Medical History
(short answers needed – pls fill in *entire* form)

Patient Name_____ Date:_____

Address:_____City:_____State:_____ Zip:_____

Phone: (best one to reach you)_____DOB:_____

E-Mail _____ Referred by:_____

Today's Complaint:_____
_____
_____

Current Health Care Provider (Name &
Contact)_____

Body Temperature
General Body Temp: hot_____ cold_____ body area(s) affected_____
When do you get a sense of the temperature changes?_____
Perspiration with exercise_____ night _____ spontaneous_____ other_____
If perspiration has unusual odor - pls describe odor: _____
Notes:_____
_____

Diet/Nutrition
Foods you eat: starches____ fats _____ protein_____ sweets_____ grains_____ veggies_____
Foods you avoid:
_____
After eating pls describe how you feel: tired_____ energized_____ other_____
Specific cravings:_____
Temperature preference of food & beverages: warm_____ hot_____ cold_____
Currently experiencing specific taste in mouth, if so what?_____
Notes:_____

Medications/Supplements/Drugs
Prescription drugs currently using:_____
Pharmaceutical allergies: _____
Vitamins/Supplements:_____
_____
Recreational drugs:_____
Alcohol: currently? _____ in past?_____ amount/day_____
Caffeine: currently? _____ in past?_____ amount/day_____
Tobacco: currently? _____ amount/day_____
Notes:_____

Elimination
Urination: # times/day_____ # times/night_____ what hours of day & night?_____
color_____ cloudy_____ does it feel complete or is there retention_____
burning_____ scanty_____ profuse_____ dribbling_____
other_____
Notes_____
Stools**:** # times/day_____ times of day_____ feels complete?_____
difficulty elimination?_____ if unusual odor - pls describe_____
Consistency: hard_____ loose_____ alternating hard/loose_____soft_____ formed_____

does it contain: undigested food (other than corn) _____ blood_____ mucous_____
Notes:_____

Sleep
hrs/night_____ time you go to bed_____ time you get up for day _____ feel rested upon waking?_____
trouble waking?_____trouble falling asleep?____ wake up during night?_____ time(s) you wake at night?_____
trouble going back to sleep?_____dreams?_____ if yes, sleep disturbing?_____
Notes:_____

Energy
Exercise: type(s)_____ frequency/week_____
Current energy level (scale of 1-10, 10 being best)_____ Best time of day?_____ worst? _____
energy level fluctuate throughout day?_____
Notes:_____

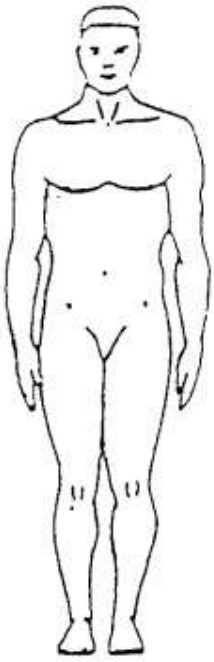
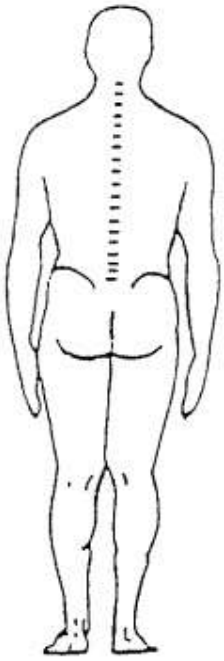
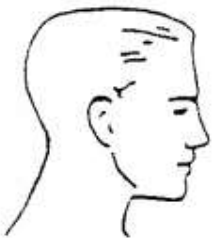
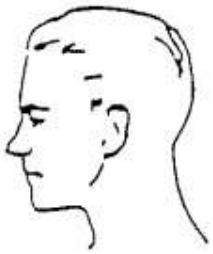
Emotions
Describe your emotions at this time_____
If significant past emotional states - pls describe_____
Pls describe childhood emotions_____
Notes:_____

Body System Review
Headaches: Frontal_____ Temple_____ Top_____ Back_____ Frequency_____
Pls describe quality of pain_____
What triggers headache?_____ dizziness_____ numbness/tingling_____
Eyes: red_____ itchy_____ watery_____ blurry_____ floaters_____ frequency of floaters_____
Grit/sleep in eye _____ decreased night vision _____ glasses_____ reason for _____
How long have you worn glasses_____ other eye problems_____
Ears: ringing_____ hi vs. low pitch_____ discharge_____ Nasal discharge: _____
Gums: bleeding_____ other _____ Teeth: sensitivities_____ cavities_____ loose_____
Throat: swollen/sore glands_____ neck/shoulder tension_____
Joints: pain/swelling_____ whichjoint(s)_____
Other:
Abdominal pain:_____ palpitations_____ heaviness in chest_____ shortness of breath_____
If yes to any of 'Other' - pls state what triggers_____
Notes:_____

Pain

If pain anywhere on body please state if it's fixed, moves, location, better/worse with pressure, cold, movement.
_____
_____
_____

Please mark areas of pain on diagram below:

Females

Menses: Date of last_____ pregnant now_____ age of menarche_____ # days in cycle_____ color of blood_____
Mid cycle pain_____ clots_____ flow_____ pain/cramping_____ tender breasts_____
cravings_____ irritability_____ mood changes_____ fatigue_____ birth control method_____
pregnancies_____ # full term _____ # premature_____ # miscarriages/abortions_____ menopause_____
age of onset_____ hot flashes_____ night sweats_____ vaginal discharge: Y__ N___ Odor_____
Pls describe_____
Notes:_____

Males

Prostate problems - pls state_____ impotence_____ premature ejaculation_____
Diseases_____ sexual energy (scale of 1-10, 10 being best) _____ other:_____
Notes_____

Please note this record will be kept confidential and will not be released to any person or agency without your written authorization.

