

Dear New Patient,

Welcome to my clinic! I look forward to working with you towards health and wellness. Traditional Chinese Medicine (TCM) is over 2500 years old and continues to be used throughout Asia, typically alongside modern Western medicine. More and more studies in the U.S. and around the world demonstrate the success of this ancient medicine in treating a wide variety of medical problems, especially those which may not be responding to Western medical treatment.

At the most basic level, a practitioner works with your body by assessing and accessing your vital energy, called Qi (“chee”) and encouraging the body to heal itself. Some of the techniques used in TCM will be very unfamiliar to you. Acupuncture is one of these techniques and involves the insertion of very fine needles into specific points to alleviate pain, swelling or discomfort, as well as facilitate healing. In addition, Chinese massage (tui na), a Japanese breathing and movement technique (sotai), the burning of herbs (moxabustion), herbal formulas, small pellets in the ears, placing magnets on the body and other modalities may all be utilized to help get your body heal.

The initial appointment is rather lengthy, lasting from 90-100 minutes. The first part of the appointment will involve an in depth discussion of your main complaint/s and your overall health. Some questions will seem unrelated to your main complaint, however, they offer insight into your unique patterns of balance and imbalance. As part of the diagnostic aspect of your treatment, I will spend some time taking your pulses and looking at your tongue as well as palpating your abdomen and any areas of pain. Abdominal diagnosis (“Hara” diagnosis) is one of the hallmarks of the Japanese styles of acupuncture.

People often ask whether or not the needles hurt. While each person differs in his or her level of sensitivity, for the most part there is minimal sensation. The needles are all sterile, solid and about twice the width of a human hair. However, if you have any concerns about the needles and pain, please let me know. Typically we can find a solution that works for both of us while still providing the necessary treatment.

For all appointments bring or wear loose fitting clothing. If you have a specific area of injury, make sure that I can easily get to that area to provide treatment. The upper and central back are commonly treated in an acupuncture session as well as the elbow and knee areas. Also, make sure that you have had something to eat before the treatment, but avoid a large meal for at least an hour before. Avoid overexertion after the appointment, as well as alcohol or excessive caffeine.

In order to get the most out of your treatments, please show up on time. Allow for extra time if you need to change your clothes or use the restroom so that all of the allotted time can be dedicated to your treatment. If you need to cancel your appointment, please provide **24-hour** notice by leaving a voicemail at 503-481-6702. I charge the cost of an office visit for any missed appointments. This covers the missed opportunity to schedule another patient at that time. Your courtesy and understanding are greatly appreciated in this.

I look forward to working with you.

Sincerely,

Tracy Thorne, MAOM, Lic.Ac.
CPT-NSCA, RYT Yoga Instructor

Consent to Treat Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Traditional Chinese Medicine (TCM) Materia Medica by licensed Acupuncturist, Tracy Thorne. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Traditional Chinese Medicine Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the prescribing practitioner as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X _____ X _____
Patient's Signature Date Practitioner Date

Patient Health History

Date: _____ Referred by: _____

Name: _____

Age: _____ DOB: _____ Gender: M F Partner Status: S M/SI D W Live alone: Y / N

Home Address: _____

Home Phone: _____ Mobile Phone: _____

Profession: _____ Employer: _____

Work Phone: _____ email: _____

Circle the phones #'s or email where I can leave detailed messages for you.

Physician's Name/Address: _____

Physician's Phone: _____ Date of Last Physical Exam: _____

Does your physician know you are seeking alternative medicine? Y / N

Emergency Contact: _____ phone: _____

Relationship: _____

Have you had Acupuncture or Chinese herbal medicine before? Y / N Was it a positive experience? Y / N

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Please print all information. Indicate areas of confusion with a question mark. Thank you.

When, where and for what reason did you last receive health care?

Please identify the health concerns that have brought you to this clinic in order of importance below:

Condition **Western Diagnosis and Treatment/s** (include whether helpful/not helpful)

a. _____

b. _____

c. _____

d. _____

Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Do you have metal allergies? Y / N Do you have fillings? Y / N Approximately how many? _____

Medications/Supplements: Please list **ALL medications** (prescribed and over-the-counter), **vitamins**, and **supplements** you are currently taking or recently took:

In the last 2 weeks:

Med/Supplement	Dose	Prescribed?	Reason/diagnosis	How Long

In the last 3 months:

Med/Supplement	Dose	Prescribed?	Reason/diagnosis	How Recently	How Long

Do you tend to have many side effects to medications? Y / N If yes, please explain: _____

