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:_____

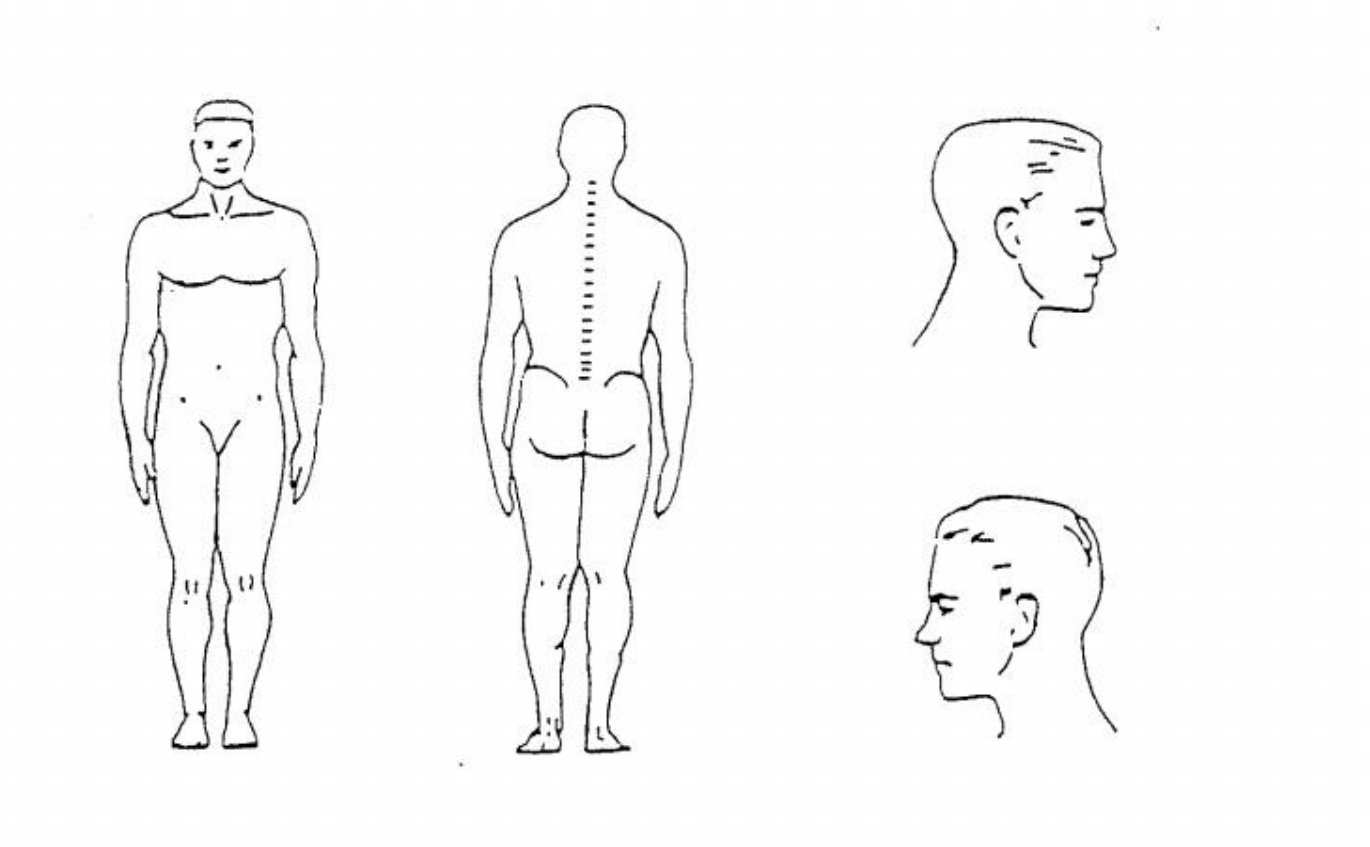
Emotions
Describe your emotions at this time_____
If significant past emotional states - pls describe_____
Pls describe childhood emotions_____
Notes:_____

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

Balancing Acupuncture
Bonnie Cashwell, MSOM, DIPL OM, L.Ac.
919-604-2735

HYPOCHLORHYDRIA QUESTIONNAIRE

1.___ belching or gas within 1 hour after eating

2. ___ heartburn or reflux

3. ___ bloating w/in 1 hour after eating

4. ___ vegan diet (void of meat, fish, dairy, eggs)

5. ___ strong odor when sweating

6. ___ vitamins upset your stomach

7.___ halitosis

8. ___ loss of taste for meat *

9. ___ feel like skipping breakfast

10. ___ feel better if don't eat

11. ___sleepy after food intake

12. ___ excess fullness sensation after eating with normal quantity of food intake

13. ___fingernails chip, peel, break easily *

14. ____ anemia unresponsive to iron

15. ____ stomach pain/cramping

16. ____ chronic diarrhea

17. ___ diarrhea soon after meals

18. ___ undigested food in stool

19. ____ black or tarry colored stool

20. ___ head injury - ever

* low mineral content - need HCL to absorb minerals & protein

1230 SE Maynard Rd, Ste 203
Cary, NC 27511

Medicare Opt Out Contract

Bonnie Cashwell, Lac is not a Medicare provider and is exempt from providing Medicare coverage effective under sections 1128, 1156 or 1892 of the Social Security Act.

By signing this contract, you agree to the following:

As either a patient or as a patient's legal representative, I _____ accept full responsibility for payment of charges for all services furnished by Bonnie Cashwell, LAc.

I understand the Medicare limits do not apply to what Bonnie Cashwell, LAc or her staff may charge for items or services furnished by Bonnie Cashwell, LAc.

I agree not to submit a claim to Medicare or any Medicare Advantage Plan. I will not ask Bonnie Cashwell, LAc to submit a claim to Medicare of any Medicare Advantage Plan.

I understand the Medicare payment will not be made for any items or services furnished by Bonnie Cashwell, LAc that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. I understand that I have the right to obtain Medicare-covered items and service from physicians and practitioners who have not opted out of Medicare. I am not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioner who have not opted out.

I also understand the Medigap plans do not, and that other supplemental plans may elect not to make payments for items and services not paid for by Medicare.

Patient Signature:_____ Date:_____

Patient's Legal Representative (if applicable): _____ ate: _____

Bonnie Cashwell, LAc signature_____ Date: _____

Medicaid Opt Out Contract: As either a patient or as a patient's legal representative, I _____ accept full responsibility for payment of charges for all services furnished by Bonnie Cashwell, LAc who is not a participating provider with North Carolina Medicaid and does not accept Medicaid as payment for medical services. If I am a patient who is or becomes eligible for North Carolina Medicaid, I understand I have the right to seek treatment with another provide that accepts North Carolina Medicaid. I or my legal representative agree to be held financially responsible for payment for services rendered by Bonnie Cashwell, LAc or her staff.

_____	_____	_____
Practitioner Name	Practitioner Signature	Date
_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Patient Legal Representative	Patient Legal Representative Signature	Date

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____