Oriental Medicine and Acupuncture Clinic
D. Michael Denbow
103A South Hill Drive
Blacksburg, VA 24060
540.951.1888
twoelmsomac@gmail.com

Confidential Client Information

Name:_____Today's Date:_____

Street Address:_____Apt:_____

City:_____State:_____Zip:_____Date of Birth:_____Age:_____

Gender:_____Status (circle): Single Married Divorced Widowed Cohabiting

Primary/Preferred Phone:_____Secondary Phone:_____

Email:_____Alternative Email:_____

Preferred method of contact (circle all that apply): Phone Email Mail

May we leave messages at the phone numbers, emails, and address listed above?_____

Current Occupation:_____Employer_____

Emergency Contact Name/Relationship:_____Phone:_____

Legal Guardian Name:_____Phone:_____

Primary care physician/provider:_____Phone:_____

OB/GYN (women) physician/provider:_____Phone:_____

How did you hear about us?_____

Confidential Medical Information

How would you like us to help you, in order of importance?

1 3

2 4

Have you received a particular medical diagnosis for your concerns? Please explain:_____

Are you receiving other treatment(s) for any of your conditions? How is it helping?_____

Have you received acupuncture before? _____Where?_____

For what condition(s)?_____

Please list all major surgeries and illnesses:

Event	Month/Year or Age

Please list all medications/supplements/herbal products you are currently taking (or attach separate list):

Item	Reason	Began and/or How Long Taking

Please list any known allergies (food, drugs, other):

Diet: (circle) omnivore carnivore vegetarian vegan raw foods paleo other:_____

Typical Breakfast:_____

Typical Lunch:_____

Typical Snacks:_____

Typical Dinner:_____

Preferred taste (circle): salty sour bitter sweet spicy

Do you crave any specific food? Explain:_____

Please indicate your use of the following (use a √):

Item	None	Light	Moderate	Heavy
Coffee				
Black tea				
Alcohol				
Tobacco				
Recreational Drugs				

What type of exercise do you engage in? _____

How long / many days a week?_____

Hobbies/interests:_____

Which of these environments makes you feel better? (circle): cold heat damp dry wind humidity fog

Which of these environments affects you adversely? (circle): cold heat damp dry wind humidity fog

What are your most commonly experienced emotions? (circle):

Anger Frustration Irritability Worry Sadness Fear Excitement Joy

How would you describe your general energy level?_____

What time of day you feel your best / worst:_____/_____

What time do you typically fall asleep / get up?_____/_____

Do you feel rested in the morning (yes or no)?_____

Please indicate if any of the following apply to you now or in the past with a with use a √:

	Diabetes		Undigested food in stools		Seasonal allergies
	Hepatitis Type: ___		Erratic stools (hard/soft)		Sinus issues
	High blood pressure		Chronic constipation		Frequent colds
	Tuberculosis		Chronic diarrhea		Asthma
	Cancer/Chemo/Radiation		Urgency before movement		Cough
	Seizures/Epilepsy		Blood or pus in stool		Chest tightness
	Hemophilia		Abdominal cramping		Bronchitis/Pneumonia
	HIV/AIDS		Weight gain/loss		
	Pacemaker		Ulcers		Acne
	Surgical Implant		Gallstones		Skin issues (eczema, psoriasis)
			IBS/Colitis/Chron's		Other skin issue:
	Sweat easily during day		Hemorrhoids		
	Night sweating				Fibromyalgia
	Fatigue		Hypo/hyperthyroidism		Chronic fatigue
	Generally feel cold		Insomnia/difficulty sleeping		Mononucleosis
	Generally feel hot				Lyme disease
	Cold feet		Stroke		
	Cold hands		Chest pain		Back pain
			Dizziness/Vertigo		Neck aches
	Poor appetite		Swelling/Edema		Joint pain
	Poor digestion		Low blood pressure		Muscle aches
	Acid reflux (GERD)		Arrhythmia		Numbness
	Bloating		Palpitations		Muscle weakness
	Gas		Heart condition/disease		Muscle cramping
	Belching				Sciatica
	Eating disorder		Head injury		TMJ
	Excessive/lack of thirst		Headaches/Migraines		Carpal tunnel
	High cholesterol		Mental illness		Bursitis/tendonitis
	Nausea		Anxiety		
	Hard stools		Depression		Hearing issues (loss, ringing)
	Loose stools		PTSD		Vision issues (correction, floaters)

