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 affect 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.

****

The courtesy of a 48-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 2-business days notice.

****

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: $155 for the initial visit (1.5 hrs. including treatment) and $100 for 1 hr. follow-up. Initial Chinese Medicine intakes are $100 and Follow up consultations for Chinese herbal medicine are $60 for 1/2 hour (plus the cost of the herbs). Pediatric (kids under 16) visits are $110 for the initial and $75 for follow-up appointments. 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.

We offer a $5 time of service discount for payments in CASH and CHECK.

Acupuncture is covered by worker's compensation, auto insurance and a number of private insurance policies. It is also reimbursable by flexible spending plans and Health Savings Accounts. Should you have coverage, we are happy to verify your coverage and bill directly if we can verify benefits. If we do not have that information on the first visit, we ask that you pay in full, and we will work out the details upon receipt of the insurance verification.

****

I have read and agree to the policies outlined above.

Date____________________ Signature X_________________________________

Root & Branch Oriental Medicine

169 West Main St, Suite 2B 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:**____/____/______

Address:____**Zip**______________

Date of Birth:_____________ **Age:**______ **Occupation:**____________________________________

Phone: Home______________________**Work**______________________**Cell:**______________________

E-mail____@______________________________

_______**Please check if you would like receive our monthly email newsletter**

Physician:______________________________________ ____

Physician Address & Phone #:____

In Emergency Notify:_______________________________________**Phone:**___________________________

How did you hear about our office?____

If you were referred, may we thank the person who referred you? Y / N

What is your goal for treatment?

____

____

____

What would you like to accomplish by working with us?

____

____

____

Is there anything that will hold you back from achieving this goal?

____

____

____

Any questions, concerns or comments you'd like to share?

____

____

____

Are you optimistic about your potential for healing?

____

____

____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal
1.	☐	☐	☐	☐
2	☐	☐	☐	☐
3.	☐	☐	☐	☐
4	☐	☐	☐	☐
5.	☐	☐	☐	☐

Please note the following for each complaint:

1. Frequency:____________________Duration:____________________

2. Frequency:____________________Duration:____________________

3. Frequency:____________________Duration:____________________

4. Frequency:____________________Duration:____________________

5. Frequency:____________________Duration:____________________

How do these conditions impair your daily activities?____________________________

____

____

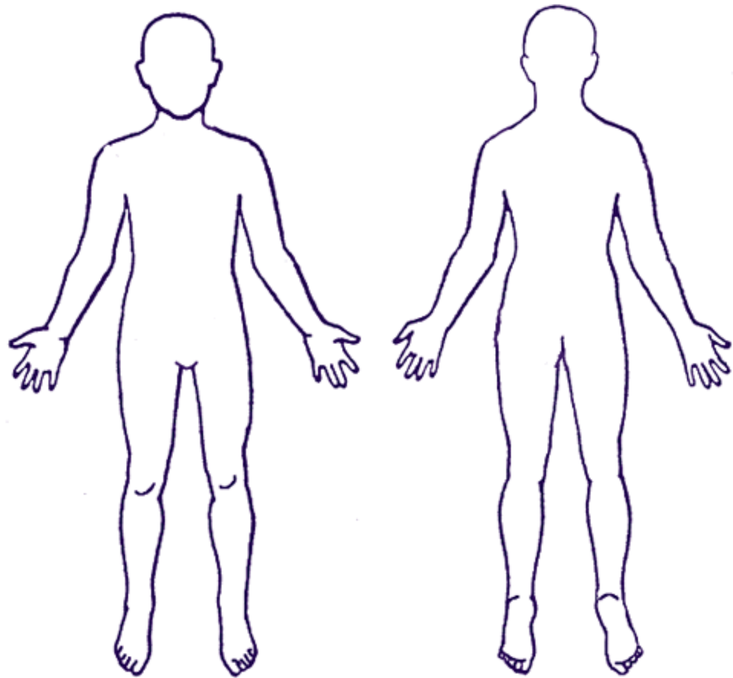
____

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:
☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed
☐Other:___________________

Do the following lessen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Exercise
☐ Other:__________________

Do the following worsen the pain?
☐ Pressure ☐ Cold ☐ Heat
☐ Other:____________________________



If you have a diagnosis for this problem, what is it?____

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. __________________

____

____

____

Who prescribed the medications or supplements?____

____

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 day? _____________ per week?___________

How much alcohol per day? ________________Per week?________________ Do you use any recreational drugs? Y / N If yes, what kind?____

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

How is your overall energy level: _____/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)

How is your overall endurance?____

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:____________

____

How was your health as a child? ____

Surgeries/Operations/Hospitalizations/Scars? ____

____

____

____

Family Medical History: (Please circle any that apply) Diabetes Cancer High Blood Pressure Mental Illness Alcoholism Heart Disease Seizures Asthma Allergies Auto immune Diseases Stroke Arthritis Pneumonia Vascular Conditions Bleeding Disorders Other:________________

Family Member	Alive	Deceased	Present Health or Cause of Death
Father	☐	☐	
Mother	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	

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

____

Your 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

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: (Please check if you experience any of the following symptoms)