I affirm that I have stated my known medical conditions and answered all questions honestly.

Signature:_____Date:_____

Office Policies and Financial Agreement

The fees for office services, supplements and supports are payable in full at the time of your visit unless other arrangements have been made. If it is necessary for you to cancel/reschedule an appointment, a **FULL 24 HOURS NOTICE** is required to avoid being charged. Any appointment cancelled or rescheduled without 24 hours notice **will be charged for a full office visit.** Please realize this time has been reserved for you and another person in need of care will be able to have time with the acupuncturist when 24 hours notice is given. Additionally, if you are more than 20 minutes late for your appointment, it may not be possible to accommodate you. *Your respect of this is appreciated.*

Any charges denied or unpaid by your health provider insurance company is your responsibility and you agree to pay the balance to Bonnie Cashwell LAc,/Balancing Acupuncture. If incorrect information is provided to your acupuncturist by your insurance company resulting in additional charges to your account, Bonnie Cashwell, L.Ac./Balancing Acupuncture is not responsible. If you are a patient who has had a non-work related accident, automobile or other injury, it is your responsibility to provide your acupuncturist with name and address of all responsible insurance companies and of your attorney.

I have read, understand and agree to the above policies.

Name (print)_____

Signature_____Date:_____

Name of child for whom I am parent/legal guardian_____

Disclosure Statement

Education and Experience: Bonnie Cashwell earned her Master of Science and Oriental Medicine degree from Southwest Acupuncture College in Santa Fe, NM - April 2009. This was a 3,045 hour education including 1140 hours of clinical practice. She is certified as a Diplomate in Oriental Medicine including Foundations of Oriental Medicine, Chinese Herbology, Acupuncture with Point Location and Biomedicine. Bonnie is certified in Clean Needle Technique. Additional training includes: qi gong, cupping, auricular acupuncture, tui na, acupressure, moxibustion, dietary and lifestyle recommendations.

Bonnie is currently licensed in North Carolina as an acupuncturist. No licenses, certificates or registrations have ever been suspended or revoked. Balancing Acupuncture complies with rules and regulations promulgated by the North Carolina Acupuncture Licensing Board (NCALB), including proper acupuncture office sanitation. Single-use, disposable, factory-sterilized needles are the only type of needles utilized.

Patient's Rights

⇒The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy, if known.
⇒The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
⇒In a professional relationship, sexual intimacy is never appropriate. **Attention males: flirtatious behavior or sexual innuendos are both inappropriate and unwelcomed.**

The practice of acupuncture is regulated by the NCALB. If you have comments, questions or complaints, contact them at PO Box 10686, Raleigh, NC 27605, 919-821-3008.

I have read and understand this document.

_____ _____

Patient's or Guardian's Signature Date

Informed Consent to Health Care by a Licensed Acupuncturist

I hereby request and consent to the performance of the following on me (or the patient named below for who I am legally responsible) by Bonnie Cashwell, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Bonnie Cashwell, L.Ac., including those working at this clinic or any other associated clinic: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, manual palpation on a variety of areas of my body, observation, range of motion evaluation, muscle, orthopedic and neurologic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal as well as dietary supplements; dietary recommendations; advice regarding exercise regimens and lifestyle counseling.

I have had an opportunity to discuss with Bonnie Cashwell, L.Ac. and/or other clinic personnel the nature and purpose of acupuncture and oriental medical procedures. I understand that although acupuncture and other oriental medical procedures have helped millions of people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine there are some risks to treatment. I understand that while unlikely, possible risks include, but are not limited to: bleeding, bruising, pneumothorax (puncture of lung), puncture of other organs, pain or other strong sensations at the location where the needle is inserted or radiating from that location, nerve pain, burns, aggravations of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocations, fractures, disc injuries and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the acupuncturist's judgment based on the facts known at the time.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedures. 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.

_____

The following is to be completed by the patient or the patient's representative. If necessary, e.g., the patient is a minor or in any way incapacitated.

_____ _____

Patient Name (printed) Patient's Representative (printed)

_____

Patient's Signature or Patient's Representative Signature

_____ _____

Date Signed Relationship of Patient's Representative

HIPAA Notice of Privacy Practices

As effort to reduce use of paper, please ask to see this document when you arrive at the clinic. Your signature indicates you have asked to see it and have been provided the HIPAA document to read.

_____

Print Name

_____ _____

Signature Date