

 **Ashland Holistic Health** 

325 A St., Ste #1 ASHLAND OR 97520
PH (541) 482.1650 www.ashlandholistichealth.com

THANK YOU FOR FILLING THIS OUT SO WE MAY BETTER SERVE YOU!

Today's Date: ___/___/___

Name _____ (_____) Male ___ Female ___ Age: ___ Birth Date ___/___/___
LAST FIRST (prefer to be called)

Mailing Address _____ City _____ State ___ Zip _____

Home Address (if different) _____

Phone #s: Cell _____ Home _____ Work _____

E-mail _____

Occupation _____ Employer _____

Employment Status: ___ Full-time ___ Part-time ___ Retired ___ Unemployed ___ Student ___ Other _____

Relationship Status: ___ Single ___ Married ___ Divorced ___ Widowed

Name of Partner/Spouse/Parent _____ Their Occupation _____

EMERGENCY CONTACT: Name _____ Phone # _____

Do you have Acupuncture Insurance? ___ No ___ Yes Ins. Co.

Whom may we thank for referring you? _____

Main Health Issue(s) you wish to address _____

What was initial cause? _____

How long have you had this/these condition(s)? _____

Is it getting worse? ___ Yes ___ No Does it bother you: ___ Sleep ___ Work ___ Other _____

What seems to make it better? _____ What seems to make it worse? _____

Other therapies you have tried or are trying to help this condition _____

Have you had acupuncture before? ___ Yes ___ No Chinese Medicine? ___ Yes ___ No

Please tell the story of this condition (use the back side of this page if necessary): _____

In general, I feel my overall health is: ___ Excellent ___ Good ___ Fair ___ Poor

Rate on a scale of 1 (poor) to 10 (great): ___ Sleep ___ Energy Level ___ Appetite ___ Digestion

Elimination regular? ___ Yes ___ No Any gas, bloating or other discomfort after eating: ___ Yes ___ No

Recent significant life events? (divorce, relocation, job change, death in family, etc.) _____

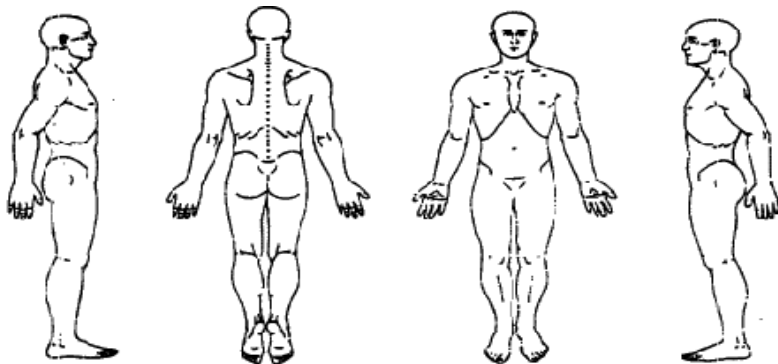
I commonly cope with stressful periods by _____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? _____

Any foreign residence or travel in last two years? _____

Circle on the diagram any areas of pain or injury

Pain: ___dull ___sharp ___stabbing ___throbbing ___cramping ___burning ___limited range of motion ___limited use



Area/Description of Symptoms

Pain Level: 0-10 (10 as highest)

Frequency

<u>Area/Description of Symptoms</u>	<u>Pain Level: 0-10 (10 as highest)</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current /Recent Health Care Providers

<u>Name</u>	<u>Dates</u>	<u>Care Provided</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Accidents/Injuries - briefly describe

MORE than 5 years ago _____

LESS than 5 years ago _____

Allergies

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc. _____

Medications - Please list all prescription and over-the-counter medications you are using

<u>Medication</u>	<u>What it's for</u>	<u>For how long?</u>	<u>Strength</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Supplements/Herbs

Were these recommended by: ___practitioner ___self ___both

<u>Supplement/Herb</u>	<u>Brand Name</u>	<u>Potency (mg, IU, etc)</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Sample of day's menu:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Water and fluids _____

Dietary preferences/restrictions _____ Cravings? _____

Favorite food? _____ Favorite flavor? _____ Do you eat meals regularly? ___ Yes ___ No

Physical exercise: ___ Avid ___ Regular ___ Sporadic ___ Rare ___ Not now Type _____

Tobacco: how much? _____ how long? _____ (previously? how much? _____ how long? _____)

Mark the following "1" if current "2" if past

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> palpitations | <input type="checkbox"/> migraines |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> sciatica | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> frequent urination | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> frequent depression |
| <input type="checkbox"/> frequent cold/flu | <input type="checkbox"/> dribbling urine | <input type="checkbox"/> heart problems | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> painful urination | <input type="checkbox"/> poor sleep | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> scanty urination | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> blood in urine | <input type="checkbox"/> severe mood swings | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> prostate problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> no/low sex drive | <input type="checkbox"/> overweight | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> allergies | <input type="checkbox"/> impotence/frigidity | <input type="checkbox"/> underweight | <input type="checkbox"/> stroke |
| <input type="checkbox"/> sinus congestion | <input type="checkbox"/> afternoon persp/fever | <input type="checkbox"/> eating disorder | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> colitis | <input type="checkbox"/> night sweats | <input type="checkbox"/> gum/teeth problems | <input type="checkbox"/> drug addiction |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> hearing problem | <input type="checkbox"/> lots of fillings | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> memory difficulty | <input type="checkbox"/> TMJ | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> parasites | <input type="checkbox"/> concussion | <input type="checkbox"/> frequent anger | <input type="checkbox"/> heartburn/acid indigestion |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> frequent frustration | <input type="checkbox"/> bloating | <input type="checkbox"/> arthritis ___ gas |

WOMEN'S HEALTH

MENSTRUAL PERIODS - Please complete this section to the best of your ability even if you no longer menstruate.

