EARTH MOON ACUPUNCTURE
HEALING FROM THE GROUND UP

GENERAL PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method (check two): ☐ **Home** ☐ **Cell** ☐ **Text** ☐ **Email**

Marital Status : Single __ Married __ Other __

Age: _____ Date of Birth: _____ Place of Birth: _____

Occupation: _____ Employer: _____

Guardian & Phone (if under 18): _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Primary Ins Name & ID: _____

Secondary Ins Name & ID: _____

PCP & Phone Number: _____

Permission to Contact PCP (Signature) : _____

Reason & Date of Last Dr. Appointment: _____

How did you hear about us? _____

Wendy Childs, L.Ac. • Michelle Denker, L.Ac. • Margaret Campbell, L.Ac. • Katharine Stewart L.Ac. • Bryon Leverman, L.Ac.
Pafoua Yang, LMT #24029 • Kylee Veerkamp, LMT #24712 • Kacie Hinojosa, LMT #25401
Earth-Moon Acupuncture • 2365 Grear Street NE Salem, OR 97301-3510
Phone 971-273-7177 • Fax 971-273-6658

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Name: _____

DOB: _____

FAMILY HEALTH HISTORY

Please fill out the table below with information about your family (or adoptive family's) health history.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Please list any diseases or ailments impacting your family below:

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Name: _____

DOB: _____

PERSONAL HEALTH HISTORY

Gender: _____ Height: _____ Weight: _____ Blood Type: _____ BP: _____

SYMPTOMS CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss Of Sleep
- ☐ Loss Of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscles/Joints/Bones

- ☐ Arms/Hands
- ☐ Back
- ☐ Feet/Legs
- ☐ Hips
- ☐ Neck
- ☐ Shoulders

Genito-Urinary

- ☐ Blood In Urine
- ☐ Frequent Urination
- ☐ Lack Of Bladder Control
- ☐ Painful Urination

Gastrointestinal

- ☐ Appetite
- ☐ Bloating
- ☐ Bloating/Belching/Gas
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach/Abdominal Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling Of Ankles
- ☐ Varicose Veins

Eye, Ear, Nose & Throat

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss Of Hearing
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Ringing In Ears
- ☐ Sinus Problems
- ☐ Vision Flashes
- ☐ Vision Halos

Skin

- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Changes In Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore That Won't Heal
- ☐ Psorasis

Men Only

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump In Testicles
- ☐ Penis Discharge
- ☐ Sore On Penis
- ☐ Other Male Issue

Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other Female Issue

Last Menstrual Period:

Last Pap Smear:

Had a Mammogram?

Could You Be Pregnant?

Number of Children?

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Updated 11/23/2020

EARTH MOON ACUPUNCTURE
HEALING FROM THE GROUND UP

Name: _____

DOB: _____

PERSONAL HEALTH HISTORY CONTINUED

CONDITIONS CHECK CONDITIONS YOU HAVE, OR HAVE HAD IN THE PAST.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Concussion
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Traumatic Head Injury
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Weight Gain/Loss

Have you had any hospitalizations, births, accidents or injuries? Please list them below.

Year/Age	What Was Wrong	What Was the Outcome

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Name: _____

DOB: _____

VISIT DETAILS

Main Complaint: _____

When Did It Start: _____ How Often Does It Happen: _____

What makes it better? What makes it worse? How severe is it?

Severity Level

☐☐☐☐☐

< Low Extreme >

Secondary Complaint: _____

When Did It Start: _____ How Often Does It Happen: _____

What makes it better? What makes it worse? How severe is it?

Severity Level

☐☐☐☐☐

< Low Extreme >

Health Habits

Please list any health habits you have, and how often:

- ☐ Caffeine _____
- ☐ Tobacco _____
- ☐ Drugs _____
- ☐ Alcohol _____

Medications

Please list any medications you're taking.

Work Concerns

Please list any occupational concerns you have below:

- ☐ Heavy Lifting _____
- ☐ Stress _____
- ☐ Hazardous Substance Exposure _____

Allergies

Please list any allergies you have.

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DOB: _____

PAIN INFORMATION

Please check which descriptions describe your current pain levels most accurately.

