# Root & Branch Oriental Medicine

## Office Policies

In order to insure that your care be as efficient and effective as possible, we have adopted the following policies and procedures.

## Appointments

We make every effort to remain on schedule. We believe that respect between patient and practitioner includes respect for each other's time. If you are late, your remaining time may not be sufficient for a full treatment, and treatment will be tailored to fit within the time available. On occasion, there are situations that arise that cause us to run over. If we are late, it will not effect the time of your treatment. If you have time restraints, please let us know.

It is recommended that you wear loose fitting clothing to appointments so that you will be comfortable and acupuncture points will be accessible.

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**The courtesy of a 24-hour notice of cancellation for any appointment is expected and appreciated. With the exception of emergencies, the patient is responsible in full for payment of a cancellation made without 24 hours notice.**

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## Confidentiality

All information gathered within the context of treatment is held in strict confidence and will NOT be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

## Fees, Payment, and Insurance Billing

Our fees: **Eileen & Geoff**: $140 for the initial visit (1.5-2 hours including treatment) and $90 for 1 hour follow-up. **Lisa & Lois**: Initial visit is $125 (1.5 hours) and follow-ups are $80 for 1-hour. Follow up consultations for Chinese herbal medicine are $60 for 1/2 hour (plus the cost of the herbs). Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash, checks, Master Card, Visa, and Discover.

A credit card is required to book your initial appointment. This card is put into our scheduling system and is immediately encrypted. We will not charge your card UNLESS you do not show up for an appointment. We generally collect payment at the time of service and do not use the card on file as a form of regular payment.

Acupuncture is covered by worker's compensation, auto insurance and a number of private insurance policies. It is also reimbursable by flexible spending plans. Should you have coverage, we are happy to supply you with the documentation you will need for reimbursement after payment is made in full. We are **not** able to provide direct billing services at this time.

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I have read and agree to the policies outlined above.

Date_____ Signature X_____

*Root & Branch Oriental Medicine*
**169 West Main St, Hopkinton, MA** **508-435-8184**

## Health History Form

**All information gathered on this form is held in the utmost confidence and released only with your permission. Though aspects of these questions may seem to be unrelated to your main complaint, and are quite personal, they are clinically significant for us to make an accurate diagnosis and provide you with the best possible care and results. Thank you for filling this out carefully and completely.**

**Patient Name:**_____ **Date:**____/____/_____

**Full Address:**_____**Zip**_____

**Date of Birth:**_____ **Age:**_____ **Occupation:**_____

**Phone: Home**_____**Work**_____**Cell:**_____

**E-mail**_____**@**_____

**Referred By:**_____ **Physician:**_____

**Physician Address & Phone #:**_____

**In Emergency Notify:**_____**Phone:**_____

**May we thank the person who referred you? Y / N**

**What is your Main Complaint(s):**_____

_____

_____

**Date main complaint first started?**_____

**How frequently does this problem bother you?**_____

**When it is bothering you, how long does the episode last?**_____

**How severe is the intensity on a scale of 0-10: (Best=0--10=worst):**

**When symptom is at its best:**_____ **/10** **When symptom is at its worst:** _____**/10** **Today:** _____**/10**

**If there is pain involved, what is the Pain Quality (Circle all that apply):**

**Dull, Achy, Burning, Sharp/Stabbing, Cold, Numb, Traveling, Gripping, Helped w/ Steroids, Bones Hurt, Throbbing, Other**_____

**What makes the pain/symptom feel better? (Circle all that apply):**

**Heat, Cold, Damp Weather, Wind, Rest, Work, Movement, Sitting, Lying, Touch/Pressure, Steroids, Stress, Other:**_____

**What makes the pain feel worse? (Circle all that apply)**

**Heat, Cold, Damp Weather, Wind, Rest, Work, Movement, Sitting, Lying, Touch/Pressure, Steroids, Stress, Other:**_____

Do you have a diagnosis for this problem? If so what?_____

What kinds of treatments have you tried to address this? _____

_____

Please List any allergies: (Drugs, chemicals, foods, environmental, herbs) _____

_____

Please list any Medications, vitamins, herbs, homeopathics you are currently taking._____

_____

_____

_____

Describe frequency and type of exercise or activity you participate in: _____

_____

Do you chew, smoke or snuff tobacco? Y / N If so how much?_____

How much coffee, tea or other caffeine do you consume per week?_____

How much alcohol?_____ Do you use any recreational drugs? Y / N

If yes, what kind?_____

**Energy Level** : (0=Low-10=High)

How is your overall Energy Level: Overall _____/10

How is your energy level after exercise? Better / Same / Worse

How is your energy level after meals? Better / Same / Worse

How is your energy level after a bowel movement? Better / Same / Worse

Do you have **Fatigue**?:

In the morning? Yes / No In the Afternoon? Yes / No

After Work? Yes / No When weather is ( Damp / Hot / Cold)

**Thirst**:

How much WATER do you drink per day?_____

Other liquids & amounts? _____

Are you thirsty frequently? (Yes/ No) Do you have thirst with little desire to drink: (Yes/ No)

Do you prefer (Hot/ Cold) beverages?

**Appetite**:

How is your appetite?_____

Do you have any unusual taste in your mouth: (Yes/ No) If so what?_____

Do you have a sensation of feeling "weighed down" or heaviness in your body? (Yes/ No)

Have you gained or lost weight in the last 6-12 months? Y / N

How much? I have Gained / Lost _____Pounds

**Hot/Cold:**

Do you have a tendency to feel: (Hotter than others / Colder than others / Neither)

Are only your Hands & Feet Cold: Yes / No If yes, Is it your... ( Hands / Feet / Both )

Frequency of colds/flu: (number per month/year/season) _____

**Past Medical History:** (Please circle all that apply and include dates)

**Significant Illnesses:** Cancer Diabetes Hepatitis High Blood Pressure VD HIV EBV Heart Disease Rheumatic Fever Thyroid Disease Seizures Auto immune Diseases Candida Other:_____

_____

_____

**Family Medical History:** Diabetes Cancer High Blood Pressure Mental Illness Alcoholism Heart Disease Seizures Asthma Allergies Auto immune Diseases Stroke Arthritis Other:_____

_____

_____

**Surgeries: (Please indicate dates):**_____

_____

**Significant Traumas:** (Auto accidents, Falls, etc.): **(Please indicate dates)** _____

_____

**Birth History:** (Prolonged labor, forceps delivery, etc.)_____

_____

Have you ever taken or had injections of steroids? (Cortisone) If so, when and for how long?_____

_____

Have you ever been on a restricted diet? Yes / No What kind?_____

**Please describe an average day's meals:**

Morning Afternoon Evening Snacks_____

_____

_____

**If you are a vegetarian or vegan, what forms of protein do you eat regularly?_____**

_____

**Emotional State:** Rate the frequency with which you experience the following emotions:

**(1=Never, 2=Occasionally, 3=Frequently, 4=Regularly)**

___Grief ___Sadness ___Depression ___Worry ___Anxiety

___Anger ___Irritability___Obsession ___Pensiveness___Fear

**Cravings:** Do you have a tendency to crave any of the following flavors: (**Check** all that apply)

___Sweets ___Sour ___Bitter ___Spicy ___Greasy ___Fried ___Salty ___Hot

**Please check if you have experienced in the last 3 months: General:** (**Check** all that apply)

____Poor Appetite ____Poor Sleep ____Fatigue ____Fevers ___Chills

_____Tremors ____Sweat Easily____Cravings ____Bruise Easily

____Poor Balance ____Night Sweats ____Localized Weaknesses

**Skin & Hair:** (**Check** all that apply)

____Rashes ____Ulcerations ____Hives ____Itching ____Eczema

____Pimples ____Dandruff ____Hair Loss ____Recent Moles

Any other changes in hair or skin (texture, color, premature graying, etc. _____

**Head, Eyes, Ears, Nose, and Throat:**

**Headaches:**

Duration:_____ Location: (Temples / Behind Eyes / Top / Back / Sinus / Other_____

Frequency: _____X/ Per: day /week/ month How long do the they last?_____

How severe is the Pain **intensity** on a scale of 0-10: (Best=0--10=worst):

When symptom is at its best: /10 When symptom is at its worst: /10 Today: /10

Is it (Better/ Worse /Neither) when you apply Pressure to the Headache?

Is it Worse with... (Improper Eating, in the Evening, Bright light / Noise)

Do they come at a certain Time of Day? If so When? _____

Do they come (Before / After / During ) your period?

What is the Quality of the Pain?

( Dull Achy / Sharp stabbing / Throbbing/ Pressure / Whole Head Feels Heavy)

Please check if you experience any of the following symptoms:

____Dizziness ____Eye Pain ____Cataracts ____Ringing in Ears (Pitch?)

____Recurrent Sore Throats ____Sores on Lips or Tongue Other?_____

**Cardiovascular:** (**Check** all that apply)

____Concussions ____Poor Vision ____Blurry Vision ____Poor Hearing ____Grinding Teeth ____Earaches

____Migraines ____Eye Strain ____Night Blindness ____Color Blindness ____Teeth Problems____Dizziness

____Spots in Front of Eyes ____Sinus Problems ____Facial Pain ____Jaw Clicks ____ Nose Bleeds
____Bleeding Gums ____Phlebitis ____Rx Glasses /Contacts ____High Blood Pressure ____Irregular Heartbeat

____Blood Clots ____Cold Hands/Feet____Palpitations ____Varicose Veins ____Low Blood Pressure

____Swelling of Hands ____Chest Pain or Pain down the Arm ____Swelling of Feet ____Difficulty in Breathing

____Fainting ____Vascular Spiders

**Respiratory:** (**Check** all that apply)

____Cough ____Coughing Blood ____Asthma____Bronchitis ____Pneumonia

____Pain with a deep breath ____Difficulty in breathing when lying down ____Shortness of Breath
____Production of phlegm (what color?_____) Any other lung problems?_____

**Gastrointestinal:** (**Check** all that apply)

| | | |
|---|---|---|
| ____Nausea | ____Constipation | ____Black/Bloody Stools |
| ____Bad Breath | ____Abdominal Pain or Cramps | ____Eating Disorders |
| ____Indigestion | ____Diarrhea | ____Bloating after eating |
| ____Belching | ____Vomiting | ____History of Recurrent/Chronic Antibiotic Use |
| ____Ulcer | ____Rectal Pain | ____Hemorrhoids (Are they Currently bleeding? Y/N |
| ____Gas | ____History of parasites | ____Chronic Use of Laxatives/Stool Softeners |

Any other stomach or intestinal problems? _____

How often do you move your bowels? _____times per (Day / Week)

What is the consistency of your stools? Loose-Diarrhea/ Hard-Constipated / Watery/ Formed/ Thin/

**Genitourinary:** (**Check** all that apply)

| | | | |
|---|---|---|---|
| ____Pain on Urination | ____Urgency to Urinate | ____Decrease in Flow | ____Frequent Urination |
| ____ Unable to hold urine | ____Blood in Urine | ____Poor Sex Drive | ____Kidney Stones |
| ____Prostate Problems | ____ Difficulty Urinating | ____ Genital Sores | ____Erection Difficulty |

Do you wake up at night to urinate? (Yes / No) How often?_____times per Night

Any particular color to your urine? _____ Do you take Vitamins? _____

**Musclo-skeletal:** (**Check** all that apply)

_____Neck Pain _____Muscle Pains _____Knee Pain _____Back Pain

_____Muscle Weakness _____Foot/Ankle Pain _____Hand/Wrist Pain _____Shoulder Pain

_____Hip Pain Any other joint or bone problem?_____

**Neuro-psychological:** (**Check** all that apply)

____Seizures _____Dizziness _____Loss of Balance ____Poor Memory

_____Concussion _____ Depression ____Bad Temper ____Easily susceptible to stress

_____Areas of Numbness _____Anxiety _____Lack of Coordination

Other?_____

## ***Men Proceed to Page 9:

**Reproductive and Gynecological:** (**Check** all that apply)

Number of pregnancies____ Miscarriages ____ First date of last menses____ Excess Facial Hair____

Number of births____ Abortions____ Last PAP date____ Premature births ____

Painful/Irregular Periods____ Menopause (Age)____ Absence of period____ Vaginal Dryness: Yes / No

Vaginal sores: Yes / No History of STD's? Yes / No

If so,what?_____ Was treatment given? Y / N

Age at first menses ____(years old) Was your VERY first period painful? Yes / No

Pale Watery Menses:____ Do you use birth control? Yes /No What type and for how long?_____

_____

Have you ever taken the birth control pill or been on Estrogen replacement therapy?_____

If so, for how long?_____

Have you had problems with fertility?_____

Are you currently sexually active?_____

Vaginal discharge: Yes / No color/quantity/odor:_____

How often Do you have this?_____

**Please be specific about the following:** **Color**- (i.e.-brown, purple, red wine, red, bright red or pale) **Quantity**: (# and size of pads/tampons per day (i.e. Regular, Super, etc.)) **Clots**: (size (i.e. Pea, Dime, Nickel, Quarter), color, and number)

**Blood** **Day 1** **Day 2** **Day 3** **Day 4** **Day 5** **Day 6** **Day 7**

**Color**: _____

**Quantity**:_____

**Clots**:_____

Number of days in your cycle from day 1-day 1? _____days-- (if it is irregular, please indicate that)

Have there been any notable changes in your cycle in the past 6-12 months? Yes /No

If So, What?_____

**PMS/Mood Changes**: (**Check** all that apply)

____Irritability _____Moodiness _____Weepy ____Depressed Other:_____

When in your cycle do you get these symptoms? ( Before Period / During Period / After Period )

**Breasts**: (**Check** all that apply)

_____Masses (Soft & Gummy / Hard & Rocklike) _____Tenderness OR Distention _____Swelling

_____Inflammation _____Cysts _____Fibrocystic Breasts Other: _____

**Pain:** (**Circle** all that apply)

If you have pain, when does it come in the Cycle: ( Before Period / During Period / After Period )

Quality of Pain ( Sharp & Stabbing / Dull ache)

Back pain? Yes / No

Duration of Pain: _____

How severe is the Pain **intensity** on a scale of 0-10: (Best=0--10=worst):

When symptom is at its best?: _____/10

When symptom is at its worst?: _____/10 Today?: _____/10

What makes the pain **Better**? (**Circle** all that apply)

Heat, Cold, Damp Weather, Wind, Rest, Touch/Pressure, Steroids, Stress,

Work, Movement, Sitting, Lying, Other:_____

What makes the pain **Worse**? (**Circle** all that apply)

Heat, Cold, Damp Weather, Wind, Rest, Touch/Pressure, Steroids, Stress,

Work, Movement, Sitting, Lying, Other:_____

## Personal:

Are you currently experiencing any significant family stress?_____

In the past year, have you experienced any significant loss? (death of loved one or pet, job loss, miscarriage, divorce or separation, etc.?) _____

Do you feel actively supported by your family and friends?_____

Do you own pets?_____ Do you consider your home life to be stressful?_____

**Emotions**:

How is your Overall Stress Level (Low=0-10=High): _____/10

Job: _____/10

Home: _____/10

Spouse/partner relationship: _____/10

How would you describe yourself emotionally?

_____

How would others describe you?:_____

_____

How do you handle anger? (Repressed expression/busting out, Irritability, Rib/Side Pain):

Other: _____

Are you comfortable expressing anger? Yes /No

What is your intuitive sense as to what "caused/ is causing" the main complaint?

_____

_____

What was going on in your life when the problem began?

_____

_____

**Comments:** Please feel free to add any other information you feel would be relevant:_____

# Root & Branch Oriental Medicine

## Protecting Your Confidential Health Information

Your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your personal information will not be used for other purposed unless we have asked for and been given your permission.

## Your health information will be used:

*To provide treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between doctor and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories or other health care personal providing your treatment.

***To obtain payment:** We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail. We will only work with companies with a similar commitment to the confidentiality of your health information.

***Inspect and copy your health information:** You have the right to read, review and copy your health information, including your chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you to duplicate and assemble your copy.

***Amend your health information:** You have the right to ask us to update or modify your records if you believe they are incorrect or incomplete. We will accommodate you as long as our office maintains this information. Please make your request in writing and inform us of the reason for the change in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.

***Documentation of your health information:** You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or health care operations. We will be able to provide you health information upon request, as long as it is not 7 years old or older.

**Request a paper copy of this notice:** You have the right to obtain a copy of this privacy notice policy for your records.

## Patient Acknowledgment:

Signature: X_____Date:_____

# Root & Branch Oriental Medicine

## Consent to Treat Form

I, hereby authorize the above practitioners to administer Acupuncture treatment relevant to my Oriental medical diagnosis and treatment, including but not limited to the following:

1. Insertion of various sized acupuncture needles into various points on my body.

2. Heat treatments using **Moxa/Mugwort** lit and burned on or near the needles or on the skin, or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of a burn ointment, which will conduct the heat and prevent burning the skin. On rare occasions, a blister will occur. The acupuncturist will explain the procedure as it is done and the patient asked to let them know the status of the heat at all times.

3. **Static or Electro stimulation** of the needles using a battery operated tool to stimulate a needle to create a current connecting a number of needles. This is most commonly used to treat pain or neuropathy.

4. **Bloodletting**, when appropriate, can be an excellent adjunct to treatment of injuries, which are acute and chronic, and can expedite the recovery process from an injury/illness. This is a technique where a point is pricked and a few drops of blood is drawn from it.

5. **Cupping** is a form of treatment, which applies suction cups to the skin to release congestion and tension in the muscles and soft tissues. Tight muscles over time will reduce the amount of blood flow to and through the muscles, a condition called ischemia, and the cupping when released, causes a release of the stagnant blood in the tissue and encourages an influx of fresh new blood into the area. At times this can leave a red or purplish mark on the skin, which should pass in a few days. It will most resemble a bruise. This technique is also used for acute respiratory conditions to help clear the lungs. **Guasha** is another technique to remove congestion/stagnant blood in an area. It is done using a variety of tools which are rubbed along an area with the use of a topical lubricant of some sort. It is great for kids, and for areas which are not accessible for cupping.

6. The use of patent or personalized **Chinese herbal formulas** to treat my condition. Patent formulas are predetermined formulas sold over the counter. The customized formulas are ordered specifically for you, and are written by your practitioner to specifically address your needs on a deeper level. Should herbs be indicated for your case, your practitioner will discuss with you the different options and make recommendations according to the specifics of your case.

I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and was given an opportunity to ask questions pertaining to my treatment. I am also aware that there are no guarantees made as to the results of treatment.

I further understand that any diagnosis given in the context of acupuncture treatment does not constitute a western medical diagnosis and recommendations may be made to pursue further medical advice or intervention if necessary.

**Signature of Patient: X**_____

**Date**: _____ **Print Name**: _____