PATIENT INFORMATION SHEET

Name: _____
Last First Middle
Name you prefer to go by: _____ Date of Birth: ___/___/___ Age: _____

Gender: ___Male ____ Female Marital Status: ___ Married ___Single ___Divorced ___Widowed __ Other

Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____ E-mail: _____

Occupation: _____ Employer: _____

In Case of Emergency, please contact: _____
Name Phone Number Relationship
Primary Care Physician: _____ Name of Referring Physician: _____

How did you hear about Mountain View Acupuncture? _____

Payment Method

____ Cash/ Check ___ Credit Card ____ Health Insurance ____ Workers Comp ____ Other

Insurance Information

Please complete the following information, as well as, provider your insurance ID card for photocopying. Thank you.

Insurance Company: _____ Phone number: _____
ID or SS #: _____ Group #: _____ Date of Birth: _____

As a service to our patients, Mountain View Acupuncture is happy to submit charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for the payment of the account balance.

I agree to be responsible for payment of services in the event that my insurance company doesn't agree to pay for these services.

_____ _____
Patient or Guardian Signature Date

INFORMED CONSENT FOR ACUPUNCTURE & ORIENTAL MEDICINE

I hereby voluntarily consent to receive acupuncture and Oriental Medicine treatment for my present health condition. I understand that treatment will be administered by Marjon Faivre, Licensed Acupuncturist (L.Ac.), Janelle Bartow, L.Ac., or Sarah Allen, L.Ac. The treatments that may be administered are described below:

Acupuncture: A safe treatment involving the insertion of small sterile needles through the skin, which may produce a temporary, mild discomfort at the acupuncture site. Acupuncture occasionally causes slight bleeding and may leave a bruise. Other possible risks from acupuncture include dizziness and fainting. I will report to the L.Ac. any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture, and infection (these are very low incidence, especially when acupuncture is administered properly.)

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A gentle tingling or tapping sensation will be felt.

Heat Therapy with Infrared Lamp: This is used as an adjunct to acupuncture to warm the body and stimulate healing. Every precaution is taken to prevent over- warming, but the rare possibility of mild burns does exist.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Occasionally, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop taking the herbs and inform the L.Ac. of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the L.Ac. of a suspected or confirmed pregnancy, or if I am a nursing mother.

Moxibustion: This involves the burning of mugwort, which is then placed on or held over the acupuncture site. Though safety precautions are used, burns and/or scarring are a potential risk of moxibustion.

By signing below, I acknowledge that:

* I have read, or had read to me, the information on this consent form
* I understand the possible risks and complications involved
* I understand that I can request more information at any time if desired
* I consent to receiving treatment that involves the above procedures
* I understand that I have the right to refuse or discontinue any treatment at any time
* I understand that this refusal may affect the expected results

_____

Patient name (please print)

_____ _____

Patient or Guardian Signature Date

If a Guardian has signed, please print your name: _____

Notice Patient Privacy
Health Insurance Portability and Accountability Act (HIPPA)

Mountain View Acupuncture is dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have written consent before we use or disclose your medical information to others for the following purposes: providing or arranging your health care, payment for reimbursement of treatment provided and related administrative activities supporting your health care.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

You are provided the right to inspect and receive a copy of your medical information, amend or correct that information, obtain an accounting of our disclosures of your patient file, request that we communicate with you confidentially, request that we restrict certain use and disclosures of your health information, and complain if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law.

If you have any questions, concerns or comments about the NOTICE or your medical information, please contact Mountain View Acupuncture, LLC at 541-388-0675. You may also send a written complaint to the US Department of Health and Human Services.

_____ _____

Patient Name (please print) Date

_____

Patient or Guardian Signature

PATIENT CONTRACT AND CANCELLATION POLICY

At Mountain View Acupuncture our number one priority is for you, the patient, to achieve your maximum health potential. While we will do everything within our scope of practice and training to ensure that you achieve a full recovery. It is important for you to know that your participation in the healing process is just as important as our role as practitioners.

The most important first step in any treatment plan is to arrive on time to all of your scheduled appointments. We allot one hour per patient for every appointment. It has been our experience that this is more than adequate for follow-up treatments. Arriving late to your appointments decreases the amount of time available for questions and most importantly treatment time. We do everything possible to be on time for our patients when they arrive and in turn ask the same of our patients.