Pain Intensity

- ☐ The pain comes and goes and is very mild
- ☐ The pain is mild and does not vary much
- ☐ The pain is moderate but does not vary
- ☐ The pain is very severe and does not vary much

Sleeping

- ☐ I get no pain in bed
- ☐ I get pain in bed but I can sleep well
- ☐ My sleep is reduced by less than 25%
- ☐ My sleep is reduced by less than 50%
- ☐ My sleep is reduced by less than 75%
- ☐ My pain prevents me from sleeping at all

Lifting

- ☐ I can lift weights without pain
- ☐ I can lift weights but it causes pain
- ☐ I can't lift weights off the floor

Standing

- ☐ I can stand as long as I want with no pain
- ☐ I have pain standing, but time doesn't affect it
- ☐ I can't stand longer than an hour
- ☐ I can't stand longer than half an hour
- ☐ I can't stand longer than 10 minutes
- ☐ I get pain upon standing

Walking

- ☐ I have no pain when walking
- ☐ I have pain walking, but distance doesn't affect it
- ☐ I cannot walk farther than a mile
- ☐ I cannot walk farther than a half mile
- ☐ I cannot walk farther than a quarter mile
- ☐ I cannot walk without causing pain

Personal Care

- ☐ I don't change how I wash/ dress to avoid pain
- ☐ Washing/dressing causes pain, but I can still do both
- ☐ Because of pain, I can't wash/dress without help

Sitting

- ☐ I can stit in a chair as long as I want
- ☐ I can only sit in my favorite chair
- ☐ I can't sit longer than an hour
- ☐ I can't sit longer than half an hour
- ☐ I can't sit longer than 10 minutes
- ☐ I get pain upon sitting

Traveling

- ☐ I get no pain while traveling
- ☐ I get some pain while traveling
- ☐ I get a lot of pain from traveling
- ☐ Pain restricts my travel

Social Life

- ☐ My social life is normal with no extra pain
- ☐ My social life is normal but with pain
- ☐ Pain only affects energetic interests
- ☐ Pain restricts my social life, I avoid going out
- ☐ Pain restricts me to my home/ no social life

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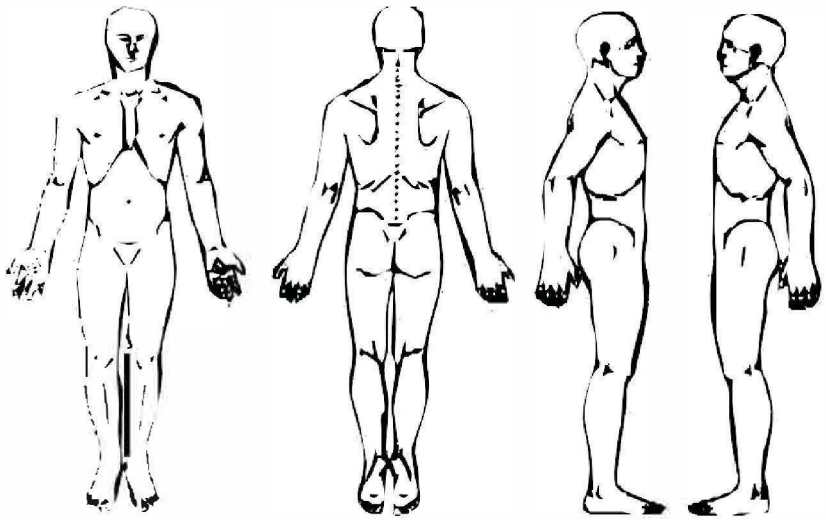
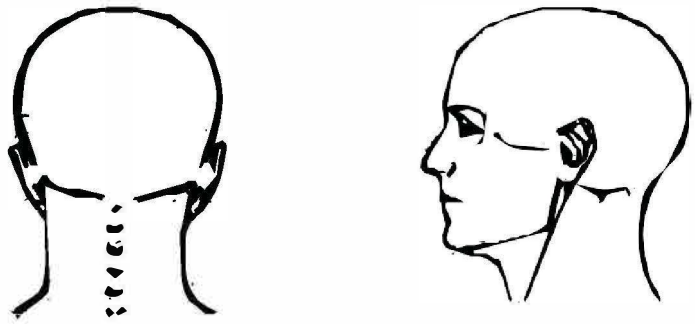
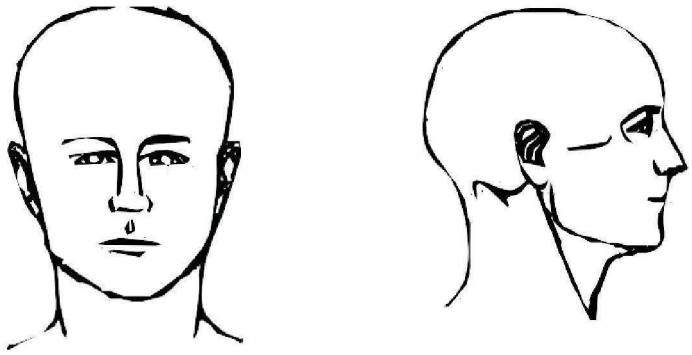
EARTH MOON **ACUPUNCTURE**
HEALING FROM **THE** GROUND **UP**

Name: _____

DOB: _____







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Financial Policy

Our goal is to provide quality individualized care in a timely manner. We would like to inform you of our financial policy regarding your care here at Earth Moon Acupuncture. Thank you for choosing Earth Moon Acupuncture for your health needs.

