Indigo Dragon

Ancient Wisdom • Modern Touch

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.

What is your Chief Complaint? _____

How does this chief complaint affect your life?_____

What is your goal of care for this complaint? _____

Date: _____

First Name	**Last Name**

Address: _____City_____State_____Zip_____

Home Phone: _____ Cell Phone:_____ Email: _____

Emergency Contact _____ Emergency Contact Phone: _____

Person Responsible for your account _____
Who can we thank for referring you? _____

Sex: __M__F Height:_____ Weight:_____ Birth date: _____Age:_____
Marital Status: __ Married __ Single __ Divorced __ Widowed Number of children:_____

Please indicate any significant illnesses you or a blood relative have had:

Illness	You	Relative	**Illness**	You	Relative
Cancer	___	___	Diabetes	___	___
Hepatitis	___	___	Heart Disease	___	___
High blood pressure	___	___	Seizure	___	___
Rheumatic Fever	___	___	Emotional Disorders	___	___
Infectious Diseases	___	___	Tuberculosis	___	___

Sexually Transmitted Diseases: __ gonorrhea __syphilis __ HIV _HPV _chlamydia Date?_____

Please Indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount
Coffee/Black Tea	___	___	_____	Tobacco	___	___	_____
Water Intake	___	___	_____	Recreational Drugs		___	_____
Alcohol	___	___	_____	Soda Pop	___	___	_____

Please Check if any of the following statements are true:

I have known allergies_ I am taking Coumadin/warfarin____ I have a pacemaker____
I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)____

List any medications and supplements you are currently taking: (use back if needed)

Medicine	**Dosage**	**Reason**	**How long**	**Prescribed by**	**Date of last checkup**

For Women

Age of 1st period (menarche)_____Are you pregnant? Yes No # of pregnancies_____

Age of last period (menopause)_____ # of births_____ # of Abortions_____ # of Miscarriages_____

Number of day between periods_____ Date of last Gyn exam_____ Pap smear results_____

Number of days of flow_____ Mammogram_____ Bone Density Scan_____

Color of flow_____ Results_____

Clots? ____Average number of tampons you use per day: 1st____2nd____ 3rd____ 4th____ + days_____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID

Location of Pain: Low abdomen Low back Thighs Other_____

Nature of Pain (Please indicate before, during or after menses)

Cramping_____ Stabbing_____ Discharge Vaginal Dryness Headache

Burning_____ Aching_____ Nausea Constipation Diarrhea

Dull_____ Bloating_____ Swollen breasts Mood Swing Hot flashes

Consistent_____ Night sweating Increased libido Decreased libido

For Men

Date of last prostate check up_____ PSA results_____ Lab results_____

Frequency of Urination: daytime_____ Nighttime_____ Color of urine: clear murky odor:_____

Symptoms related to prostate

Delayed stream Dribbling Incontinence Retention of Urine

Rectal Dysfunction Increased libido Decreased libido Premature ejaculation

Impotence Back Pain Groin Pain Testicular pain

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please mark symptoms you experience.

___lack of appetite
___excessive appetite
___loose stool
___digestive problems, Indigestion
___vomiting
___belching, burping
___heartburn/reflux
___feeling the retention of food in stomach
___tendency to become obsessive in work & relationships
___insomnia, diff sleeping
___heart palpitation
___cold hands and feet
___nightmares
___mentally restless
___laughing for no reason
___angina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or cold in genital
___cough
___shortness of breath
___low sense of smell
___nasal problems
___skin problems
___feeling of claustroph
___bronchitis
___colitis, diverticulitis
___constipation
___hemorrhoids
___recent use of Antibiotics
___eye problems
___jaundice
___difficultydigesting oil
___gall stones
___light colored stoool
___soft or brittle nails
___easily angered
___difficulty w/ decisions
___spasms or twitching muscles

___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones
___decreased sex drive
___hair loss
___urinary impairment
___fatigue
___edema
___blood in stool
___black tarry stool
___bruise easily
___difficult to stop bleeding
___asthma
___tendency to catch colds easy
___intolerance to weather changes
___allergies
___hay fever
___dizziness
___tendency to faint easily
___high cholesterol levels
___sudden weight loss