____Dizziness ____Eye Pain ____Cataracts ____Sores on Lips or Tongue

____Recurrent Sore Throats ____Ringing in Ears (High Pitch/White Noise/Hissing)

____Concussions ____Poor Vision ____Blurry Vision ____Rx Glasses /Contacts ____Poor Hearing

____Migraines ____Eye Strain ____Night Blindness ____Color Blindness ____Teeth Problems

____Spots in Front of Eyes ____Sinus Problems ____Facial Pain ____Jaw Clicks ____ Nose Bleeds

____Bleeding Gums ____Grinding Teeth ____Earaches

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)

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

____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 ____Phlebitis ____High Blood Pressure ____Irregular Heartbeat ____Dizziness

Respiratory: (In the past 3 months, **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 ____Use of Laxatives/Stool Softeners /Miralax

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

____ Difficulty Urinating ____ Genital Sores

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 _____Shoulder Pain

_____Muscle Weakness _____Foot/Ankle Pain _____Hand/Wrist Pain _____Areas of Numbness

_____Hip Pain Any other joint or bone problem?____

Neuro-psychological & Emotional Conditions: (**Check** all that apply)

____Seizures _____Dizziness _____Loss of Balance ____Poor Memory

_____Concussion _____ Depression ______Bad Temper ____Easily susceptible to stress

_____Anxiety _____Lack of Coordination ____ Bi-Polar

Other? ____

Female Reproductive and Gynecological:

Regular menstrual cycle? □ Y □ N Pregnant? □ Y □ N

Number of children: ________________ Number of pregnancies:___________________

Age of first menstruation: ___________ Age of menopause (if applicable):___________

Was your first period painful? ________

Average number of days of flow: ______ Average # of days of cycle (From day 1to day 1):_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Size & Number of pads or tampons							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							

Nausea (check if yes)							
Other							

	Severe	Moderate	Slight	Normal
Vaginal Discharge	☐	☐	☐	☐
Bleeding between periods	☐	☐	☐	☐

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea ☐ Vomiting ☐ Water retention ☐ Breast swelling
☐ Food cravings ☐ Headaches ☐ Migraines ☐ Breast tenderness
☐ Depression ☐ Irritability ☐ Anxiety
☐ Other emotions:____

☐ Dull pain, where?____________________ ☐Sharp pain, where?______________________________

Back pain? Yes / No Duration of Pain: ____

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

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, Rest, Touch/Pressure, Stress, Movement Other:____

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

Heat, Rest, Touch/Pressure, Stress, Movement Other:____

(**Check** all that apply)

Miscarriages ____ First date of last menses____ Excess Facial Hair____

Abortions____ Last PAP date____ Premature births ____

Painful Periods____ Absence of period____ Pale Watery Menses:____

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

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

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?____

Have there been any notable changes in your cycle in the past 6-12 months?   Yes /No   If yes, what?____

Men only:

☐ Swollen testes   ☐ Testicular pain   ☐ Impotence   ☐ Premature ejaculation
☐ Feeling of coldness or numbness in external genitalia __Erection Difficulty __Prostate Problems
☐ 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?_________________________

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?

____

Have you experienced addictions, or physical/emotional trauma in your life? _________________________

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: ___________________________

What to Expect On Your First Visit

It is not uncommon for patients to come to our practice with little to no exposure to acupuncture or Chinese medicine prior to their first visit. In order to minimize any nervousness, we feel it is best that you have a clear understanding of what you can expect from us and what will help us to give you the best attention and treatment.

The initial visit will include a review of your reasons for seeking treatment along with reviewing the intake form in greater detail. This gives you an opportunity to give us more details on your medical history, and for us to arrive at a more accurate Chinese medical diagnosis. There will be time for discussion about your case, the treatment options, and for us to explain to you anything that would be helpful for you to understand in order to participate fully in your quest to feel better. Depending upon the complexity of your case, usually there is time for a treatment of somewhere between 20-45 minutes.

- It is our preference that you have an opportunity to experience not just acupuncture, but our style of treatment at the first visit.
- We may talk about changes you can consider making in your diet, lifestyle, ergonomics, home care, etc., in order to support the treatment process.
- Depending upon your needs, you may be prescribed herbs or supplements.
- We may give you written information that will help you to understand the diagnosis and pathology from a Chinese medical perspective.
- IDEAL CLOTHING FOR YOUR VISIT: Please wear loose fitting pants that can be rolled up to above the knee (no blue jeans please) and women can also wear (or bring to change into) a loose fitting tank top so we can get access to the areas on your back and shoulders.

Treatment Plan:
We generally recommend that patients commit to a treatment plan in order to get the most benefit from your treatments. Acupuncture, and the diet and lifestyle changes that are made as part of your healing, take time to build on each other and to generate solid change. Just as you might have gone to a physical therapist for a course of treatment for an injury, so too do you need to see the acupuncturist for a course of treatment for most conditions.

Acupuncture is a treatment modality that is intended to not only help people get relief from their health problems, but it is meant to correct the underlying reason for the condition in the first place…and then to keep people healthy long-term. Therefore, when you achieve the desired results of your treatment, it is advisable that you consider coming in for maintenance treatments to maintain your strength, immunity, and overall health. It also allows you to keep on top of your health and to stay focused on healthy diet and lifestyle behaviors. Maintenance treatments can be monthly, quarterly, or biannually, and can be discussed with your practitioner what might be ideal for you.

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 our office did not create the health information requested, 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 are 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. **Gua sha** is another technique to remove congestion/stagnant blood in an area. It is done using a variety of tools that are rubbed along an area with the use of a topical lubricant of some sort. It is great for kids, and for areas that 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**: ____