MERIDIAN ACUPUNCTURE
Carrie Lovemark L.Ac, MTCM
213 S. Old Pacific Hwy, Suite #100
Myrtle Creek, OR 97457
P: (541)860-1515 F: (541)543-2220

PATIENT INFORMATION

Name: _____ Age: _____ DOB: _____Sex : _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Please indicate below any preferences or restrictions regarding phone calls/messages:

- For appointment confirmation: _____
- Regarding medical or insurance information: _____

Referring Physician: _____ Phone #: _____

Primary Physician (if different): _____ Phone #: _____

HEALTH INSURANCE INFORMATION

Insurance Co. Name: _____ Member ID #: _____

Insurance Address: _____

Insurance Phone # (for providers): _____

PRIMARY INSUREDS INFORMATION (if different from patient)

Primary Insured's Name: _____ Primary Insured's DOB: _____

Primary Insured's Address: _____ Primary Insured's Phone #: _____

Relationship to Patient: _____ Primary Insured's ID#: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Work/Cell #:_____

TERMS OF ADMISSION TO CARE

Please check and sign below to indicate that you have read and understood each section.

PATIENT INFORMATION

_____ I certify that the information given above by me is correct.

_____ I have reviewed the clinic's *Notice of Privacy Practices* regarding my health information. I authorize release of any information necessary to coordinate medical care, including disclosure to other health care professionals for the purpose of evaluating my health, diagnosing medical conditions, and providing treatment, and to secure payment for services rendered.

FINANCIAL POLICIES

_____ **Assignment of benefits and Financial Responsibility.** I assign any and all insurance benefits to Carrie Lovemark, L.Ac of Meridian Acupuncture. I understand services rendered are charged to me, and **I am personally financially responsible for all charges, regardless of insurance coverage or insurer non-payment of billed charges.**

_____ **Benefits verification. I have been advised to verify my benefits directly with my insurer, and that fees for treatment may not be covered by insurance.** I understand that Carrie Lovemark, L.Ac. may inquire about insurance benefits as a *courtesy* to patients, but **does not represent insurance companies, is not financially responsible for benefits verification, and does not guarantee insurer payment of billed charges.**

_____ **Bounced checks.** I understand that a $25 fee will be assessed per bounced check.

LATE CANCELLATON/MISSED APPOINTMENTS

_____ I understand that **IF I DO NOT PROVIDE MORE THAN 24 HOURS ADVANCE NOTICE of appointment cancellation, or fail to show for a scheduled appointment, I WILL BE CHARGED $35 FOR A MISSED APPOINTMENT.** Exception to missed appointment charges is solely at the discretion of Carrie Lovemark L.Ac. **(If you are unable to make a scheduled appointment, please call the office as soon as possible at 541-860-1515 in order to avoid missed appointment charges. Voicemail is available for messages 24 hours/day every day).**

_____ I understand that three missed appointments without 24 hours prior notification may result in discharge from care, and further scheduling is solely at discretion of the practitioner.

Patient signature: _____Date:_____

PATIENT MEDICAL HEALTH HISTORY

What is the chief complaint for which you are seeking treatment today? When and how did it begin?

_____

_____

_____

Have you been given a diagnosis for the problem by a physician, if so what is it?

_____

MEDICAL HISTORY - ***Please indicate if you CURRENTLY OR HAVE EVER HAD any of the following:***

CONDITIONS	**Date of Onset & Present Status**
Cancer	
HIV/AIDS	
Implants or Prosthetic	
Pacemaker or Defibrillator	
Irregular heartbeat, arrhythmia, valve prolapse	
Epilepsy	
Spinal Fracture or Cord Injury	
Bone Fractures: where?	
Blood Clots: where?	
Osteoporosis/Osteopenia	
Pregnancy	
Bleeding Disorder	
Sensory Loss: where?	
Fainting Spells	
Anemia	
High or Low Blood Pressure *circle*	
Hypoglycemia	
Diabetes: *circle Type I or II*	
Compromised immunity or immune-suppressive medications	
Hepatitis: *circle A B C D E*	
Accidents or significant traumas	

Please check below any and all of the following symptoms you are having *CURRENTLY*:

General:

- ☐Weights Loss
- ☐Weight Gain
- ☐General Weakness
- ☐Fatigue or drowsiness
- ☐Fever
- ☐Moodiness
- ☐Depression
- ☐Obsessive thoughts or habits
- ☐Eating Disorders
- ☐Insomnia
- ☐Disturbed Sleep
- ☐Abnormal Sweating
- ☐Strong Thirst
- ☐Chills
- ☐Loss of Motivation
- ☐Anxiety
- ☐Confusion
- ☐Excessive Appetite
- ☐Poor Appetite
- ☐Bleeding or Bruising easily
- ☐Cravings
- ☐Memory Loss
- ☐Irritability
- ☐Panic Attacks
- ☐Difficulty concentration
- ☐Other: _____