Please indicate if any of the following apply to you now or in the past with a with use a √:

Women only:		Both Men and Women:		Men only:	
	Irregular periods		STD		Erectile dysfunction/impotence
	Painful periods		Herpes		Prostate issues
	Bleeding between periods		Kidney stones		Ejaculatory pain
	Clots with period		Low sex drive		Vasectomy
	Menstrual cramping		Urgent/frequent urination		Discharge
	Breast pain		Difficulty urinating		Fertility issues
	Vaginal discharge		Blood in urine		
	Hot flashes		Pain during urination		
	Night sweating		Prolapses/Hernias		
	PCOS/Ovarian Cysts		History of UTI		
	Endometriosis				
	PMS				

Women only:
Age when periods began:_____Last Pap:_____

Is your cycle regular?_____Length of cycle:____days Duration of flow:____days

Any difficulties during teen years?:_____

Birth control history (method and duration of use):_____

Pregnancies:_____ # live births (indicate years)_____

Miscarriages:_____ # abortions:_____

Describe any PMS symptoms (circle): bloating breast tenderness irritability mood swings fatigue

loose stools acne other:_____

Age of Menopause:_____Any difficulties?_____

Is there a chance you may be pregnant?_____

Family medical history (circle all that apply for parents, grandparents and siblings):

Cancer Seizures High blood pressure Stroke/CVI Diabetes Hepatitis Asthma

Heart attack/CHF Other:_____

If you could change three things about your life/self, would they be?_____

_____

Are you currently experiencing family stress? (circle) Yes No

Have you experienced any significant loss in the last year (death of loved one or pet, miscarriage, job loss, divorce or separation, significant move, etc.)?

_____

How much energy are you willing to invest in your own healing? Are you willing to make lifestyle changes?:

_____

Please share any additional information you feel is relevant to your healing or would like to discuss:

_____

I have answered these questions to the best of my ability and knowledge.

Patient's Signature (or Patient Representative and Relationship to Patient) Date

Acupuncturist Date

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INFORMED CONSENT TO ACUPUNCTURE CARE

I hereby 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 the acupuncturist named below 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 below, 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 may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping.

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 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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's Name (print)

_____

Patient's Signature (or Patient Representative and Relationship to Patient) Date

_____

Acupuncturist Date

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Office Policies

Cancellation Policy: Missed appointments without a 24-hour advance notice will be subject to a full visit fee except in cases of emergencies. This fee is due prior to or at your next appointment.

Fees and Payment Policy: We charge for services provided. Fees are as posted in the clinic and/or as discussed with the clinic staff. Payment is due at the time of service. We accept cash and check. Returned checks are charged a $35 fee. If you have financial concerns, please discuss them with our staff prior to it becoming an obstacle to your healing.

Insurance: This office does not bill any insurance company and that responsibility falls upon the patient to collect from any company that will reimburse for services rendered at this clinic. We will provide you with the information required for your insurance carrier to the best of our ability. Payment is due at the time of services.

Arrival Time: Please arrive on time to get the full value of your treatment. If you find that you cannot be on time, please notify our office as soon as possible. If you are late for your appointment, the practitioner may not be able to see you at that time or may not be able to give you the full amount of time originally slotted for you.

By voluntarily signing below I acknowledge that I understand the office policies.

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Five Phases, LLC, dba Oriental Medicine and Acupuncture Clinic (OMAC), may use and disclose health information (treatment, payment or healthcare operations) about me to carry out treatment, payment and healthcare operations. Please refer to the OMAC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Two Elms OMAC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to OMAC at the address listed at the top of this page.

With my consent, OMAC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice of carrying out treatment, payment and healthcare operations such as appointment reminders, payment notices, insurance items, and any call pertaining to my clinical care.

With my consent, OMAC may mail my home or other designated location any items that assist the practice of carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements.

With my consent, OMAC may email the address(es) I have provided any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, patient statements, and answering questions or engaging in written discussions concerning my care.

I have the right to request that OMAC restricts how it uses or discloses my Protected Health Information (PHI) to carryout treatment, payment and healthcare operations.

By signing this form, I am consenting to OMAC's use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Two Elms OMAC may decline to provide treatment to me.

Patient's Name (print)

Patient's Signature (or Patient Representative and Relationship to Patient) Date

Acupuncturist Date