Cancellation Policy: I agree to call no less than 24 hours before my scheduled appointment if I must cancel my appointment. Failure to do so may result in my insurance or myself being billed the full amount of my treatment. At the very least I will be charged a **$85 cancellation fee**, due before my next scheduled appointment.

Patient Obligations/ Requirements: As a patient of mountain View Acupuncture, I agree to show up for my regularly scheduled appointments. I agree to follow my acupuncturist's recommendations regarding lifestyle change, including, but not limited to dietary changes, partaking in regular exercise and stretching, following instructions for prescribed herbal formulas and other suggestions my practitioner may make in the interest of my long term health and healing.

By signing below, I acknowledge that:

* I have read, or had read to me, the information on this form and agree to be an active participant in my healthcare.

_____
Patient Name (please print)

_____ _____
Patient or Guardian Signature Date

If a guardian has signed, please print your name: _____

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HISTORY OF PRESENT CONDITION

Chief Complaint: _____

Complaint is a result of: Injury Auto Accident Job Related Other

Date of Injury/ Accident/ Other: _____/_____/_____

Current Treatment of this Condition:

_____

Dates: _____ Doctor/Practitioner: _____

Previous Treatment of this Condition:

Dates: _____ Doctor: _____ Treatment: _____

Dates: _____ Doctor: _____ Treatment: _____

Other: _____

_____

Did you have an MRI or X-Rays taken? _____ If yes, when? _____/_____/_____

What type of treatment, if any, has provided the most relief? _____

What are your goals and expectations for treatment of this condition?

1. _____
2. _____
3. _____
4. _____

What other health concerns would you like to address?

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY

Do you have a family history of any of the following?

Arthritis	Depression	High Blood Pressure
Alzheimer's	Drug / Alcohol Addiction	Mental Illness
Anemia	Epilepsy	Migraine Headaches
Asthma / Hay fever	Glaucoma	Stroke
Cancer	Heart Disease	Other: _____

ALLERGIES

Drug Allergies:_____

Drug Hypersensitivities: _____

Food Allergies: _____

Environmental Allergies: _____

Chemicals / Other: _____

MEDICATIONS & SUPPLEMENTS

Please list all medications that you are currently taking and your reason for taking them:

Type: _____ Dosage: _____ Dates: _____

Type: _____ Dosage: _____ Dates: _____

Type: _____ Dosage: _____ Dates: _____

Type: _____ Dosage: _____ Dates: _____

Other: _____

Have you taken antibiotics frequently throughout your life?_____ If yes, why? _____

Please list all vitamins & herbal supplements that you are currently taking and your reason for taking them:

_____

_____

HOSPITALIZATIONS & SURGERIES

Date: _____ Procedure: _____ MD/ Hosp: _____

Date: _____ Procedure: _____ MD/ Hosp: _____

Date: _____ Procedure: _____ MD/ Hosp: _____

Other: _____

_____

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REVIEW OF SYSTEMS

Please circle: **Y**= current condition **N**= never experienced **P**= past condition

Mental & Emotional
Anxiety **Y N P**
Depression **Y N P**
Mood Swings **Y N P**
Poor Concentration **Y N P**
Poor Memory **Y N P**

Head
Head Injury **Y N P**
Headaches **Y N P**
Migraines **Y N P**
TMJ / Jaw Pain **Y N P**
Teeth Grinding **Y N P**

Eyes
Glasses or Contacts **Y N P**
Dryness / Tearing **Y N P**
Floaters / Spots **Y N P**
Twitching **Y N P**
Blurry Vision **Y N P**
Poor Night Vision **Y N P**
Eye Disease **Y N P**

Ears
Impaired Hearing **Y N P**
Ear Pain / Ache **Y N P**
Tinnitus / Ear Ringing **Y N P**
Dizziness **Y N P**
Vertigo **Y N P**
Ear Disease **Y N P**

Nose & Sinuses
Sinus Congestion **Y N P**
Sinus Infections **Y N P**
Hay Fever **Y N P**
Frequent Colds **Y N P**
Rhinitis **Y N P**
Other:_____

Mouth & Throat
Frequent Sore Throat **Y N P**
Dry mouth **Y N P**
Hoarseness **Y N P**
Halitosis **Y N P**
Dental Cavities **Y N P**
Canker Sores **Y N P**
Enlarged Lymph **Y N P**
Other:_____

Endocrine
Diabetes **Y N P**
Hypo or Hyper-thyroid **Y N P**
Hypoglycemia **Y N P**
Excessive Thirst **Y N P**
Excessive Hunger **Y N P**
Fatigue **Y N P**
Excessive Sweating **Y N P**

