



Welcome to Meridian Acupuncture.

As a practitioner of Traditional Oriental Medicine, I offer an integrated approach to health, including acupuncture, herbs, and nutrition. My goal is to provide the highest quality medical care by combining traditional wisdom with modern technology. I am committed to helping you achieve health and vitality through a program of healing, prevention, and education. I believe the quality of your health determines the quality of your life.

Enclosed are the intake forms for you to fill out. Please complete and bring them to your appointment. The initial intake and treatment will take approximately 1-½ hours. I **recommend a protein-rich meal two to three hours before each treatment and no refined sugar or caffeine** due to acupuncture's strong effect on the body. For your convenience, I accept cash, checks, and credit cards. I am also happy to check if your insurance covers acupuncture, as many do today. Feel free to call me if you have any questions. Thank you for choosing Meridian Acupuncture. I look forward to meeting you.

Sincerely,

Chantelle DeShazer, L.Ac.

PATIENT QUESTIONNAIRE

Date of first visit ____ / ____ / ____
Name _____ Male / Female
Address _____
City / State / Zip _____
Home Phone _____ Work _____ Cell _____
Occupation _____ Employer _____
Birthdate ____ / ____ / ____ Age _____ Email _____
Marital Status _____ Number of children _____
Emergency contact _____ Phone _____
Relationship _____

Have you received acupuncture therapy before? Y / N By whom? _____
Who may we thank for referring you? _____
Did your injury occur at work? Y / N Is your accident auto related? Y / N
Medical Physician / Phone _____
Are you pregnant? Y / N

Payment and Cancellation Policy

I, the undersigned, understand that payment for all care received is my responsibility. I also understand that a 24-hour cancellation notice, whenever possible, is necessary to avoid charges.
Payment is due at time of service.

Insurance and Worker's Compensation

I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits to Chantelle DeShazer, L.Ac., for services billed to my insurance carrier.

Insurance information

Person responsible for account _____
Relationship to patient _____ Birthdate _____ Soc. Sec.# _____
Address _____ Home phone _____
Person Responsible Employed by _____ Occupation _____
Insurance Company _____
Address _____
Phone _____ Adjustor _____
Policy # _____ Group # _____ Effective Date _____
Insurance type: HMO PPO ASHN Worker's Comp Auto Other

If my health insurance company denies payment to the acupuncturist, I understand that I am responsible to her for the full amount.

Signature: _____ Date: _____

Thank you for your time and patience in filling out these necessary forms.

COMPREHENSIVE ACUPUNCTURE EXAMINATION

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

NAME _____ Date _____ Time _____ Account No. _____

Birth Date: _____ Height _____ Weight _____

Major Complaint/s _____

Other Complaints: _____

Date of onset (when you first noticed your problem)? _____

Pain is: Minimal Slight Moderate Severe

How long have you had this condition? _____

Have you had this in the past? Yes No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: Getting worse Constant Comes and Goes

Medications/Drugs/Herbs you are currently taking: _____

List Surgeries/Operations you have had and dates: _____

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): Arthritis Asthma Anemia Heart trouble Cancer
 Diabetes Epilepsy Stroke Kidney or bladder trouble Gallstones Ulcers High blood pressure
 Chronic fatigue Hepatitis Jaundice Sudden weight loss Sudden weight gain

Other: _____

FAMILY HISTORY: (Has any member of your family had any of the above)? Yes No If yes, which member and what did they have? _____

ENERGY LEVEL: High (Time of day) _____ Low (Time of day) _____

STRESS: None Moderate Severe What causes it? _____

SWEATING: Night sweats Rarely sweat Excess sweating _____

CIRCULATION: Feelings of Hot Cold What area? _____

Bleed easily Cold limbs Other: _____

SKIN: Dry Itchy Moist/clammy Burning Changing moles or lumps (cysts/tumors) Boils

Frequent skin rashes Acne Hair loss/thinning Dry scalp Skin puffy/wrinkled

Bruises easily (black and blue spots) Hives Other: _____

SCARS: (List ALL scars from accidents or surgeries) _____

SLEEP PROBLEMS: Trouble falling asleep Trouble staying asleep Restful Excess dreaming

Other: _____ How many hours do you sleep a night? _____

HEAD: Headaches (what area?) _____ Dizziness Memory loss Loss of balance

Other: _____

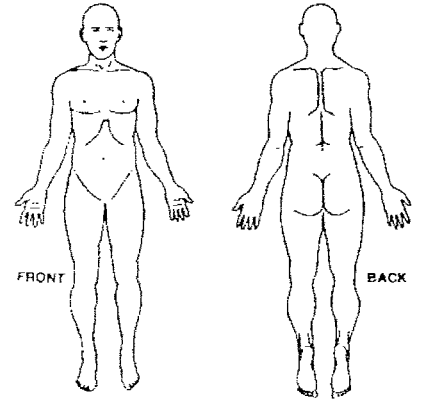
EYES: Eye pain Dry eyes Blurred vision Darkness under eyes Other: _____