What other forms of treatment have you had? _____

List any other health problems you have now _____

List any allergies, food sensitivities or food craving that you have_____

List any accidents, surgeries, or hospitalizations (include date)_____

Lab Results: (include copies)

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	____	____	____	____	____	_____
Family	____	____	____	____	____	_____
Diet	____	____	____	____	____	_____
Sex	____	____	____	____	____	_____
Self	____	____	____	____	____	_____
Work	____	____	____	____	____	_____
Exercise	____	____	____	____	____	_____
Spiritual	____	____	____	____	____	_____

Clinical Notes- Acupuncturist's Use Only

Onset

Location

Duration

Characteristics

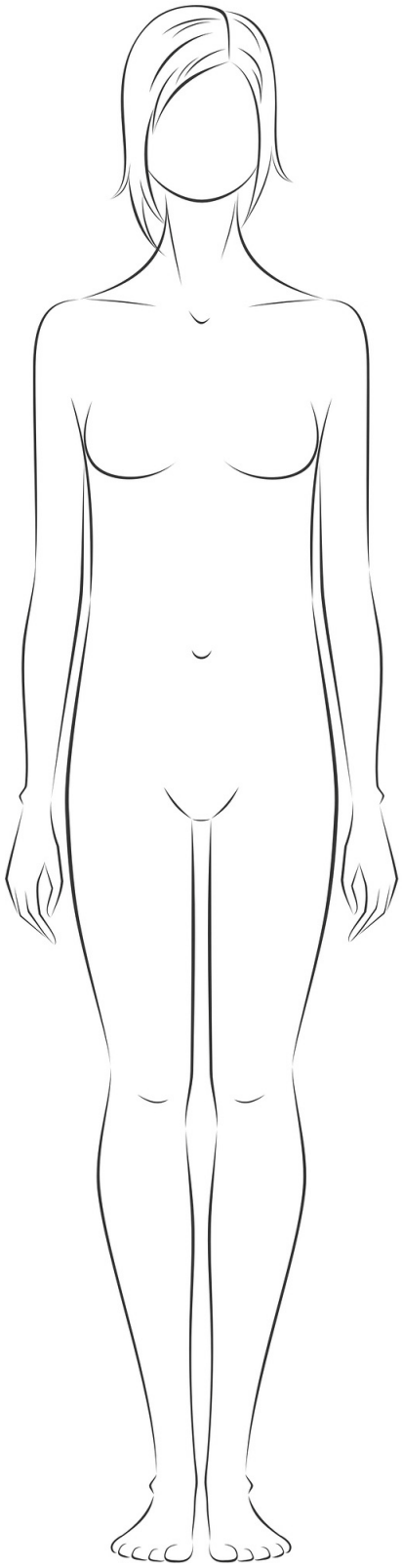
Aggravated/All

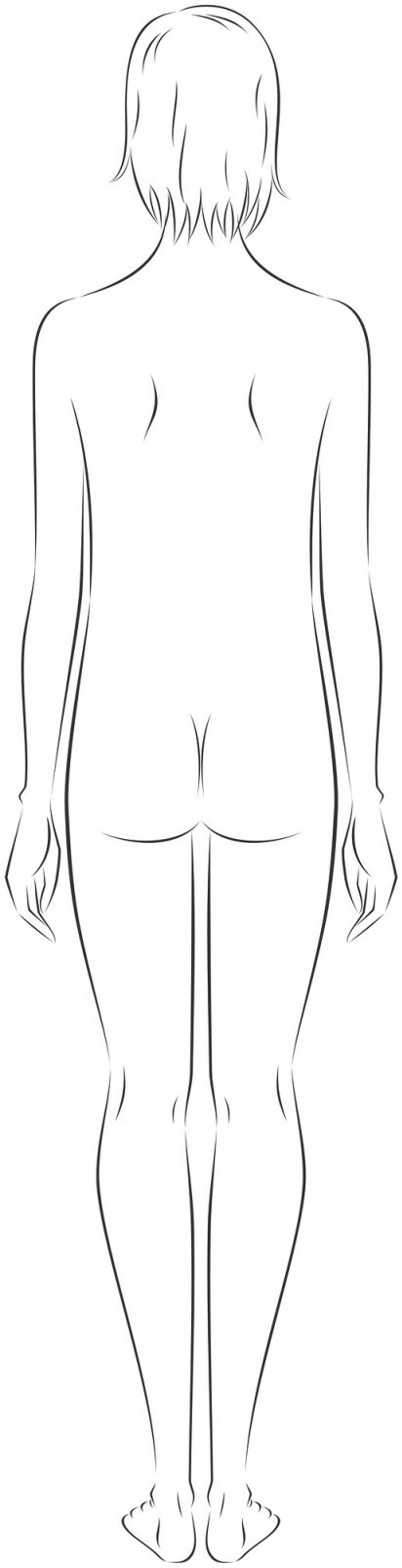
Related Issues

Treatment

Significance

Please indicate areas needing treatment.





Right Left Left Right

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Acupuncture and Oriental Medicine
CONSENT AND RELEASE FORM

I the undersigned do hereby authorize Indigo Dragon Acupuncture, L.Ac. to perform the following:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the body.
- **Electro acupuncture:** Small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Moxa:** Indirect burning of an herbal compound on acupoints using stick or cone moxa.
- **Cupping:** Cups made of glass or other materials are placed on the skin with a vacuum created by heat or suction device.
- **Tui Na:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Nutritional Advice:** Includes diet and herbal recommendations.

I understand the potential benefits and risks of these procedures include:

- **Potential Benefits:** (Including but not limited to): Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.

- **Potential Risks** (Including but not limited to): Discomfort, pain, bruising, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, broken needle, possible aggravation of symptoms existing prior to the acupuncture treatment.

- Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to treatment.

I have had an opportunity to ask Indigo Dragon questions about these procedures, and I voluntarily consent to having them perform one or more of these actions. I understand there are no guarantees that these procedures will cure or improve my condition. In order for Indigo Dragon to perform these procedures, I release them from any and all liability that may occur in connection with my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time. I authorize all practitioners below to perform treatments and to communicate with each other about my medical needs.