Approximately how many times have you taken antibiotics: _____

Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you? _____

Have you traveled outside the US in the last year? Y / N Where: _____

Do you have any infectious diseases? Y / N If yes, please identify: _____

Family History:	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Check (√) and note the following that a family member has or had:

Cancer (type)	_____	_____	_____	_____	_____	_____
Diabetes (type)	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____

Patient Data:

Current Height: _____ Waist: _____ Hips: _____ BF: _____ BMI: _____
 Current Weight: _____ Lowest Weight in last 5 years: _____ Highest in last 5 years: _____
 Resting Heart Rate: _____ BP: _____ last checked: _____
 Cholesterol: HDL _____ LDL _____ Total _____ last checked: _____

Please describe your typical exercise habits/training regime:

Hospitalizations and Surgeries/Trauma (include exploratory procedures, e.g. arthroscopy, biopsy)

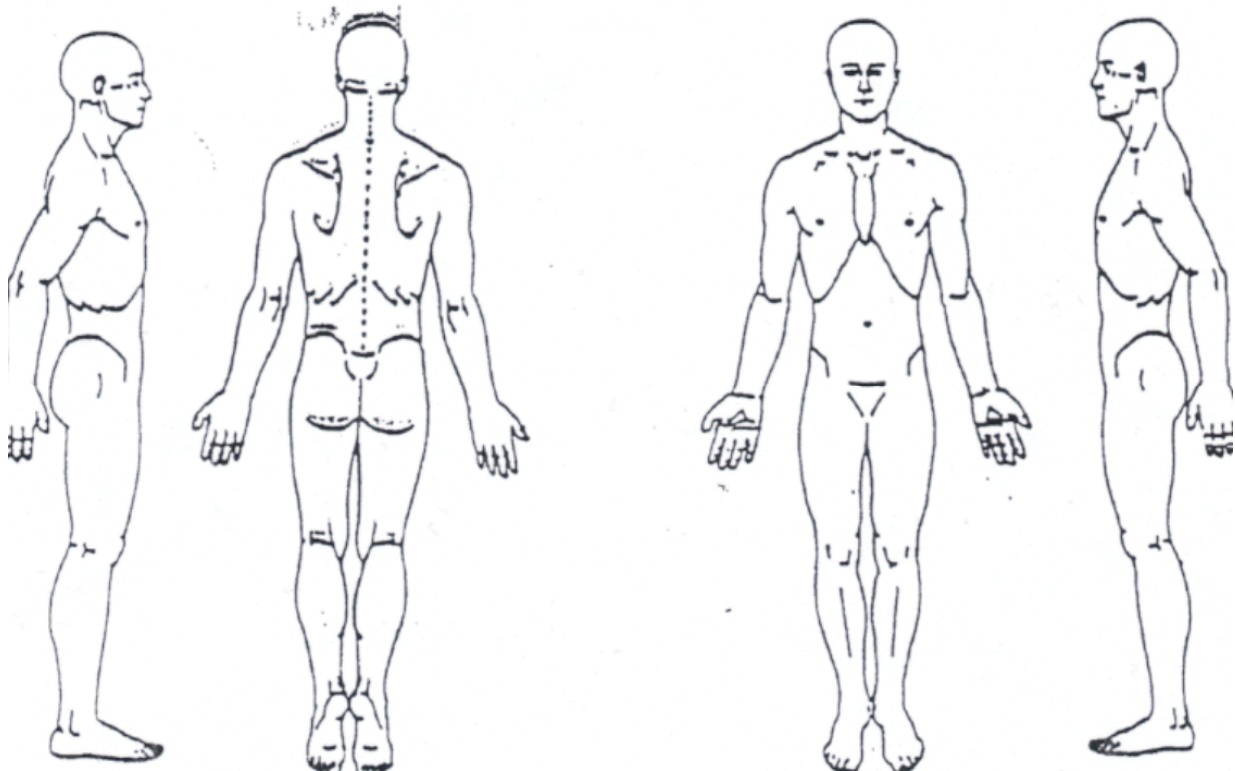
<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

X-Rays/CAT Scans/MRI's/Bone Scans/Bone Densitometry other Special Studies:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Musculoskeletal/Neurological; R or L handed: R / L Ambidextrous

- 1) Please mark areas of pain, discomfort, numbness, weakness or temperature changes and explain:
- 2) Indicate Level of Pain by marked areas: (low) 1 2 3 4 5 6 7 8 9 10 (excruciating)



