



Wedgwood Acupuncture & Botanical Medicine

8034 35th Ave. NE. Seattle, WA 98115 Tel: (206) 525-1328; Fax: (206) 524-2276

Dear new patient,

Thank you for making an appointment at Wedgwood Acupuncture & Botanical Medicine Clinic.

We have enclosed our new patient forms for you to fill out. If your health insurance plan can cover your acupuncture treatment, please call your insurance company, and complete our INSURANCE VERIFICATION FORM. We have also enclosed our INFORMED CONSENT FORM to familiarize you with our office procedures. Please read, complete, and sign these forms and bring them with you to our clinic on your initial visit date.

If you are from South:

1. Merge onto **I-5 NORTH** toward **VANCOUVER BC**.
2. Take exit **#171/WA-522** onto **NE 73RD ST** - go **0.5** mi.
3. Turn **LEFT** on **12TH AVE NE** - go **0.1** mi.
4. Turn **RIGHT** on **NE 75TH ST** - go **1.2** mi.
5. Turn **LEFT** on **35TH AVE NE** - go **0.3** mi.
6. Arrive at **8034 35TH AVE NE, SEATTLE**, on the **RIGHT**.

If you are from North:

1. Merge onto **I-5 SOUTH** toward **SEATTLE**.
2. Take exit **#172/N 85TH ST** onto **CORLISS WAY N** - go **0.6** mi.
3. Bear **LEFT** on **NE 80TH ST** - go **0.1** mi.
4. Turn **RIGHT** on **BANNER WAY NE** toward **N.E. 75TH ST.** - go **0.3** mi.
5. **BANNER WAY NE** becomes **NE 75TH ST** - go **1.4** mi.
6. Turn **LEFT** on **35TH AVE NE** - go **0.3** mi.
7. Arrive at **8034 35TH AVE NE, SEATTLE**, on the **RIGHT**.

If you are from Bellevue:

1. Merge onto **WA-520 WEST** toward **SEATTLE**.
2. Take the **MONTLAKE BLVD** exit - go **1.6** mi
3. Continue on **NE 45TH ST** - go **0.3** mi.
4. Bear **LEFT** on **NE 45TH PL** - go **0.2** mi.
5. Bear **LEFT** on **35TH AVE NE** - go **1.7** mi.
6. Arrive at **8034 35TH AVE NE, SEATTLE**, on the **RIGHT**.

If you are from Bothell/Lake City Way:

1. Merge onto **NE BOTHELL WAY/LAKE CITY WAY NE** toward **SEATTLE**.
2. Turn **LEFT** on **NE 95TH ST** - go **0.7** mi.
3. Turn **RIGHT** on **35TH AVE NE** - go **0.7** mi.
4. Arrive at **8034 35TH AVE NE, SEATTLE**, on the **LEFT**.

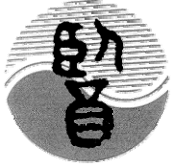
Your appointment time is reserved especially for you. If you are unable to keep the appointment time, please give us 24 hours notice. If you have any other questions, please call (206) 525-1328.

See you soon!

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INSURANCE VERIFICATION FORM

Please call your insurance company and complete this form by asking the following questions.

Patient name: _____

Date of call: _____ Time: _____ Spoke to: _____

Insurance Co: _____ Phone #: (____) _____

Insured: _____ Relation to Patient: _____

Policy #: _____ Group #: _____

1. Is Acupuncture covered on this plan? Yes / No
2. Is a referral required from my Primary Care Physician? Yes / No
3. Is pre-authorization required? Yes / No
4. Am I limited to specific diagnosis codes? Yes / No
(If yes, does one of these codes apply to your illness? Yes / No)
(If no, stop here)
5. Is there a deductible? Yes / No
If yes, what is the deductible? \$ _____
How much has been met? \$ _____
6. Is there a maximum yearly benefit for Acupuncture? Yes / No
Is that per calendar year / fiscal year / renewal date?
_____ # of visits per year. _____ # of visits used year to date.
\$ _____ of Acupuncture care per year. \$ _____ used year to date.
7. What percentage is covered? _____ %
8. Is there a co-payment or leftover percentage that I am responsible for?
 Yes / No If yes, what is it? \$ _____
9. Does my plan cover herbal prescriptions? Yes / No
10. Are benefits for other forms of alternative health care (Chiropractic, Massage, Naturopathic) taken from the same pool as Acupuncture?
 Yes / No

Claims Address: _____

City: _____ State: _____ Zip: _____

Please note, benefits stated by a representative cannot be guaranteed.

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ACUPUNCTURE AND ORIENTAL MEDICINE INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the private practitioners of Wedgwood Acupuncture and Botanical Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique used to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

Gua Sha: rubbing on an area of the body with a blunt, round instrument.

