

Queen Anne Natural Health

Significant Trauma (auto accidents, falls, etc./dates):	
Past Medical Problems (type and date):	
Surgeries (type of and date):	
Date that you last visited a medical doctor?	Reason for visit:
Comments: (please describe any other issue(s) you would like to discuss):	

For All: (Please check all that are or have been applicable to you – if past, indicate age or date.)

General:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Strong thirst (for hot or cold) | <input type="checkbox"/> Thirst, but no desire to drink | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> Chills | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Unusual Fatigue | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cravings, for what _____ | |

Skin and Hair:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Hives | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Other, please specify: _____ | |

Head, eyes, ears, nose and throat:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Eyes strain |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw clicks, aches |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Earaches or infections | <input type="checkbox"/> Spots in front of the eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Sores on lips or inside mouth | <input type="checkbox"/> Headaches, where on head: _____ | |
| <input type="checkbox"/> Other, please specify: _____ | | |

Cardiovascular:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Phlebitis/varicose veins | <input type="checkbox"/> Chest pain or discomfort |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Other heart or blood vessel problems: _____ | |

600 West McGraw Street #1, Seattle, WA 98119

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Respiratory:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing lying down |
| <input type="checkbox"/> Coughing or blowing nose | w/ phlegm: what color? _____ | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain on breathing |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Recurrent cold or flu |
| <input type="checkbox"/> Other lung or breathing problems: _____ | | |

Gastrointestinal:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Other stomach or intestinal problems: _____ | | |

Genito-Urinary:

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Other kidney or urogenital problems: _____ | |

Musculoskeletal:

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/wrist pain |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Recurrent sprains/injuries | <input type="checkbox"/> Other: _____ | |

Neuropsychological:

- | | | |
|--|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Concussion/brain injury |
| <input type="checkbox"/> Bad temper/easily angered | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stressed easily | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |

For men only: (Please check all that are or have been applicable to you - if past, indicate age or date.)

- | | |
|---|--|
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Exhaustion after sex |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Nighttime urination |
| <input type="checkbox"/> Scanty ejaculation | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Loss of force when urinating | <input type="checkbox"/> Dribbling after urination |

For women only: (Please check all that are or have been applicable to you - if past, indicate age or date.)

- | | |
|---|---|
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> No period |
| <input type="checkbox"/> Sweet cravings | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Tender breasts before period | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Habitual miscarriage |
| <input type="checkbox"/> Infertility issues | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Heavy periods |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Uterine hemorrhage |

Age when menses started: _____ Birth Control (type/change): _____
Pregnancies (date/age): _____ STD/Herpes/HPV: _____
Miscarriages (date/age): _____ Last PAP (date/results): _____
Abortions: (date/age) _____ Menopause (date/age): _____

Other gynecological or fertility concerns: _____

Queen Anne Natural Health

Consent Form for Oriental Medicine Treatment

I, _____, hereby authorize **Kate Townsend, L.Ac., LMP** (1996 Masters of Acupuncture, NIAOM, WA State License Number: AC00000326) to perform the following specific procedures:

Acupuncture: insertion of thin, sterilized needles into the skin and underlying tissues at specific points on the body.

Cupping: a technique to relieve symptoms in which cups are placed on the skin with a vacuum created by heat or other devices.

Plum Blossom: a light tapping of an area of the body with a small sterile hammer which has seven points.

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

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or raw herbs. Herbs may be taken internally or used externally, and may include shell, mineral, and animal materials. *Note: Over 98% of the herbs used are botanical. Conditions may call for the use of an animal product. Do you wish to be informed if this is the case? [] Yes [] No*

Dietary Advice: based on East Asian Medical principles

Moxa: indirect or direct burning of mugwort leaf (*artemesia*) on specific areas of the body.

Tui Na/Acupressure: a form of Chinese bodywork which may include massage, sustained pressure points or stretching.

Electro-acupuncture: stimulation of acupuncture points with a mild electrical current.

Heating Lamp and Heating Pad: warms areas of the body.

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

Potential side effects: May include but are not limited to discomfort, pain, minor bruising, infection and blistering at the site of the procedure, broken or unremoved needles, temporary discoloration of the skin, loose bowel movements, abdominal cramping, and aggravation of symptoms existing prior to treatment. Occasionally needle sickness may occur (dizziness, nausea, or fainting). Risk of needle shock increases for patients with low blood sugar or severe lack of sleep. For this reason, it is recommended that patients always eat prior to receiving treatment.

Potential benefits: Relief of symptoms, resolution of underlying condition, prevention of recurrence, and increased overall health.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Kate Townsend, L.Ac., LMP regarding cure or improvement of my condition. I agree to keep my practitioner updated and informed about any health changes that may occur. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. ***If you are pregnant, have a bleeding disorder, pacemaker or any active infections you must make that information known to your acupuncturist prior to treatment.**

I understand that a record will be kept of my health services provided to me. This record will be kept confidential and not be released to others without my consent, unless 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 agree to pay the following fees: **\$130.00** initial acupuncture visit, **\$85** follow-up visit, **\$40** Herbal consultation.

I agree to give **24-hour cancellation notice** for any appointment or pay the full treatment fee. **Please Initial** _____

Signature of Patient, Representative, or Guardian

Date

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Insurance Registration Form

Name: _____ Date: _____

Email Address: _____ Cell #: _____

Address: _____ Zip: _____

Home Phone #: _____ Work #: _____ Employer: _____

Social Security # _____ Date of Birth _____

Insurance Group: _____ Member ID #: _____

Group ID #: _____ Contact #: _____

Relationship to insured _____ Sex: M/F _____ Single _____ Married _____ Other _____

Insured's Name & Date of Birth (if other than self) _____

Referring Physician: _____ Dx. Code: _____

Emergency Contact: _____ Cell #: _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the provider listed below. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature: _____ Date: _____