Jennifer Fritschy graduated from Southwest Acupuncture College with a Doctorate degree D.O.M.
• Cailfornia License # AC10676
Amy Ligani graduated from Pacific College of Oriental Medicine with a Masters degree M.S.T.O.M
• California License # AC11507
Ashley Lanahan graduated from Bastyr University with a Masters degree M.S.A.O.M.
• California License # AC11360
Kristen Mauer graduated from Pacific College of Oriental Medicine with a Masters degree M.S.T.O.M.
• California License # AC 19422

X _____ _____

Signature of patient (or guardian if under 18) **Date**

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CONFIDENTIALITY AND PAYMENT AGREEMENT

Indigo Dragon Acupuncture follows HIPAA guidelines. If you have not received a copy of the Notice of Privacy Practices explaining these guidelines and how we implement them, you may request one from our office.

Please read thoroughly and acknowledge that you will adhere to the following payment policies:

- If I **am not** covered by insurance, I am responsible for the paying fees at the time of service. Accepted forms of payment are personal checks, Visa and MasterCard. I will receive a $25.00 service charge for non-sufficient funds.

- If I **am** covered by insurance, I understand that services of acupuncture may not be covered under my plan. Common reasons are: deductibles are not met, maximum number of treatments has been used, condition that I am being treated for are not covered by my insurance.

- Outstanding balances that my insurance company does not reimburse will be my responsibility, and will be charged to billed form. Accepted forms of payment are personal checks, Visa and MasterCard. I will receive a $25.00 service charge for non-sufficient funds, and late payments are due within 30 days of notice.

- If I opt to submit insurance claims on my own behalf, I will be provided a Superbill to submit to my insurance company.

- I will inform Indigo Dragon Center 24 hours in advance should I need to cancel an appointment, or I may be held responsible for an appointment fee.

- I understand herbal products are non-returnable items.

I have read and agree to the above terms:

_____ _____

Signature of patient (or guardian if under 18) **Date**

NEW