Heating Lamp or Pad: produces heat on the acupoints or meridian areas to relieve symptoms.

Laser Acupuncture: use of laser light on acupoints and meridians.

Electrical Acupuncture: use of electrical device to produce electrical stimulation on the acupuncture needles.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of the symptoms prior to the acupuncture treatment.

Potential Benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: We do not use labor stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the doctor if they know or suspect that they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Wedgwood Acupuncture and Botanical Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Wedgwood Acupuncture and Botanical Medicine may have a precept student for observation only. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment.

Date

Signature of Patient, Patient Representative or Guardian

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PATIENT INFORMATION

NAME:	DATE OF BIRTH:
HOME PHONE: OK to Call? Yes () No () Emergency Only ()	WORK PHONE: OK to call? Yes () No () Emergency Only ()
HOME ADDRESS: NUMBER & ST CITY, STATE & ZIP	PLACE OF BUSINESS: POSITION HELD SOCIAL SECURITY #:
PERSON TO CONTACT IN EMERGENCY:	RELATIONSHIP TO PATIENT:
COMPLETE ADDRESS OF ABOVE PERSON:	HOME PHONE: WORK PHONE:

INSURANCE INFORMATION

INSURANCE COMPANY NAME:	GROUP NUMBER:
SUBSCRIBER:	SUBSCRIBER ID#
Is your condition related to work, injury, or auto accident? (Specify)	

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I, the undersigned, have insurance coverage with (name of the insurance company or write "none" if uninsured) _____ and assign directly to Wedgwood Acupuncture and Botanical Medicine Clinic all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize your clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian/Patient _____ Date _____

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PATIENT HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name:		Date:	
Sex:	Age:	Date of Birth:	Place of Birth:
Height:		Weight:	Occupation:
Relationships: <input type="checkbox"/> Married		<input type="checkbox"/> Divorced/separated	<input type="checkbox"/> Widowed
<input type="checkbox"/> Single		<input type="checkbox"/> Cohabiting	<input type="checkbox"/> Homosexual/Bisexual
Regular Health Provider:		Specialty:	Phone:
Date of Last Medical Care:		Reason:	
Diagnosis of Problem: (If available)		May we contact your health care provider concerning your records? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Referred to this office by : Dr. <input type="checkbox"/> Friend <input type="checkbox"/>			
Internet <input type="checkbox"/> Yellow pages <input type="checkbox"/> Ads <input type="checkbox"/> Others <input type="checkbox"/>			
Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had an acupuncture treatment before?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Are you nervous about needles?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a tendency to faint?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Do you bleed for a long time or bruise easily?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Are you extremely hungry at the present time?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Are you extremely tired right now?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have diabetes?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have hepatitis or AIDS?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Have you ever had hepatitis?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a pacemaker?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Are you taking any medications now?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Are you undergoing any other treatment therapies now?			
Yes <input type="checkbox"/> No <input type="checkbox"/> Women - are you pregnant?			

PRESENT HEALTH

What do you consider to be your most important health problem?
Reason for today's visit? (Specify)

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FAMILY HISTORY

<p>Has any blood relative had any of the following?</p> <p>Cancer <input type="checkbox"/> Allergies <input type="checkbox"/> TB <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Others:</p>	<p>General state of health/age of your parents & siblings: (If deceased, state cause)</p>
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MEDICAL HISTORY

<p>Past major illnesses:</p>	<p>Major accidents, falls, etc. :</p>
<p>Hospitalizations/surgeries/radiation treatments:</p>	<p>Location of all major scars:</p>
<p>Allergies to drugs, chemicals, foods, environment:</p>	

LIFESTYLE

<p>Work environment: What type of stress (chemical, physical and psychological) do you have in your job?</p>	<p>Exercise: Do you have a regular exercise program? If yes, describe it.</p>
<p>Sleep: Average hours of sleep each night</p> <p>Do you have difficulty sleeping? Often <input type="checkbox"/> sometimes <input type="checkbox"/> never <input type="checkbox"/></p> <p>Do you dream? Often <input type="checkbox"/> sometimes <input type="checkbox"/> never <input type="checkbox"/></p> <p>What type of dream:</p>	<p>Leisure: Describe your primary interests or hobbies.</p>

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Diet:
 Are you satisfied with your present diet? yes no explain:
 List any foods that you crave:
 List any foods that give you a bad reaction:
 List all the foods and the time you eat on an average day:
 Breakfast at Lunch at Dinner at Snacks at

Food:.....	Food:.....Food:.....	Food:.....
.....
.....

