MODERN EDGE Acupuncture

Amber Kreiger, L.Ac.
Lynden Day Spa
1610 Grover Street, Ste B3
Lynden, WA 98264
Cell: 360-318-6030
ModernEdgeAcupuncture@gmail.com

Modern Edge Acupuncture Health Intake Form

Name: _____ **Date:** _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ **Age:** _____ **Sex:**_____(fill in the blank)

Marital status: o Married o Divorced o Single o Separated o Widowed o Partnered

Address:_____**City:** _____
State: ____ **Zip:** _____ **Cell Phone:** _____**Home Phone:**_____
Which number would you prefer to be reached at? C H **Email:** _____

Occupation: _____ **Employer:** _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Who may we thank for referring you? _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Name of your primary physician: _____**Other providers seen (Chiropractors, Physical Therapists, etc.):**_____

Medication(s) you are currently taking? If you have a large list please write on attached sheet of paper.

Name:	For Treatment of:	Dosage:	Start Date

Supplements (if any- vitamins, herbs, minerals, etc.):_____
_____
_____
_____

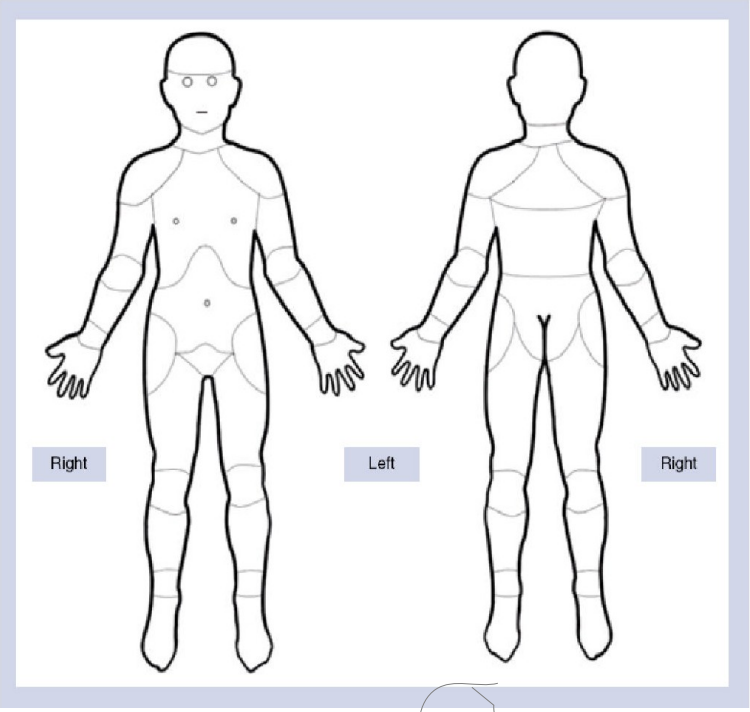
Major Concerns (in order of significance to you):

1	4
2	5
3	Additional

How do these concerns impair your daily activities?_____
_____
_____

Patient Medical History : Please list any relevant health history information,such as surgeries, western medical diagnosis, and/or diagnostic tests (like X-ray, MRIs, Blood test results):_____
_____
_____

Musculoskeletal: On the figures below, please mark clearly any areas of pain and discomfort:



Circle your type of discomfort: Sharp Fixed Burning Moving Cramping Aching Dull Throbbing Tingling Numbness Tightness

Describe:_____
_____
_____
_____
_____
_____
_____
_____

In the following categories, please circle any that you experience now and underline any that you have experienced in the past.

Emotional:

Mood Swings Nervousness Irritability Worry Anxiety Depression Unmotivated

Energy and Immuniity:

Fatigue Wired Chronic Infections Autoimmune Condition:_____

Head, Eye, Ear, Nose, and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Throat Clearing Throat Irritation Post nasal drip Eye Twitching Runny nose

Respiratory:

Pneumonia Frequent Common Colds/Flus Difficulty Breathing Emphysema

Persistent Cough Allergies Asthma Tuberculosis Shortness of Breath

Wheezing Other Respiratory Problems:_____

Cardiovascular:

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Lightheadedness

Palpitations/Fluttering Stroke Heart Murmurs Varicose Veins Other:_____

Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Irritable Bowl Syndrome Passing Gas

Heartburn/GERD Belching Hemorrhoids Food Allergies/Sensitivities:_____

GallBladder Disease Liver Disease Abdominal Pain Chron's Disease Ulcerative Colitis

Constipation Diarrhea Alternating Constipation & Diarrhea Nervous Stomach

Genito-Urinary Tract:

Kidney Disease Painful Urination Frequent UTI Frequent Urination Kidney Stones

Incomplete Urination Blood in Urine Frequent Urination at Night (#of times):_____

Female Reproductive/Breasts:

Irregular Cycles Breast Lumps/Tenderness Painful Intercourse Heavy Flow Clotting

Vaginal Discharge Premenstrual Problems Bleeding Between Cycles Menopausal Symptoms

Difficulty Conceiving Painful Periods Mid-cycle/Ovulation Pain Other:_____

Menstrual/Birthing History:

1. Age of First Menses: _____4. Birth Control Type: _____7. # of Abortions: _____

2. # of Days of Menses: _____5. # of Pregnancies: _____8. # of Live Births: _____

3. Length of Cycle: _____6. # of Miscarriages: _____9. # of Children:_____

Male Reproductive:

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Premature Ejaculation Erectile Dysfunction Painful Intercourse Other:_____

Neurologic:

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine:

Hypothyroid Hypoglycemia Hyperthyroid Night Sweats Feeling Hot or Cold Diabetes: Type1 or 2

Other:

Anemia Cancer Rashes Eczema/Hives Psoriasis Rib Side Pain Cold Hands/Feet

Easily Bruise HIV/Sexually Transmitted Diseases:_____

Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. How would you rate your average energy level, 0 to 10, with 10 being high energy?_____

c. Exercise routine:_____

d. How would you rate your average stress level, 0 to 10, with 10 being high stress?_____

e. Stress reduction tools: _____

f. How many hours per night do you sleep? _____Do you wake rested? Y N

g. Do you enjoy work? Y N Why/Why not?_____

h. Nicotine/Alcohol/Caffeine/Cannabis Use:_____

_____

_____

i. Have you experienced any major traumas? Y N Explain: _____

_____

_____

j. How many glasses of water do you drink per day? _____

Is there anything else we should know?

_____

_____

_____

_____

_____

_____

_____

_____

FOR OFFICE USE:

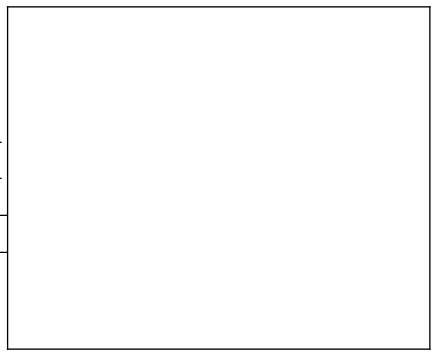
Tongue Qualities:

_____

_____

_____

_____



		cun	guan	chi
RIGHT HAND	S			
	M			
	D			

		cun	guan	chi
LEFT HAND	S			
	M			
	D			

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Modern Edge Acupuncture Informed Consent Form & Cancellation/Missed Appointment Policy

WAC 246-802-120 Patient Informed Consent The law states that patients receiving acupuncture must give their informed consent prior to receiving treatment. Informed consent is for the patient to be advised of the credentials of the practitioner and the scope of practice of acupuncture in the state of Washington.

Practitioner's Qualifications:
Amber Kreiger, L.Ac. received her acupuncture license from the state of Washington (# AC 60068855) on February 24, 2009. She graduated from the Pacific College of Oriental Medicine, Chicago, IL in 2008. She holds a Diplomate in Oriental Medicine from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

Scope of Practice for WA Acupuncturists: As stated by law, Licensed Acupuncturists in the state of Washington are allowed to use the methods listed below as therapy:
1) Use of acupuncture needles to stimulate acupuncture points and muscular motor points
2) Dietary advice based on Traditional Chinese Medical theory (this can be interpreted to include Chinese herbal therapy)
3) Acupressure (this actually can be any form of soft tissue manipulation except joint manipulation)
4) Dermal friction technique (gua sha)
5) Point injection therapy 6) Moxibustion 7) Cupping 8) Infra-red light 9) Laser-puncture 10) Sono-puncture 11) Use of electrical stimulation

Side Effects: Side effects from the above may include, but are not limited to
a) Some pain in the insertion area following treatments (you may feel like you were stuck with a needle)
b) Minor bruising (at the point of insertion or surrounding area)
c) Infection (We use only pre-sterilized disposable needles, so your chances of contracting a disease are very minimal, however whenever the skin barrier is broken, one stands a chance of infection)
d) Needle shock (fainting from the insertion of the needle such as when you have blood drawn)
e) A broken needle (very rare since the needles are not reused and reheated after each use, however still possible)
f) Herbal and nutritional supplements traditionally are considered safe in the practice of Traditional Chinese Medicine. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I hereby request and consent to the performance of acupuncture treatments and other treatments and other procedures within the scope of acupuncture on me (or on the patient named below for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or are serving as back-up for the acupuncturist named above.

Patient Signature (or parent/guardian):_____Date:_____

Patient's Printed Name: _____

Agreement by the Patient Regarding Cancelled/Missed Appointments

Patient understands that a missed appointment (No Show) will result in a $50 charge for that appointment, as well as if the patient fails to give the spa 24 hours notice of a change of appointment.

Patient Signature: _____ Date: _____

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Modern Edge Acupuncture Privacy Policy Form

Notice of Privacy Practices: As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

• We may use or disclose your health information for our normal healthcare operations. For example we may enter your information into our computer.
• We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
• We may use information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you of your appointments. If you are not at home, We may leave this information on your answering machine or with the person who answers your telephone.
• In an emergency, we may disclose your health information to a family member or another person responsible for your care.
• We may release some, or all, of your health information when required by law.
• Except as described above, this practice will not use or disclose your health information without your prior written authorization.
• You may request in writing that we not use or disclose your health information as described above, We will let you know if we can fulfill your request.
• You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
• Because we may need to contact you from time to time, we will use whatever address or telephone number you prefer.
• You have the right to transfer copies of your health information to another practice. We will mail your files for you.
• You have the right to see and receive a copy of your health information, with a few exceptions. Give us written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies, $23 administrative fee, plus .15 cents per page copied.
• You have the right to request and amendment or change to your health information. Give us your request to make changes in writing. If you want to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
• You have the right to receive a copy of this notice.
• If we change any of the details of this notice, We will notify you of the changes in writing.
• You may file a complaint with the Department of Health and Human Services, 200 Independence A venue, SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Acknowledgement: Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

Patient Signature (or parent/guardian):_____Date:_____

Patient's Printed Name:_____