Please check all that apply: **N: Never; P: Past; C: Current**

Neurologic / Orthopedic

	N	P	C		N	P	C
Muscle weakness				Difficulty/Loss of Balance			
Muscle Atrophy				Vertigo/dizziness			
Numbness/Tingling				Light headedness			
Loss of function				Memory Loss/confusion			
Referring pain				Tremors			
Broken Bones				Seizures			
Change in Structure				Shingles			
Paralysis				Concussion			

Other: _____

Energy and Immunity: Current Energy Level: (can't move) 1 2 3 4 5 6 7 8 9 10 (exuberant)

	N	P	C		N	P	C
Excessive Fatigue				Persistent low grade fever			
Chronic Fatigue				Swollen/painful lymph nodes			
Slow wound healing				Chronic Infections			
Easily chilled				Aversion to wind/Air conditioning			
Difficulty regulating Body Temp				Easily catch colds/flu			

Sleep/Rest Hours of sleep/night: _____ Go to bed at regular times? Y / N _____ When _____

	N	P	C		N	P	C
Insomnia				Feel Rested upon waking up			
Difficulty Falling Asleep				Excessive/Vivid Dreams			
Easily Crash at night				Nightmares			
Difficulty Staying Asleep				Restless Sleep			
Wake up Easily				Snoring			
Difficulty Waking Up				Apnea			

Emotional

	N	P	C		N	P	C
Mood swings				Lonely			
Nervousness				Afraid			
Irritability				Easily Startled			
Quick Temper				Suicidal thoughts			
Depression				Despair			
Grief				Restlessness			
Worry				Indifferent			

Skin / Hair / Nails

	N	P	C		N	P	C
Bruise easily				Acne			
Sweat easily				Rashes			
Sweat more in 1 area				Hives			
Night sweats				Itching			
Low/no sweat				Dry/Scaly skin			
Hair Loss				Red Skin			
Excess Hair				Psoriasis			
Dry Hair				Eczema			
Ridges in Nails				Scars (where)			
Brittle Nails				Other:			

Please check all that apply: N: Never; P: Past; C: Current

Head, Eye, Ear, Nose, Mouth and Throat, Teeth

	N	P	C		N	P	C
Impaired Vision				Sinus problems			
Eye Pain/Strain				Allergies			
Glasses/contacts				Nose Bleeds			
Tearing				Frequent Colds or Sore throats			
Eye Dryness				Difficulty Swallowing			
Cataracts				Unusual Tastes in Mouth			
Floaters				Mouth sores			
Light Sensitivity				Loss of Voice			
Poor Night Vision				Weak Voice			
Ringling in the ears				Stutter			
Earaches				Dry Throat / Mouth			
Headaches				Cavities, how many?			
Teeth Grinding				Loss of Adult Teeth			
TMJ / Jaw problems				Other:			

Respiratory

Do you smoke? Y / N

Did you ever smoke? Y / N

When did you quit? _____

	N	P	C		N	P	C
Bronchitis				Persistent cough			
Pneumonia				Difficulty Breathing			
Emphysema				Unusual Shortness of Breath			
Pleurisy				Sighing			
Asthma				Chest Breather			
TB				Abdominal Breather			

Cardiovascular

	N	P	C		N	P	C
Heart Disease				High Blood Pressure			
Heart Attack				Low Blood Pressure			
Angina / Chest Pain				Aneurysm			
Heart Murmurs				Varicose Veins			
Slow Heart Rate				Spider Veins			
Fast Heart Rate				Calf Cramps			
Arrhythmia				Swollen Extremities			
Heart Valve problems				Cold Hands / Feet			
Stroke				Difficulty regulating temperature			
Other:				Other:			

Endocrine

	N	P	C		N	P	C
Hyperthyroid				Diabetes			
Hypothyroid				Blood Sugar Irregularities			
Adrenal Fatigue				Other:			

Hepatic

	N	P	C		N	P	C
Gall Bladder disease				Hepatitis			
Liver Disease				Exposure to Toxic Chemicals			
Other:				Other:			

Please check all that apply: *N: Never; P: Past; C: Current*

Digestive/Gastrointestinal

	N	P	C		N	P	C
Nausea/vomiting				Blood in Stool			
Hiccoughs				Mucous in Stool			
Heartburn				IBS			
Belching				Ulcers			
Epigastric Pain				Eating Disorders			
Abdominal Pain				Cravings			
Bloating				Low Appetite			
Passing Gas				Excessive Appetite			
Diarrhea				Loss of taste or smell			
Constipation				Excessive cravings			
Alternating Diarrhea/constipation				Unusual Taste in mouth			
Easily lose weight				Bad Breath			
Easily gain weight				Hemorrhoids			

