Willamette Acupuncture & Wellness
289 E. Ellendale Ave. Suite 202, Dallas, OR 97338
(503) 751-1460

New Patient Health History Form

Patient Information
First Name_____ Last Name_____ Date_____
Preferred Name_____ Email address_____
How did you hear about us?_____
Address_____ City_____ State_____ Zip_____
Phone (Home)_____ Work_____ Cell_____
Birth Date_____Occupation_____Employer_____
Marital Status_____ Emergency Contact_____ Phone_____

Payment Information
Name of party responsible for payment _____Phone_____
Do you have health insurance? No__Yes__
How do you plan on handling payment of your account? Debit/Credit___Cash___Check___Insurance___
Name of company_____ ID#_____ Group#_____
****If an auto accident, please provide:**
Insurance Company Name_____ Contact person_____
Phone_____ Claim #:_____

Have you ever:	**No**	**Yes**	**Date & Details**
Been in an auto accident?	___	___	
Had surgery?	___	___	
Had metal implants?	___	___	
Do you have a pacemaker?	___	___	

Current Complaint
Reason for visit:_____
_____
Nature of Complaint ___Automobile ___Work ___Other
Date of Injury/onset of condition _____
Have you ever had same condition? ___Yes ___No If yes, when? _____
List of other practitioners seen for this injury/condition_____
Have you ever received acupuncture? ___Yes ___No
Have you ever received a massage? __Yes __No
Circle the pain level you are experiencing right now on a scale of 1 to 10: None 1 2 3 4 5 6 7 8 9 10
Do these symptoms interfere with your activities of daily living (sleep, exercise, work, etc?) Y__ N__
Explain:_____
Please list the medications you are taking and for what conditions:_____
_____
_____
Please list the vitamins, minerals, or herbs you currently take:_____

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Health Problems and Concerns:

Please mark an "X" to indicate if you have experienced in the past.
Mark a "C" if currently experiencing the issue:

__ Alcohol/Drug Addiction
__ Allergies
__ Anemia
__ Acid Reflux (GERD)
__ Arthritis
__ Asthma/Lung Disease
__ Autoimmune Disorder
__ Blood Clots
__ Cancer
__ Chest Pain
__ Digestion Problems
__ Depression/Anxiety
__ Diabetes
__ Eating Disorder
__ Ear/Nose/Throat condition
__ Pacemaker
__ Fatigue
__ Frequent Urination
__ Headache
__ Heart Disease
__ High Blood Pressure
__ Hot Flashes
__ Irregular Menstrual Cycle
__ Frequent Infections
__ Kidney Disease
__ Memory Loss
__ Loss of Balance/Dizziness
__ Muscle Cramps/Spasms
__ Recent Weight Changes
__ Hepatitis (A,B,C)/Liver Disease
__ HIV/AIDS
__ Prostate condition
__ Rash
__ Insomnia
__ Spinal Curvatures
__ Stroke or TIA
__ Swollen Joints
__ Thyroid Condition

Primary Physician_____

List any family history of present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc):_____

Have you been treated for any health conditions in the last year? __No __Yes

If yes, please describe_____

Please list any known allergies to food or medications_____

WOMEN: Date last menstruation_____ Is there a chance that you are pregnant?_____

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Informed Consent for Treatment

Massage:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand the massage therapist will use different techniques, such as stroking, kneading, friction, stretching and/or percussion. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a qualified physician for any mental or physical ailment of which I am aware. The most common risks of massage include mild, short term muscle soreness and surface level bruising. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I have been asked if I have any further questions and my questions have been answered. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks, movements, or advances made by me will result in immediate termination of the session and a permanent ban from the clinic, and I will be liable for payment of the appointment. I have read and understand this form and give my consent to receive care.

Acupuncture:

I hearby request and consent to the performance of acupuncture treatments and other treatment procedures within the scope of practice of acupuncture on me by any licensed Acupuncturist employed, associated with or working as call-coverage at Willamette Acupuncture and Wellness.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua-sha, 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 have 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 site that may last a few days, and dizziness or fainting. Burns and/or scarring are potential risks of moxibustion and cupping, and when treatment involves the use of heat lamps. Bruising is a common side effect of cupping and gua-sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Willamette Acupuncture and Wellness uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects 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, like pharmaceutical drugs, 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 Name:_____ DOB:_____

Patient Signature: _____Date:_____

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CLINIC ACCOUNT POLICY

- Payment is expected at the time of service.
- As a service to you, we will bill your insurance company. If we can document your coverage, **we will ask you to pay your co-pay, co-insurance, deductible or non-covered service fee at the time of each visit**. If we have to wait to document your coverage, we will bill you later for co-insurance, deductibles or non-covered service fees.
- If your insurance policy requires a referral for acupuncture care, you are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.
- We make every effort to get accurate information from your insurance company. At times, however, insurance companies give us inaccurate information. For this reason, we periodically review our accounts and may have to inform you of a balance due.
- **Information received from the insurance company is not a guarantee of benefits. You are responsible for all charges incurred in this office.**
- If your account is assigned to an attorney for collection and/or suit due to delinquency, the prevailing party shall be entitled to reasonable attorney's fees and cost for collection.
- By signing below you authorize any insurer to make payment for services rendered by Willamette Acupuncture and Wellness directly to Willamette Acupuncture and Wellness.
- If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference.
- Personal injury accounts (automobile accidents) require that certain paperwork be filed by you with your insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you must pay at the time of service for your care and be reimbursed by any insurance company involved.
- Patients paying in full at the time of service may receive a 30% time of service discount. This discount is the approximate cost to us of billing an insurance company for services rendered. We pass these savings on to you; however, we will do no billing for these services. If, at a later date, you ask that insurance billings be done, the amount of the discount will be added back to your account prior to any billing being done.

- **Initials: _____We require 24 hour notice if you need to cancel your appointment. You will be charged a $35.00 fee for any appointment missed without letting us know 24 hours in advance.**

- We are required by federal and state law to maintain the privacy of your health information. We are also required to give you a HIPAA policy outlining our privacy practices.

I have read and understand the above account policy and HIPAA privacy policy.

Patient Name:_____ DOB:_____

Patient Signature:_____Date:_____