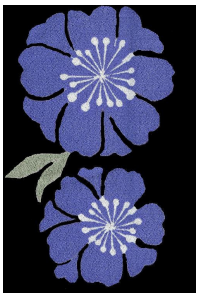


Welcome.

To those of you who are new to acupuncture and to those who are returning, welcome, and best wishes to you on your journey to better health. I look forward to working with you.

For new patients, the initial office visit consists of a thorough health history, where we will review your health concerns and the issues that you would like to address. This will be followed by an acupuncture treatment. The first office visit takes 75-90 minutes. Follow-up appointments may last 50-60 minutes. Please be assured that anything that happens in treatment is strictly confidential.

- Prior to each visit, please make sure that you have eaten something within 2 hours of treatment — a light snack will do fine.

- Please wear or bring loose fitting clothing in order to easily access parts of the body during treatment. Draping is also provided to ensure comfort.

- The office is scent-free. Please refrain from wearing perfume, cologne, or other strongly-scented products on the day of your appointment.

Please contact us for any questions, we're happy to help.

If you are unable to keep an appointment, kindly give 24 hours notice, or you may be charged for the missed appointment. This does not apply to inclement weather or emergencies.

Serra May Plourde, MAc., Lic.Ac. • 672 Main Street, Suite 3 • Holden, Mass. 01520 • 508.829.8878

Health History Questionnaire

Please fill out this questionnaire carefully so that you can be provided with a complete evaluation. *All of your answers will be held absolutely confidential.* If you have questions, please ask. If there is anything you wish to mention which is not asked on this form, please note it in the "Comments" section. Thank you.

Date

Name (First & Last)		Home Phone	Work Phone
Street		City	State/Zip
Date of Birth	Age	Height	Weight
Emergency Contact/phone			
Family physician		Occupation	Referred by

Have you been treated by acupuncture or Oriental medicine before? Yes No
Main problem(s) you would like help with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep and sex?
Have you been given a diagnosis for this problem? If so, what?
What kinds of treatment have you tried?

Past Medical History (please include date)

Significant Illnesses (please circle all applicable)

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Venereal Disease Other

Surgeries

Significant trauma (auto accidents, falls, etc.)

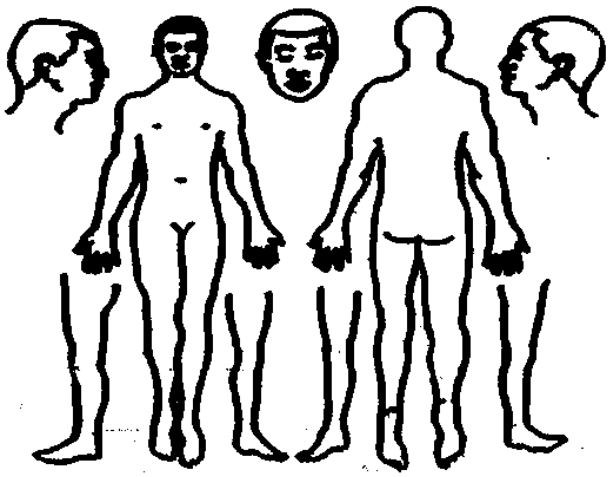
Allergies (drugs, chemicals, foods)

Family Medical History

Cancer Diabetes High Blood Pressure Heart Disease Stroke

Asthma Allergies Other _____

Indicate any painful or distressed areas:



General

Please check if you have had (in the last three months):

- ❒ Fevers
- ❒ Sweat easily
- ❒ Bleed or bruise easily
- ❒ Peculiar tastes or smells
- ❒ Sudden energy drop (what time of day?) _____
- ❒ Poor sleeping
- ❒ Chills
- ❒ Weight loss
- ❒ Strong thirst (hot or cold drinks)
- ❒ Fatigue
- ❒ Night sweats
- ❒ Cravings
- ❒ Change in appetite
- ❒ Weight gain

Skin and Hair

- ❒ Rashes
- ❒ Itching
- ❒ Dandruff
- ❒ Change in hair or skin texture
- ❒ Ulcerations
- ❒ Eczema
- ❒ Loss of hair
- ❒ Hives
- ❒ Pimples
- ❒ Recent moles

Any other hair or skin problems? _____

Head, Eyes, Ears, Nose and Throat

- ❒ Dizziness
- ❒ Glasses
- ❒ Poor vision
- ❒ Cataracts
- ❒ Ringing in ears
- ❒ Sinus problems
- ❒ Grinding teeth
- ❒ Teeth problems
- ❒ Concussions
- ❒ Eye strain
- ❒ Night blindness
- ❒ Blurry vision
- ❒ Poor hearing
- ❒ Nosebleeds
- ❒ Facial pain
- ❒ Jaw clicks
- ❒ Migraines
- ❒ Eye pain
- ❒ Color blindness
- ❒ Earaches
- ❒ Spots in front of eyes
- ❒ Recurrent sore throats
- ❒ Sores on lips or tongue
- ❒ Headaches (where, when?)

Any other head or neck problems? _____

Cardiovascular

- ❒ High blood pressure
- ❒ Irregular heartbeat
- ❒ Cold hands or feet
- ❒ Blood clots
- ❒ Low blood pressure
- ❒ Difficulty in breathing
- ❒ Swelling of hands
- ❒ Phlebitis
- ❒ Chest pain
- ❒ Fainting
- ❒ Swelling of feet

Any other heart or blood vessel problems? _____

Patient Name _____ Date _____

Respiratory

- ❒ Cough
- ❒ Bronchitis
- ❒ Difficulty in breathing when lying down
- ❒ Coughing blood
- ❒ Pneumonia
- ❒ Production of phlegm
- ❒ What color?
- ❒ Asthma
- ❒ Pain with a deep breath

Any other lung problems? _____

Gastrointestinal

- ❒ Nausea
- ❒ Constipation
- ❒ Black stools
- ❒ Bad breath
- ❒ Abdominal pain or cramps
- ❒ Vomiting
- ❒ Gas
- ❒ Blood in stools
- ❒ Rectal pain
- ❒ Chronic laxative use
- ❒ Diarrhea
- ❒ Belching
- ❒ Indigestion
- ❒ Hemorrhoids

Any other problems with your stomach or intestines? _____

Genito-Urinary

- ❒ Pain upon urination
- ❒ Urgency to urinate
- ❒ Decrease in flow
- ❒ Do you wake up to urinate? How often?
- ❒ Frequent urination
- ❒ Unable to hold urine
- ❒ Impotency
- ❒ Any particular color to your urine:
- ❒ Blood in urine
- ❒ Kidney stones
- ❒ Sores on genitals

Any other problems with your genital or urinary system? _____

Reproductive and gynecologic

- ❒ Pregnancies #:
- ❒ Abortions: #:
- ❒ Period between menses
- ❒ Irregular periods
- ❒ Last PAP
- ❒ Breast lumps
- ❒ Live births #:
- ❒ Premature births #:
- ❒ Duration of menses
- ❒ Painful periods
- ❒ Vaginal discharge
- ❒ Menopause Age:
- ❒ Miscarriages #:
- ❒ Age of first menses
- ❒ Unusual character (heavy, light)
- ❒ Clots
- ❒ Vaginal sores

Changes in body/psyche prior to menstruation _____

_____

Do you practice birth control? What type and for how long? _____

Musculoskeletal

- ❒ Neck pain
- ❒ Back pain
- ❒ Hand/wrist pains
- ❒ Muscle pain
- ