

# 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. You may want to *bring a pair of shorts* with you to change into for the treatment.

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***\*\*\*The courtesy of a 24 hour notice of cancellation for any appointment is expected and appreciated. The patient is responsible 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 are currently \$125 for the initial visit. Follow up acupuncture treatments are \$80 for 1-hour. Follow up consultations for Chinese herbal medicine are \$50 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, and Visa.

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.

\*\*\*\*\*

I have read and agree to the policies outlined above.

Date \_\_\_\_\_ Signature **X** \_\_\_\_\_

# Root & Branch Oriental Medicine

77 West Main Street, 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? \_\_\_\_\_

Do you have any allergies: (Drugs, chemicals, foods, environmental, herbs) Please List.

Are you currently taking any **medications**, vitamins, herbs, homeopathics? If so **please list**.

Do you exercise regularly? Describe frequency and type of activity

Do you chew, smoke or snuff tobacco? 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? What kind? \_\_\_\_\_

### **Energy Level**

How is your overall Energy Level: (0=Low-10=High) Overall /10

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

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

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

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? 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                      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
_____	_____	_____	_____
_____	_____	_____	_____

**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    \_\_\_ Other: \_\_\_\_\_

**Please check if you have had in the last 3 months:**

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

\_\_\_ Poor Appetite    \_\_\_ Poor Sleep    \_\_\_ Fatigue    \_\_\_ Tremors  
\_\_\_ Fevers    \_\_\_ Chills    \_\_\_ Night Sweats    \_\_\_ Sweat Easily

\_\_\_Cravings \_\_\_Bruise Easily\_\_\_Localized Weaknesses \_\_\_Poor Balance

**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 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 \_\_\_Concussions \_\_\_Migraines \_\_\_Eye Strain  
\_\_\_Eye Pain \_\_\_Poor Vision \_\_\_Night Blindness \_\_\_Color Blindness  
\_\_\_Cataracts \_\_\_Blurry Vision \_\_\_Spots in Front of Eyes \_\_\_Earaches  
\_\_\_Ringing in Ears (Pitch?) \_\_\_Poor Hearing \_\_\_Sinus Problems \_\_\_Nose Bleeds  
\_\_\_Recurrent Sore Throats \_\_\_Grinding Teeth \_\_\_Facial Pain \_\_\_Bleeding Gums  
\_\_\_Sores on Lips or Tongue \_\_\_Teeth Problems \_\_\_Jaw Clicks \_\_\_Wear Glasses / Contacts

Any other head or neck problems? \_\_\_\_\_

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

\_\_\_High Blood Pressure \_\_\_Low Blood Pressure \_\_\_Chest Pain or Pain down the Arm  
\_\_\_Irregular Heartbeat \_\_\_Dizziness \_\_\_Fainting  
\_\_\_Cold Hands or Feet \_\_\_Swelling of Hands \_\_\_Swelling of Feet  
\_\_\_Blood Clots \_\_\_Phlebitis \_\_\_Difficulty in Breathing  
\_\_\_Varicose Veins \_\_\_Vascular Spiders \_\_\_Palpitations

Other? \_\_\_\_\_

**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      \_\_\_Vomiting      \_\_\_Diarrhea  
\_\_\_Constipation      \_\_\_Gas      \_\_\_Belching  
\_\_\_Black/Bloody Stools      \_\_\_Ulcer      \_\_\_History of Recurrent/Chronic Antibiotic Use  
\_\_\_Bad Breath      \_\_\_Rectal Pain      \_\_\_Hemorrhoids (Are they Currently bleeding? Y/N)  
\_\_\_Abdominal Pain or Cramps \_\_\_Eating Disorders      \_\_\_History of parasites  
\_\_\_Bloating after eating      \_\_\_Indigestion      \_\_\_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      \_\_\_Frequent Urination      \_\_\_Blood in Urine      \_\_\_Poor Sex Drive  
\_\_\_Urgency to Urinate      \_\_\_Unable to hold urine      \_\_\_Kidney Stones      \_\_\_Erection Difficulty  
\_\_\_Decrease in Flow      \_\_\_Sores on Genitals      \_\_\_Prostate Problems      \_\_\_Difficulty Urinating

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? \_\_\_\_\_

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

Number of pregnancies \_\_\_\_\_ Number of births \_\_\_\_\_ Premature births \_\_\_\_\_  
Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Age at first menses \_\_\_\_\_ (years old)  
First date of last menses \_\_\_\_\_ Last PAP date \_\_\_\_\_ Was your *VERY first* period painful? Yes / No  
Excess Facial Hair \_\_\_\_\_ Menopause (Age) \_\_\_\_\_ Painful/Irregular Periods \_\_\_\_\_  
Pale Watery Menses: \_\_\_\_\_ Absence of period \_\_\_\_\_

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? \_\_\_\_\_

Vaginal sores: Yes / No      Vaginal Dryness: Yes / No

History of STD's? Yes / No If so, what? \_\_\_\_\_

Was treatment given? \_\_\_\_\_

**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:** \_\_\_\_\_

How many days does your monthly cycle last? \_\_\_\_\_ 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 1 or more below)

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, Work,                      Movement,                      Sitting,                      Lying,  
Touch/Pressure,                      Steroids,                      Stress,                      Other: \_\_\_\_\_

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

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

**Musculo-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      \_\_\_\_ Areas of Numbness

\_\_\_\_ Poor Memory      \_\_\_\_ Concussion      \_\_\_\_ Depression      \_\_\_\_ Anxiety

\_\_\_\_ Bad Temper      \_\_\_\_ Easily susceptible to stress      \_\_\_\_ Lack of Coordination

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 do *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 would like to discuss: \_\_\_\_\_

# 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 purposes 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 personnel 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 stimulation of the needles using a battery operated tool to stimulate a needle and create a current connecting a number of needles.
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 generally in the form of tension. Tight muscles over time will reduce the amount of blood flow to and through the muscles, a condition called ischemia, and the cupping applies suction to the muscle which, 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.
6. The use of patent or personalized Chinese herbal formulas to treat my condition.

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: \_\_\_\_\_