Missed Appointments/No Show/Cancellations without 24-hour prior notification: No-shows, late arrivals and cancellations without 24 hour prior notification prevents us from providing care to those who need access to acupuncture and massage. In order to be respectful of the needs of other patients, please be courteous and call or email the office if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. We require that you contact our office 24 hours in advance by phone, or via email, info.earthmoon@gmail.com. **Failure to comply will result in a $25 charge**, calling in for day-of appointment availability or dismissal. This charge is not covered by your insurance company.

Late Arrivals: Arriving more than 10 minutes late will result with the need to reschedule your appointment or a reduction of the allotted time for your services.

Copayments and Coinsurance: Copayments are a fixed amount for a covered service paid by the patient each time a medical service is accessed and due at the time of service. Coinsurance is a percentage that is your patient portion and will be billed to you.

Medicare MGD Patients: If the patient has a Medicare Advantage plan, we will check their plan benefits to verify whether or not the plan will pay for Acupuncture or Massage Therapy. If the plan benefit coverage includes these services we will bill the insurance company accordingly. If the plan benefit coverage does not include these services, we do offer our services at a time of service discounted rate for all Self-pay patients.

Payment Plan: Payment plans are arranged based on proof of financial hardship and the patient's financial history with Earth Moon Acupuncture with approval from management staff.

Acupuncture Self-Pay Package Information: The following packages for treatment are as follows for those without Acupuncture Benefits or Self-pay who pay at time of service (These prices and package prices are subject to change without notice):

Initial consultation with treatment - $195.75

Reassessment visit with treatment - $151.50

Follow up visit with treatment - $93.75

6 treatment visits* - $525.00

12 treatment visits* (Includes 2 free visits) - $875.00

*2 visits will be used upon initial consultation or reassessment visit

Bemer Mat Therapy: $25 per treatment or $200 for a package of 10 treatments

Massage Self-Pay Package Information: The following packages for treatment are as follows for those without massage benefits or Self-pay who pay at time of service (These prices and package prices are subject to change without notice):

Massage 15 mins Chair Massage - $22.40

Massage 30 mins Swedish/Reflexology/Chair Massage - $44.00

Massage 60 mins Swedish/Lomi Lomi/Cupping - $77.00

Massage 90 mins Swedish/Lomi Lomi/Cupping - $115.50

Massage 90-105 mins Hot Stone - $135.10

Massage 75 mins Shiatsu - $96.60

Massage 3 treatment package - 60 mins - $ 214.50

Massage 3 treatment package - 90 mins - $ 321.75

Massage 3 treatment package - 90-105 mins Hot Stone - $376.35

Massage 3 treatment package - 75 mins Shiatsu - $269.10

Please sign below signifying that you have read, understand and agree to this financial policy:

Print Name: _____ Date: _____

Signature: _____

2365 Grear St NE Salem, OR 97301
Phone: 971-273-7177 Fax: 971-273-6658

Patient Name: _____DOB:_____ Date: _____

HIPAA Patient Consent

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent. **The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.**

Print Patient/Representative Name: _____

Patient/Representative Signature:_____ **Date:** _____

Right of Access to Medical Information

I direct my healthcare and medical services provider to disclose and release my protected health information described below via verbal, electronic or hard copy to the following person(s):

☐ No one

Name: _____ Relationship: _____

Phone: _____ Email: _____

This authorization shall be effective until **(Check one):**

□ All past, present, and future periods, OR

□ Date or event: _____ unless I revoke it. (You may at any time.)

Name: _____ Relationship: _____

Phone: _____ Email: _____

This authorization shall be effective until **(Check one):**

□ All past, present, and future periods, OR

□ Date or event: _____ unless I revoke it. (You may at any time.)

Patient/Representative Name: _____

Patient/Representative Signature:_____ Date: _____

EARTH-MOON ACUPUNCTURE & WELLNESS

ACUPUNCTURE/MASSAGE INFORMED CONSENT TO TREAT

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Pafoua Yang LMT #24029 Kylee Veerkamp, LMT #24712
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Acupuncture

I hereby request and consent to the performance 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 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, including all those working at the 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 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 site 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 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, stomachache, 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 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.

Patient Name - _____ DOB- _____

Patient Signature - _____ Date - _____

Massage

It is my choice to receive massage therapy which may include the use of hot stones and or cupping and I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Patient Name - _____ DOB- _____

Patient Signature - _____ Date - _____