Skin
Acne **Y N P**
Lumps **Y N P**
Eczema **Y N P**
Rashes **Y N P**
Itching **Y N P**

Respiratory
Cough **Y N P**
Asthma or Wheezing **Y N P**
Shortness of Breath **Y N P**
Sputum **Y N P**
Bronchitis **Y N P**
Other: _____

Cardiovascular
High Blood Pressure **Y N P**
Angina **Y N P**
Palpitations **Y N P**
Heart Disease **Y N P**
Other: _____

Gastro-Intestinal
Nausea / Vomiting **Y N P**
Constipation **Y N P**
Diarrhea **Y N P**
Abdominal Pain **Y N P**
Heartburn **Y N P**
Acid Reflux **Y N P**
Change in Appetite **Y N P**
Bloating or Gas **Y N P**
Ulcer **Y N P**
Liver Disease **Y N P**

Urinary
Painful Urination **Y N P**
Increased Frequency **Y N P**
Incontinence **Y N P**
Frequent UTI's **Y N P**
Other: _____

Musculoskeletal
Arthritis **Y N P**
Joint Pain **Y N P**
Stiffness **Y N P**
Muscle Spasms **Y N P**
Muscle Cramps **Y N P**
Weakness **Y N P**
Other: _____

Neurological
Numbness **Y N P**
Tingling **Y N P**
Paralysis **Y N P**
Seizures **Y N P**
Dizziness **Y N P**
Vertigo **Y N P**
Poor Balance **Y N P**
Tremor **Y N P**

Vascular
Deep Leg Pain **Y N P**
Cold Hands / Feet **Y N P**
Other: _____

Male Reproduction
Hernias **Y N P**
Testicular Pain **Y N P**
Impotence **Y N P**
Prostate Disease **Y N P**
Herpes **Y N P**
Discharge / sores **Y N P**

Female Reproduction
Painful Menses **Y N P**
PMS **Y N P**
Ovarian Cysts **Y N P**
Cervical Dysplasia **Y N P**
Abnormal Discharge **Y N P**
Breast Tenderness **Y N P**
Irregular Menstruation **Y N P**
Spotting **Y N P**
Dryness or Itching **Y N P**
Difficulty Conceiving **Y N P**
Pain During Intercourse **Y N P**
Hot Flashes **Y N P**
Night Sweats **Y N P**
Herpes **Y N P**
Number of Pregnancies: _____
Number of Births: _____

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LIFESTYLE

Do you exercise? Yes No If yes, what type? _____

How many days per week? _____

How many hours of sleep do you get per night? _____ Do you wake feeling rested? _____

How would you rate your personal stress? _____ Job-related stress? _____

Do you smoke? Yes No If yes, how many years? _____ Packs per day? _____

Alcohol Intake? Yes No If yes, how many drinks per day / week? _____

Caffeine Intake? Yes No If yes, what type? _____ Amount per day?_____

TYPICAL DIET

Breakfast: _____

Lunch: _____

Dinner: _____

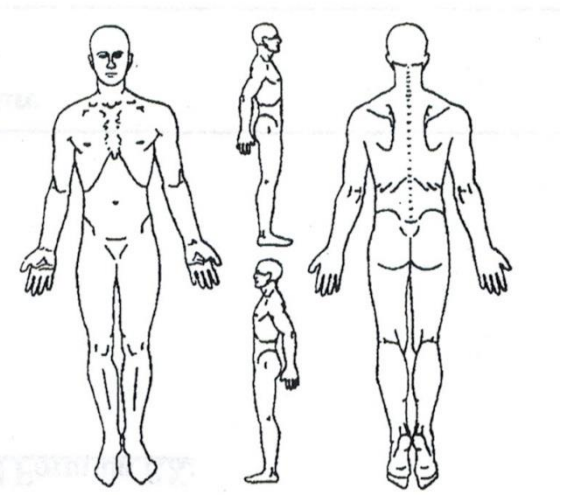
Snacks: _____

Fluid Intake: _____

Food Cravings: _____

MUSCULOSKELETAL PAIN

Location: _____



Type: Sharp Dull Radiates to: _____

Intensity:
1 **10**

Frequency: _____

Duration: _____

Aggravating Factors: _____

Alleviating Factors: _____

Any other information that you would like to include: _____

THANK YOU