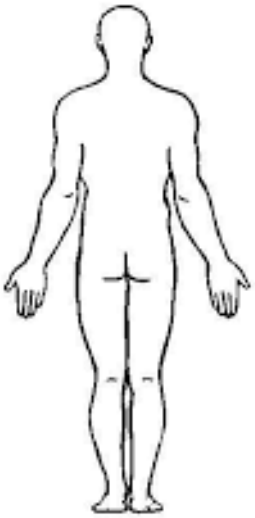
_____

What types of treatments have you tried?

_____

Where does this issue affect you (if applicable?)





If you're dealing with pain, what would you rate your pain on a scale of 0-10 (0= none at all, 10= excruciating, can't do anything)?

_____

_____

_____

Please check any symptoms that you have experienced in the past or currently experience:

General

	past	**current**		**past**	**current**
sweating easily during the day	☐	☐	fatigue	☐	☐
night sweating	☐	☐	fevers	☐	☐
bleed or bruise easily	☐	☐	chills	☐	☐
change in appetite	☐	☐	weight loss/gain	☐	☐
dizziness/vertigo	☐	☐	poor sleep	☐	☐

Skin & Hair

	past	**current**		**past**	**current**
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	loss of hair	☐	☐
acne	☐	☐			

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐			

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐			

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐			

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐			

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births _____

# of miscarriages _____ # of abortions _____

Have you been through menopause? At what age? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

For Men Only:

	past	**current**		**past**	**current**
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Lifestyle

Current medications/herbs/supplements:

_____

_____

Describe your meals during a typical day:

Breakfast:_____

Lunch: _____

Dinner: _____

Other: _____

Current exercise routine (if any):

_____

Do you drink alcohol? How many drinks per week?

_____

Do you use tobacco? What kind and how much/many per day?

_____

Do you use recreational drugs? What kind and how often?

_____

Allergies (medications/foods/chemicals/etc.):

_____

Surgeries and Hospitalizations (type and date):

_____

_____

Significant Trauma (falls, injuries, auto accidents, concussions, etc.):

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke

□ Diabetes □ Heart Attack □ Hepatitis □ Asthma □ Other _____

Please list any other relevant information or issues you would like to discuss:

_____

_____

EAST ASIAN MEDICINE INFORMED CONSENT TO TREAT and FINANCIAL POLICY
Maple Valley Acupuncture, Licensed in WA State
Tracey Steger, LAc, AEMP, WA License #AC60503211, Tara McCormick, LAc, AEMP, WA License #AC60742084, Dionea Nadir, LAc, AEMP, WA License #61016845

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of East Asian medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, 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 within the scope of Chinese/East Asian medicine may include, but are not limited to, acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridian, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping; dermal friction technique; infra-red; sonopuncture; laserpuncture; point injection therapy (aquapuncture); 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; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and superficial heat and cold therapies.. I understand that the herbs may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application 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, dizziness or fainting, and needle sickness. Rarely, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and 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 effect 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 East Asian Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify the acupuncturist named below if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify an acupuncturist member who is caring for me if I am or become pregnant. ***Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema must inform practitioners prior to any treatment.***

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups. I understand that the acupuncturist may review my patient records and lab reports.

I am responsible for payment. In the event that my insurance coverage expires or denies payment, for any reason, I understand that I am personally responsible for all fees incurred. I am responsible for payments toward deductible, and for copays or co-insurance. I understand that I am responsible for letting my practitioner know if pre-authorization for acupuncture treatment is required per my insurance plan. If I do not let my practitioner know, I am responsible for any claims denied because a pre-authorization request was not submitted.

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the practitioners' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a $40 cancellation fee.

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.

Signed_____ Dated_____

Printed Name_____

MAPLE VALLEY ACUPUNCTURE
AND HERBAL MEDICINE

Notice of Privacy Practices

Please review the information below carefully. This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA). HIPPA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This act provides the patient rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

Our Responsibility: We respect our legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are require to maintain the privacy of your health information and how we may use it and disclose your health care information. We do not use your health information inside our office our outside without your written permission. In some limited cases, the law requires us to disclose your health care information without either a written or verbal consent.

Safeguards in place at our office include: Limited access to facilities where information is stored, Policies and procedures for handling information, Requirements for third parties to contractually comply with privacy laws, All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Use and Disclose With Consent:

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations in this office. Treatment can be stopped with refusal to sign the form. We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization. Please note that communicating about health information via e-mail or text messaging is not considered HIPAA compliant.

Use and Disclosure Without Consent:

In some limited situations, the law requires us to use and disclose your health information without your permission. These examples include:

- When state or federal law mandates certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims or suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
- Disclosures in response to subpoenas of orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.

Your Rights Regarding Your Health Information:

You have the following rights with respect to your protected health information, which you can exercise in writing to our office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to the request restriction. If we do agree the restriction, we must abide by it unless you agree in writing to remove it.
- The right to ask to communicate with you in a confidential way, such as contacting you at work rather than at home. Please provide a written request.
- The right to see or get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a health care provider. Please complete our written records request for billing or medical records release.
- The right to receive an accounting disclosure of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice at your request.

You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services in the event you feel your privacy rights have been violated.

I request the following restrictions to the use of disclosure of my health information:

_____

_____ _____

Signature Date