Stool: Daily bowel movement? **Y / N** # of B.M's/day: _____

	N	P	C		N	P	C
Yellow, green				Formed			
Gray				Small pellets			
Dark brown				Loose			
Black				Watery			
Strong smelling				No smell			
Painful or strenuous				urgent			

Kidney/Bladder

	N	P	C		N	P	C
Urinary Tract Infection				Bladder Stones			
Frequent (>6x/day)				Kidney Stones			
Infrequent (<3x/day)				Night Urination			
Heavy Flow				Cloudy Urine			
Dribbling Flow				Blood in Urine			
Uncontrolled Flow				Dark Yellow			
Urgency				Light Yellow			
Pain w/Urination				Clear			
Strong Smell				No Smell			

Female Sexual/Reproductive

<i>Breast health</i>	N	P	C		N	P	C
Nipple discharge				Breast lumps/tenderness			
Breast cancer				Fibrocystic breasts			
<i>Vaginal Discharge</i>							
Excessive amount				Clear, white			
Small amount				Yellow, strong smelling			
Sticky				watery			

Last Breast Exam: _____ Do you self exam: **Y / N** Last PAP: _____ Abnormal PAP: **Y / N**

Please check all that apply: N: Never; P: Past; C: Current

Female Sexual/Reproductive (cont)

	N	P	C		N	P	C
Yeast Infection				STD			
Difficulty w/intercourse				Infertility			
Low sexual Desire							

Sexually Active: Y / N Current Birth Control Type: _____ How long? _____

of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Menstruation/Menopause:

Age of First Menses: _____ # of Days of Menses: _____ Length of Cycle: _____

	N	P	C		N	P	C
Regular Periods				Irregular Periods			
Amenorrhea (no period)				Bleeding between Periods			

Circle all that apply:

- Color of Blood:** Bright Red Dull Red Pale/Pink Purple Black Brown
- Consistency of Blood:** Thick/Sticky Thin/Dilute Watery Mucous Normal
- Volume/flow of Blood:** Heavy Medium Light Scanty Start/Stop Spotting
- Clots:** Egg size Quarter size Tiny Not sure None
- Pain/Cramps:** Before – during - after Severe - moderate - slight Stabbing - achy - sinking
- PMS:** Mood swings Crying/sadness Irritable/angry Rage Difficulty concentrating Disorientation
- Back pain Headaches Breast pain/swelling Abdominal Bloating Changes in stool
- Other: _____

Menopause Age of onset _____ Symptoms of Menopause; _____

Male Sexual Reproduction

	N	P	C		N	P	C
Prostate pain/swelling				STD			
Testicular Pain/swelling				Hernia			
Penile discharge				Dribbling semen day/night			
Erectile difficulties				Low sexual desire			

Other: _____

Prenatal/Birth Are there any circumstances surrounding your gestation or birth that were out of the ordinary (e.g. illness of mother, forceps delivery, fetal distress, cesarean). Y / N If yes, please explain: _____

Childhood Illness (please circle any that you have had):

- Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other: _____

Immunizations (please circle any that you have had and indicate when you had them):

- Polio Tetanus Measels/Mumps/Rubella Pertussis Diphtheria Hep A Hep B Influenza

Others: _____

Diet:

Vegetarian _____ Lacto-Vegan _____ Vegan _____

Food Allergies: _____

Food Intolerances: _____

Index: Always / Usually / Sometimes / Never

Do you typically eat at least 3 meals per day? A / U / S / N Do you eat at regular times: A / U / S / N

Chew food thoroughly? A / U / S / N Is your food sustaining / satisfying? A / U / S / N

Discuss/Do work while eating? A / U / S / N Frequently have conflict while eating? A / U / S / N

Watch TV while eating? A / U / S / N Mostly eat alone or in a group? _____

How much time do your meals take? _____ Sit or Stand when you eat? _____

Please describe typical breakfast, lunch dinner and snacks:

Breakfast	Lunch	Dinner	Snacks

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Caffeinated beverages/day: _____ Alcohol consumption/week: _____

Lifestyle:

Occupation: _____ Hours work/week: _____

Do you enjoy work? Y / N Why / Why not?

Television hours/day: _____ TV in bedroom? Y / N Reading hours/day: _____ Quiet time: _____

Interests and hobbies:

How do you usually decompress or relieve stress?

Any regular meditation or prayer?

I will notify my practitioner if there is ANY CHANGE AT ALL in my Health History or Health status.

Patient Signature: _____ **Date:** _____