VETIVER ACUPUNCTURE

8317 SE 13th Ave
Portland, Ore. 97202
503.709.3935

First Name:	Last Name:	Male/Female
Address:		
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:		
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

_____

_____

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

List any major disease or illness in your immediate family and indicate family member:

List all medications or supplements, including herbs and vitamins you are currently taking:

Occupation:

Do you have a regular exercise program? _____ Please describe. _____

Are you on a restricted diet? _____ What kind? _____

How much sugar/dessert do you eat per week?

How much dairy do you eat per week?

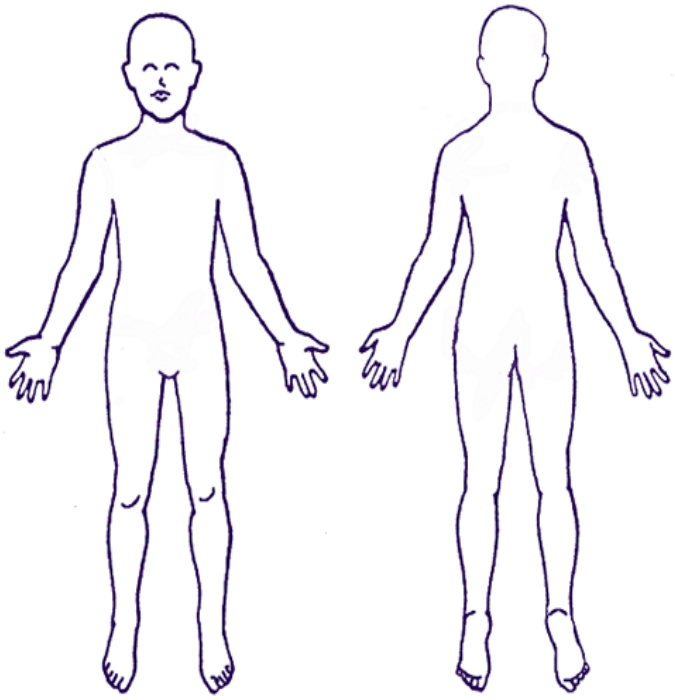
How many packs of cigarettes do you smoke per week?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Do you do any drugs? How much per week?

Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).



PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Dizziness
□ See floating black spots

_____

□ Palpitations
□ Sore on tongue
□ Restlessness
□ Anxiety
□ Chest pain
□ Insomnia

_____

□ Cough
□ Sinus congestion
□ Dry mouth, throat, nose, or skin
□ Allergies seasonal or food
□ Chills and fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

_____

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet
□ Burning sensation after eating

□ Bad breath
□ Large appetite
□ Mouth, canker or cold sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea
□ Diarrhea alternating with constipation
□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shoot eyes/dry eyes
□ Anger easily
□ Skin rashes
□ Headache
□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears

Urine is:

□ Normal color □ Clear
□ Dark yellow □ Reddish
□ Cloudy □ Scanty
□ Bad odor
□ Burning □ Painful
□ Difficult □ Urgent

Libido (sex drive) is:

□ Normal □ Low □ High

Women only:

❑ Are you pregnant now?
□ Yes □ No

❑ Number of children:_____

❑ Number of pregnancies:_____

❑ Age of first period:_____

❑ Age of menopause if applicable:_____

❑ Is your menses cycle regular?
□ Yes □ No

a. Average number of days in flow:____

b. The flow is:
□ Normal □ Heavy □ Light

c. The color is:
□ red □ dark □ purple
□ light brown □ brown

d. Do you have the following menstruation related symptoms?

□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

e. Birth control:_____

Men Only:

□ Discharge

□ Pain or swelling of testicles

□ Ejaculatory problems

□ Impotence/erectile dysfunction

Signature _____ **Date**_____

VETIVER ACUPUNCTURE STUDIO

Brooke Meadows, L.Ac.

INFORMED CONSENT

I hearby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Brooke Meadows, LAc 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 Brooke Meadows LAc, including those working at Vetiver Acupuncture or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Shiatsu (Chinese massage), Chinese herbal medicine, NAET and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instruction provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption 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, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of 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 effects 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 Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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.

PATIENT SIGNATURE: _____

(Or Patient Representative, please indicate relationship if signing for patient)

DATE: _____

VETIVER ACUPUNCTURE STUDIO

Brooke Meadows, L.Ac.

NOTICE OF PRIVACY PRACTICES

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. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Within the clinic

The patient's chart is secured in a locked file in our clinic at all times. Access to this office is limited to practitioners, employees, and supervised guests only.

Outside of the clinic

Should we meet outside of the clinic, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only within the office to protect your privacy and to ensure that important information is documented in your chart.

Discussion of your case

Vetiver Acupuncture practitioners may consult with other healthcare practitioners and clinical/laboratory specialists to better understand the patient's case and determine the best treatment plan. These conversations and transfers of information by phone, fax, or email are confidential and names are not used unless necessary. Consent from the patient is required either verbally or in writing to allow for the sharing of the patient's private information.

Release of records

Your confidential healthcare information is private and will not be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax. A confidential patient information cover sheet accompanies all faxes.

I have read and understand my right to privacy, as stated above, and agree to have the practitioners and/or staff of Vetiver Acupuncture maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or staff of Vetiver Acupuncture if I need any special arrangements pertaining to this issue.

Vetiver Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative: _____

Patient Name (please print): _____

Date: _____