Since age _____ Regular? ___ Yes ___ No Flow lasts _____ days Length of cycle _____

Color of blood: ___ light red ___ dark red ___ brownish ___ other: _____ ___ light ___ heavy ___ clots

Date of last menses _____ PMS ___ breast distention ___ moodiness ___ bloating ___ other: _____

___ Menstrual cramps (which days)? _____

HISTORY - Mark the following "1" if current "2" if past

hysterectomy pain with intercourse fibroids breast reconstruction

D&C dryness with intercourse irregular bleeding lumpectomy

tubal ligation interstitial cystitis breast implants mastectomy

ablation yeast infections breast lumps (please describe _____)

irregular PAP smear pain during ovulation fibrocystic breasts

vaginal discharge (color _____ frequency/when _____ amount _____)

Date of last PAP smear _____ Results _____

PREGNANCY/BIRTH CONTROL

Are you pregnant now? ___ Yes ___ No Do you think you may be? ___ Yes ___ No

Number of pregnancies: _____ Number of children _____

Terminations? _____ Miscarriages? _____ Tubular pregnancies? _____

Difficulty in conceiving? _____

Birth control method(s): _____

MENOPAUSE

No menses since: _____

Experiences/symptoms you are currently feeling/having or had in the past during menopause? _____

FEE POLICY

- Payment may be made by cash, check, Visa, Master, or Discover; returned checks are subject to a \$25 fee
- We require 24-hr. notice for appointment cancellation and reserve the right to charge for appointments canceled without said notice
- We want everyone to be able to receive necessary treatment. If unusual circumstances or hardship prevents you from continuing treatment, please speak with our Office Manager.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date

INSURANCE ELIGIBILITY

I, the undersigned, do hereby authorize payment directly to this office for all the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance, and also responsible for monitoring my own insurance benefit usage.

I hereby authorize Jenn Collins, L.Ac., Molly Romero, L.Ac., and Ashland Holistic Health to release all information necessary to secure these benefits. I authorize the use of this signature on all my insurance submissions.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date

INFORMED CONSENT STATEMENT

Jenn Collins, L.Ac. and Molly Romero, L.Ac. are Oregon Licensed Acupuncturists, both holding a Masters of Science in Oriental Medicine as well as national certification in acupuncture through the National Commission for Certification of Acupuncturists.

Under Oregon law, acupuncture is defined as an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by stimulation of specific points by insertion of needles, with scope of practice including traditional and modern Oriental medical and acupuncture techniques of diagnosis & evaluation, use of an extensive herbal pharmacopoeia, vitamins, minerals, dietary advice, as well as Oriental massage, exercise and related therapeutic methods.

Jenn Collins, L.Ac. and Molly Romero, L.Ac. are not medical doctors. They do not claim to diagnose, treat or cure any medical conditions or pathologies nor prescribe medicine nor in any way represent themselves as so doing. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not for your care is your right, and acupuncturists at Ashland Holistic Health assume no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that:

- *no claims are made for acupuncture, herbal medicine, nutritional or dietary recommendations to treat or cure any medical condition*
- *all information given is for educational purposes only*
- *there is no implied or stated guarantee of success or effectiveness of any specific treatment plan or guidelines*
- *I am free to act upon or disregard the recommendations of Jenn Collins, L.Ac. and/or Molly Romero, L.Ac. as I so choose.*

I hereby release Jenn Collins, L.Ac., Molly Romero, L.Ac., and Ashland Holistic Health from any and all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints.

I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of Jenn Collins, L.Ac. and/or Molly Romero, L.Ac. to participate in a professional relationship with her pursuant to the statements herein.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date

PRIVACY POLICY

This notice will remain in effect until it is replaced or amended by changes in law.

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.

We receive personal information and health information in several ways: from you, from other healthcare providers, and from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship, we will likely use and disclose health information by submitting the authorization in writing. Disclosures will be made to any personal representation you choose to have your protected health information.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communication without your written authorization. This office may send birthday cards, newsletters and appointment reminders by telephone, post cards, or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Client Rights

- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of your healthcare information that this office has disclosed.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- Upon written request you have the right to amend your Protected Health information.
- You have the right to receive all notices in writing.

If you have any questions, complaints or want more information, please contact our Office Manager at the phone number/address listed at the top of this page. You may submit a written complaint to the U.S. Department of Health and Human Services.

I, the undersigned, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. A copy of these Privacy Policies may be obtained upon request.

Client / Representative NAME (Printed)

Client / Representative SIGNATURE

Date