Medicine and drugs: (List any medicines, vitamins, herbs and their dosage, taken in the past month.)

Smoking: Don't smoke Quit, when Cigarettes per day Cigars per day	Drinking: Coffee/tea/cola per day Beer/wine per day Liquor per day	Other drugs used: Marijuana, cocaine, etc. Never/Rarely Sometimes Often
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REVIEW OF SYSTEM

If you are having any of the following problems at this time, please place a check on the line in front of it. Also, fill in the blanks where indicated.

General Condition			
<input type="checkbox"/> Fever	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Strong thirst (cold or hot drink)	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Feelings of heat
<input type="checkbox"/> Chills	<input type="checkbox"/> Hot soles & palms	<input type="checkbox"/> Feelings of cold	<input type="checkbox"/> Energy drop at _____ (time of day)
<input type="checkbox"/> HIV (+) or AIDS	<input type="checkbox"/> Easily fatigued	<input type="checkbox"/> Energy drop at _____ (time of day)	
Skin and hair			
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Rashes	<input type="checkbox"/> Hives	<input type="checkbox"/> Pimples
<input type="checkbox"/> Itching	<input type="checkbox"/> Dry skin or hair	<input type="checkbox"/> Oil skin or hair	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Recent moles	<input type="checkbox"/> Abnormal growths	<input type="checkbox"/> Sores or wounds do not heal	
Head, Eyes, Ears, Nose, and Throat			
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Dizziness or vertigo
<input type="checkbox"/> Glasses	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Color blindness	<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Earaches	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Nasal stuffiness	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Recurrent sore Throats
<input type="checkbox"/> Dry throat/mouth	<input type="checkbox"/> Lots of saliva	<input type="checkbox"/> Persistent hoarseness	<input type="checkbox"/> Sores on lips/tongue
<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Gum problems	<input type="checkbox"/> Grind teeth	
Neuropsychological system			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Concussion
<input type="checkbox"/> Easily stressed	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety/ fear	<input type="checkbox"/> Bad temper
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Overwhelming joy	<input type="checkbox"/> Treated for mental problem	
<input type="checkbox"/> Don't know how to relieve stress			

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Cardiovascular System			
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain & tightness	<input type="checkbox"/> Fast heartbeat
<input type="checkbox"/> Slow heartbeat	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Fainting	<input type="checkbox"/> Swelling in limbs
<input type="checkbox"/> Leg pain when walk	<input type="checkbox"/> Leg vein trouble	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> High cholesterol
Pulmonary System			
<input type="checkbox"/> Cough	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tight chest	<input type="checkbox"/> Coughing with blood
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Color of sputum _____
<input type="checkbox"/> Frequent catching colds & flu			
Gastrointestinal System			
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Belching	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Bloating after meals	<input type="checkbox"/> Acid reflex
<input type="checkbox"/> Gas/cramping	<input type="checkbox"/> Loose stools	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Black stools
<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Bowel movements frequency _____ times.	
Hepatic and Biliary System			
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hypochondric pain	<input type="checkbox"/> Gall stone
<input type="checkbox"/> Cholecystitis	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Ascites	<input type="checkbox"/> Liver enlargement
Genitourinary System			
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Burning urination	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Urgent need to urinate
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Urine scanty and dark	<input type="checkbox"/> Edema
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> STD	<input type="checkbox"/> Prostate trouble
<input type="checkbox"/> Discharge from penis	<input type="checkbox"/> Impotence	<input type="checkbox"/> Wake up to urinate at night _____ times.	
Musculoskeletal System			
<input type="checkbox"/> Joint pain/ stiffness	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Upper back pain
<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Numbness/ tingling	<input type="checkbox"/> Leg pain
<input type="checkbox"/> Pain interferes with normal daily activities			
Locations of problems (list below)			
Pregnancy/Gynecological System			
<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Are you pregnant now?	<input type="checkbox"/> Menopause	<input type="checkbox"/> PMS	<input type="checkbox"/> Fibroid
# of pregnancies _____	# of births _____	# stillborn/abortions _____	Birth control type _____
Last PAP smear _____	Last menses _____	Period: Every _____ days	Lasts _____ days
Please circle one in each category below:			
Cycle: <input type="checkbox"/> Regular or <input type="checkbox"/> Irregular		Flow: <input type="checkbox"/> Excessive, <input type="checkbox"/> Scanty, <input type="checkbox"/> Normal	
Blood: <input type="checkbox"/> Dark Red, <input type="checkbox"/> Bright Red, or <input type="checkbox"/> Pale Red		Clots present: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cramping: <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes, pain is <input type="checkbox"/> Before, <input type="checkbox"/> During, or <input type="checkbox"/> After the period.			

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