EARS: Poor hearing Earaches Ear discharge/infections Ringing/buzzing in ears

Other: _____

NOSE: Frequent nose bleeds Sinus trouble Frequent colds Other: _____

PLEASE MARK YOUR AREAS OF PAIN



THROAT: Sore throat Hoarseness Difficulty swallowing Jaw problems Teeth/gum problems Swollen tongue

Other: _____

CHEST: Hard to breathe Wheezing Shortness of breath Mucus rattles when breathing Trouble breathing at night
 Pain/pressure in chest Palpitations Persistent cough Coughing blood Coughing phlegm

Sputum color _____ Consistency _____

Other: _____

BLOOD PRESSURE: High Low Do not know

BOWELS: Diarrhea Constipation Bloody stools Black stools Mucus in stools Hemorrhoids

Lower bowel gas Stools have foul odor Colon problems Number of bowel movements a day _____

Other: _____

URINE: Color _____ Amount _____ Frequent urination Daytime At night

Strong smelling urine Hard to urinate Pain or burning on urinating Blood in urine

Frequent infections Water retention Other: _____

MUSCULOSKELETAL: Pain in: Neck Shoulder Between shoulders Arms/hands Hip Knee

Fingers Big toe Upper back Mid back Lower back Bones sore/painful Loss of grip

Swollen knees/elbows Leg cramps at night Weakness in legs Weak ankles Stiff all over

Tingling in feet Muscle spasm/cramps Loss of feeling in hands/feet Painful joints Bursitis

Other: _____

NEUROLOGICAL: Nervousness Depressed Easily angered Easily irritated Frequent crying

Worry/Anxiety Mood swings Memory confusion Poor concentration Suicidal Tremors

Numbness/tingling in limbs Poor coordination Muscle weakness Feel weak and shaky Seizures

Neuralgia (nerve pain) Shingles Other: _____

FEMALES: Pregnant? yes No Last monthly period _____ Last PAP test _____

Form of birth control: None Pill Other: _____

Age started menstrual cycle _____ Age stopped _____ Menstrual pain Low backache

Irregular Clotting Heavy bleeding Light scanty bleeding Color _____

Water retention Mood changes Miss periods Low or no sex drive Painful breasts Hot flashes

Food cravings Other: _____

Discharges: Yellow Thick White Odor Itching Liquid Other: _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____

No. Cesareans _____ Operations: Cervix Uterus Ovaries Other: _____

MALES: Low sexual drive Lack of sexual drive Impotence Ejaculation causes pain Discharges

Pain or burning while urinating Premature ejaculation Prostate trouble Other: _____

APPETITE: Excessive appetite Poor appetite Appetite keeps changing Feel tired or weak if a meal is missed

Excessive thirst Never thirsty Other: _____

Specific food cravings? Yes No If yes, what? _____

Other: _____

DIGESTION: Stomach gas Lower bowel gas Heartburn Burning/belching Stomach pain

Stomach cramps Nausea Vomiting Bad breath Sores in mouth Weight gain Weight loss

Bitter/sour taste in mouth Abdominal bloating How long after eating? _____

Food allergies? yes No If yes, to what? _____

NUTRITION: List some of your favorite foods _____

Do you: Skip breakfast Eat a snack Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? Yes No How often? _____

Do you plan your meals according to the "Four basic food groups"? Yes No

How many glasses of water do you drink a day? _____ Filtered Bottled

Do you use: Alcohol? Yes No Amount per week _____ Type _____
 Tobacco? Yes No Packs per day _____ How many years _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? Yes No
 Eat green or yellow vegetables at least twice a day? Yes No
 Eat frequently between meals? Yes No
 Chew your food thoroughly before swallowing it? Yes No
 Drink juice, milk or other drinks
 instead of water when thirsty? Yes No
 Always add salt at the table? Yes No

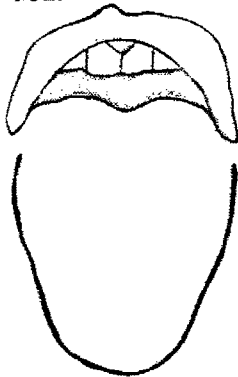
Eat meat or dairy products 2 or more times a day? Yes No
 Eat the same foods almost every day? Yes No
 Eat when you are not hungry? Yes No
 Eat until you feel full? Yes No
 Occasionally go on a "crash" diet? Yes No

Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

EXAMINATION

TONGUE:



Color _____

 Coat _____

 Body _____

PULSE
 RIGHT _____
 LEFT _____

GENERAL CHARACTER

TEMPERATURE: _____
 BLOOD PRESSURE: _____

APPEARANCE: Excellent Good Fair Well-nourished Undernourished Debilitated Thin
 Husky Overweight _____

MOVEMENT: Guarded Slow Impaired Needs assistance Deformity _____

SKIN COLOR: _____ **FACIAL COLOR:** _____ **EYES:** _____

AREA CLIMATE: Body odors _____ Smell _____

ABDOMEN (by palpation): Organ swelling Masses Hernia Pain _____

ABDOMINAL REFLEX(es): _____

ASSESSMENT/EVALUATION/FINDINGS: (Internal, emotional, dietary, channel disorders, trauma, constitution, inactivity, overworked, etc.)