Musculoskeletal & Neurological:

- ☐Muscle Pain
- ☐Joint or Bone Pains
- ☐Nerve Pains
- ☐Limited range of motion
- ☐Muscle Weakness
- ☐Paralysis
- ☐Numbness and tingling sensations
- ☐Tremors or involuntary movements
- ☐Other: _____

Cardiovascular & Pulmonary:

- ☐Heart Disease
- ☐Chest Pain
- ☐Uncomfortable heart beat or murmurs
- ☐Asthma
- ☐Fainting
- ☐Bronchitis
- ☐Emphysema
- ☐Pneumonia
- ☐Cough
- ☐Cold hands or feet
- ☐Wheezing
- ☐Difficult/Painful Breathing
- ☐Bloody Sputum
- ☐Excessive Phlegm

Gastrointestinal:

- ☐Nausea
- ☐Vomiting
- ☐Diarrhea
- ☐Constipation
- ☐Loss of Bowel Control
- ☐Gas
- ☐Belching
- ☐Reflux
- ☐Difficulty Swallowing
- ☐Bad Breath
- ☐Bloating
- ☐Black, tarry or bloody stools
- ☐Food intolerance
- ☐Hemorrhoids
- ☐Abdominal Pain

Genitourinary:

- ☐Pain on urination
- ☐Frequent urination
- ☐Blood in urine
- ☐Perianal Numbness and Tingling
- ☐Urgency to urinate
- ☐Unable to hold urine
- ☐Kidney Stones
- ☐Other: _____
- ☐Decreased urine output
- ☐Nocturnal Urination
- ☐Hernias

Gynecological: (Women only)

- ☐Painful Menses
- ☐Light Menstrual Flow
- ☐Irregular Menses
- ☐Unusual Menses
- ☐Heavy Menstrual Flow
- ☐Premature Births
- ☐Miscarriages
- ☐Abortions
- ☐Clots in Menses
- ☐Vaginal Dryness
- ☐Abnormal Vaginal Odor
- ☐Other: _____

Age at first menses: _____ Age at Menopause: _____ Days in Cycle: _____
Duration of Bleeding: _____ First day of Last Menses: _____
Do you practice birth control and what type? _____ How long? _____

Skin and Hair:

- ☐Rashes
- ☐Sores
- ☐Hives
- ☐Lumps
- ☐Dry Skin
- ☐Acne
- ☐Hair Loss
- ☐New moles or growths
- ☐Recent mole changes
- ☐Changes in texture of hair or skin
- ☐Eczema
- ☐Swelling

Head/Eyes/Ears/Nose/Throat:

☐Dizziness	☐Ringing in Ears	☐Grinding Teeth
☐Migraines	☐Difficulty Hearing	☐Sores on lips or tongue
☐Vertigo	☐Sinus problems	☐Facial Pain
☐Spots in front of eyes	☐Recurrent sore throats	☐Teeth Problem
☐Blurry Vision	☐Nose bleeds	☐Jaw Clicking

☐Headaches: *When and Where:* _____

Endocrine:

☐Thyroid Disorders ☐Parathyroid Disorders ☐Other: _____

PLEASE LIST ANY OTHER COMPLAINTS OR MEDICAL CONDITONS NOT INDICATED ABOVE:

_____

_____

Please list any surgical operations you have ever had, with approximate dates?

1. _____
2. _____
3. _____
4. _____

Please list any medications you take on a regular basis, dosages included:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list any known allergens, including food, herbs, supplements, medications and environmental:

_____

What exercise do you get, how often? _____

What is your sleep quality and quantity? How many hours do you typically sleep?

_____

Describe your typical dietary habits:

Breakfast: _____

Lunch: _____

Dinner: _____

Alcohol, Tobacco, Marijuana or other recreation drug use: _____

Please list any major medical conditions and cause of death (if any) in immediate family:

Maternal:_____

Paternal: _____

Siblings: _____

The above information regarding my medical history is, to the best of my knowledge, complete and accurate. I agree to promptly inform Carrie Lovemark, L.Ac. of any changes in my health status and/or additional medical history.

Patient name (please print) _____

Patient signature_____ Date _____

Guardian or interpreter signature_____ Date_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

ACUPUNCTURIST NAME: Carrie Lovemark L.Ac.

PATIENT SIGNATURE: _____ Date: _____