Welcome to Tacoma Acupuncture Health and Wellness…
Thank you for choosing us!

For your first visit:

Wear comfortable clothes that allow easy access to the legs, arms and stomach. If you are not able to wear such clothes we have sheets available.

Do not plan on any strenuous or altering activities during the same day of treatment. Examples of activities to avoid might be over use of alcohol, anything that worsens your condition, or too much caffeine. This allows the treatment to be more effective.

We recommend keeping a journal of some kind during your treatment. Things to note are changes in your condition energy levels, cravings, bowel movements, urination, libido, sleep and/or moods. This helps us to pinpoint patterns in your body to assist us in your treatment.

Your appointment will be at **5702 N. 26th St. Suite B, Tacoma, WA 98407**. Maps can be found on the Contact page of www.TacomaAcupuncture.com. More information and updates on what we offer can also be found on the website.

Please remember to bring all of your forms and payment information. If you are using insurance please check to see that you have acupuncture benefits and know if your deductible has been met as well as if you have a co-pay or co-insurance.

We appreciate your promptness and try to do the same to start your appointment on time. ☺

We look forward to working with you on your health goals!

Date of Birth____/____/____ Age____ SS#_____
Last name_____ First name_____ M.I._____
Mailing address_____
City _____ State_____ Zip_____
(Circle one) Home/cell phone_____ work_____
email_____
What ways may we contact you (circle one)? Email Phone Call Text

Emergency contact_____ Phone_____Relationship_____

Do you have insurance? ___yes ____no
If yes, please provide a copy of your insurance card and the following info
Insured name (if not client) _____
Insured person's Birth date _____SS#_____
Insurance company name _____
ID # (include alpha) _____Group#_____
Provider's Phone # or Customer Service # on the back of the card_____

Health History
Primary Health concern_____
Secondary Health concern_____
Name and location of your physician_____Date of last check-up_____
Your health as a child good fair poor Childhood illnesses_____
Hospitalizations year reason year reason
_____

Surgeries year reason year reason
_____
Immunizations_____

Current Medications
Prescription (use the back if needed)_____
non prescription_____
Vitamins_____herbs_____

Allergic Reactions
Drugs_____Foods_____
Environmental_____
List any chemical, metals, dusts, or fumes that you have been repeatedly exposed to.
_____

Diet
Do you have a special diet?_____food cravings_____

Exercise
Type/s_____ Times per week_____ how long_____

Sleep
Average hours per night_____ Quality of sleep_____ # of times wake to urinate_____

Work
Employer_____ Hours per week_____ Stress Level scale 1-10 (1= no stress) _____
Stress reducing activities_____
Hobbies/recreations _____
Alcohol use history Frequency_____ Type_____ Alcohol problems ___yes ___no ___in the past
Nicotine use history Cigarette smoking ____yes ___no # of packs per day____# of years smoking___
If you have stopped, # of years stopped (please answer above question for when you did smoke)
Other nicotine_____
Caffeine Use type _____frequency per week_____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS AND CHECK ANY THAT HAVE BEEN A PAST ISSUE:

General:
Poor appetite
Fevers
Sweat
Localized weakness
Bleed or bruise easily
Peculiar tastes or smells
Strong thirst
Thirst no desire to drink
Poor sleeping
Chills
Tremors
Poor balance
Fatigue
Night sweats
Cravings
Changes in appetite
Weight gain
Weight loss
Tend towards feeling cold
Tend towards feeling hot

Skin and hair:
Rashes
Itching
Dandruff
Changes in hair or skin
Ulcerations
Eczema
Loss and/or thinning of hair
Hives
Pimples
Recent moles
Oily skin
Dry skin
Other hair or skin problems

Head, eyes, ears, nose and throat:
Dizziness
Glasses
Poor vision
Cataracts
Ringing in ears
Sinus problems
other stomach or
intestinalproblems

Genito-urinary:
pain or urination
urgency to urinate
decrease in flow
frequent urination
unable to hold urine
impotency
blood in urine
kidney stones
sores on genitals
cloudy urine
dark colored urine
waking to urinate
other urinary or genital problems
Grinding teeth
Concussions
Eye strain
Night blindness
Poor hearing
Nose bleeds
Facial pain
Jaw clicks
Migraines
Eye pain
Color blindness
Earaches
spots in front of the eyes
recurrent sore throats
sores on lips, tongue or mouth
headaches: where and when
other head or neck:

Cardiovascular:
high blood pressure
anemia
irregular heart beat
cold hands or feet
blood clots
low blood pressure
dizziness
swelling of hands
difficulty in breathing
other heart or blood vessel
problems

Respiratory:
cough
bronchitis
difficulty in breathing
when lying down
production of phlegm
what color?
coughing blood
pneumonia
asthma
pain with a deep breath
congestion
other lung problems

Gastrointestinal:
nausea
constipation
black stools
bad breath
abdominal pain or cramps
chronic laxative use
vomiting
gas
blood in stools
rectal pain
diarrhea
belching
indigestion
acid reflux
hemorrhoids

Pregnancy and Gynecology:

# of pregnancies _____
# of births _____
premature births
miscarriages
abortions
age of first menses_____
days between menses____
duration
date of last menses_____
painful periods
heavy periods
light periods
vaginal discharge
PMS
Clots
Irregular periods
Vaginal sores
Breast lumps

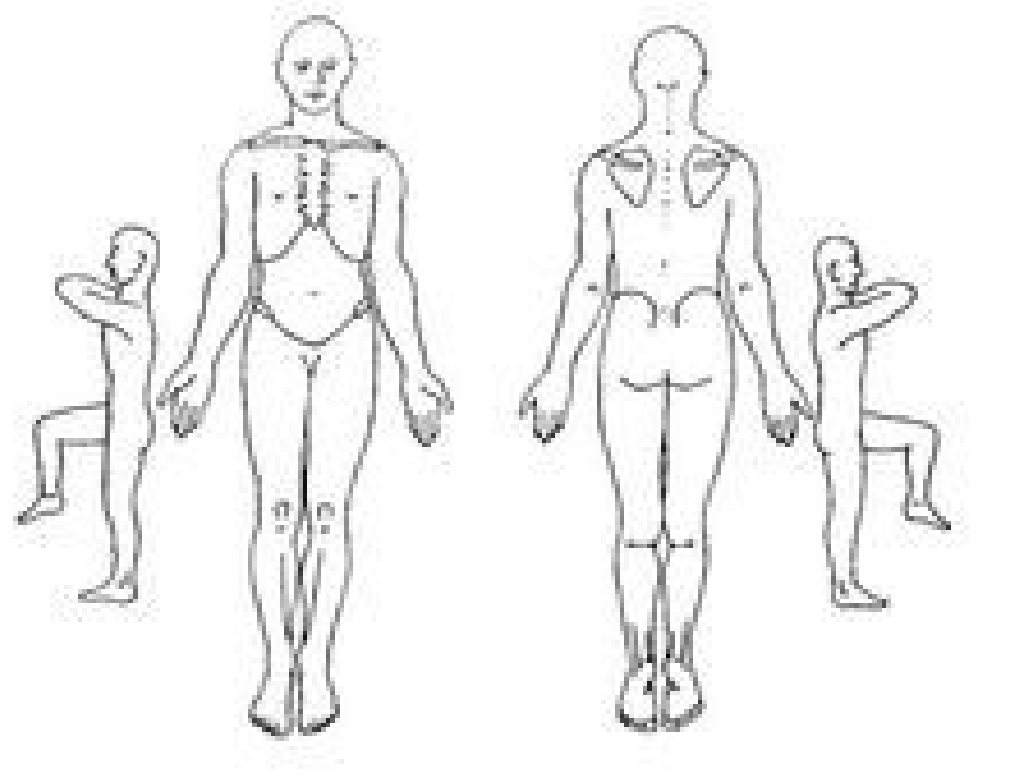
Do you Practice birth control?
What type?
_____
How long?
_____
Last pap? _____

Musculoskeletal:

Neck Pain
Back pain
Hand/wrist pain
Muscle spasms
Shoulder pain
Knee pain
Foot/ankle pain
Hip pain
Muscle weakness

Neuropsychological:

Seizure
Areas of numbness
Concussion
Bad temper
Dizziness
Lack of coordination
Depression
Easily susceptible to stress
Loss of balance
Poor memory
Anxiety
Have you ever been treated for emotional problems?
Y____ N____
Have you ever considered or attempted suicide? Y___ N___



Draw on the picture noting any area of pain, numbness, or discomfort.

Please add any additional information:_____
_____
_____
_____

POLICIES

Payment is due at time of service. We are a small business that bills insurance as a service for you. To help all of us have a smooth relationship with the insurance billing. **Please do the following:**

1 Prior to the visit, contact your insurance carrier to confirm coverage or other restrictions and let us know what they are at your first visit.
2 When you get your Explanation of Benefits (EOB) in the mail, please review it for deductibles, coinsurance and copays. If you owe money, please consider this EOB as an invoice and send in the amount due to TAHW. If you have questions, please call us so we can work with you.
3 Copays and Products are due at time of service - we accept cash, check and credit cards. A payment plan is possible – just ask .

While we will do what we can, it is the patient's responsibility to resolve lack of payment issues.
Finance charges of 12% are applied after 60 days to all unpaid balances (calculated from date of service). _____initial here.

I acknowledge that I have read and understand the above information. I hereby instruct and direct my insurance company to pay by check made out to TAHW for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the final charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. I agree to pay, in a current manner, any balance of said professional services charges not covered by insurance.

Cancellation Policy

Cancellations that are within 24 hours of the scheduled treatment time will result in a charge of the scheduled services.
Email reminders are a courtesy; please keep track of your appointments.

I have read and understand the above information and have discussed any concerns or question related to the above information prior to treatment, and consent to treatment at Tacoma Acupuncture.

_____

Signature of Patient or guardian (above, on line) Date

Consent for Oriental Medicine/Scope of Practice

The "Scope of Practice" for an acupuncturist in the state of Washington includes but is not limited to the following list of techniques:

- Use of acupuncture needles to stimulate acupuncture points and meridians
- Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians
- Moxabustion
- Acupressure
- Cupping
- Dermal friction technique (gua sha)
- Chinese massage (Tuina)
- Sonoscope
- Laserpuncture
- Dietary advice based on traditional Chinese medical theory

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Side effects may include, but are not limited to the following: pain following treatment in insertion area, minor bruising, infection, needle sickness, broken needle, temporary discoloration of the skin, aggravation of symptoms existing prior to treatment.

Patients with bleeding disorders, pacemakers, seizure disorders, or women, who are currently pregnant, please verbally notify the practitioner.

Potential benefits: Drugless relief of presenting symptoms, improved general health, elimination of the presenting problem, reduction of pain and associated symptoms.

With this knowledge, I voluntarily consent to the above procedures, realizing TAHW regarding cure or improvement of my condition has given no guarantees to me. I hereby release TAHW from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of Patient or guardian (above, on line) Date