EIGHT PRINCIPLES: (Yin/Yang, Internal/External, Hot/Cold, Deficient/Excess) _____

PAIN ASSESSMENT

Patient Name _____ Date _____

Chief Complaint 1. _____ 2. _____

Is your present problem due to an injury

On the job? Auto Accident? Personal Injury? Other _____

Did your pain begin Gradually? Suddenly?

Do you have pain All the time? Sometimes?

Is your pain worse when you

Sit Bend Walk Lift Push Pull Other _____

Which of the following areas do you have the most pain, discomfort or restriction of motion?

Neck Shoulders Arms Hands Upper Back Mid Back Low Back

Pelvis Hips Legs Knees Feet Other _____

IN AN 8 HOUR DAY RATE THE PERCENTAGE OF YOUR PAIN WHEN YOU:

Sit _____ % of the time

Stand _____ % of the time

Walk _____ % of the time

OCCASIONALLY = 33%
 FREQUENTLY = 34-66%
 CONTINUOUSLY = 67-100%

WHAT PERCENT OF YOUR TIME ARE YOU:

Housebound? _____ %

Chairbound? _____ %

Bedfast? _____ %

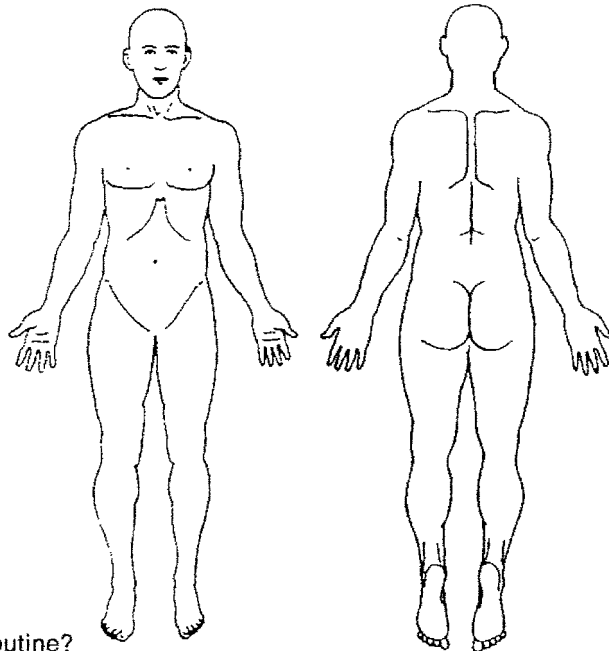
RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE FOLLOWING SCALE

1 = LEAST PAIN
10 = EXTREME PAIN

EXTREME
10
9
8
7
6
5
4
3
2
1
0
NO PAIN

MARK AREAS OF PAIN ON THE FIGURES BELOW USING THESE CODES

- +++ BURNING
- 000 STABBING
- SHARP
- ... CONSTANT



Does your pain interfere with your Work? Sleep? Daily Routine?

Do you feel your present condition is Temporary? Permanent? Don't know

List any additional comments you wish to make regarding your condition _____

Patient Signature _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbs, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

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

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.

To be completed by the patient:

PATIENT'S NAME _____
(PLEASE PRINT)

PATIENT'S SIGNATURE _____

DATE SIGNED _____

ARE YOU PREGNANT? YES NO

NAME OF CLINIC/OFFICE _____

NAME(S) OF TREATING ACUPUNCTURIST(S): _____

**To be completed by the patient's representative,
if necessary, e.g., if the patient is a minor or is
physically or legally incapacitated:**

NAME OF PATIENT _____
PLEASE PRINT

PATIENT'S REPRESENTATIVE _____
PLEASE PRINT

RELATIONSHIP OR AUTHORITY OF PATIENT _____

WITNESS _____

Meridian Acupuncture
Chantelle DeStegen

APPROVED BY CALIFORNIA ACCUPUNCTURE ASSOCIATION (Rev. 12/92)

This is only one example of informed consent. There are other forms that could satisfy legal requirements for documenting consent. You may wish to consult your own legal counsel and/or your malpractice carrier.

NOTICE OF HEALTH INFORMATION PRACTICES

This office creates detailed records of the care and services you receive. We at Meridian Acupuncture are committed to maintaining the privacy of your protected health information.

The Federal Government and the State of California have passed legislation requiring health plans, healthcare clearinghouses, and healthcare providers furnish the individuals with a notice as to how their health information may be used and disclosed to third parties. This notice also details your rights regarding your protected health information. Please read the notice carefully. Copies are available at the front desk.

Chantelle DeShazer is the privacy officer for this office. She will be happy to answer any questions you have regarding how your health information is handled in this office.

Please sign below and return to the front desk:

I have () read and () received a copy of the Meridian Acupuncture Privacy Notice.

Date: _____ Signature: _____

Print name: _____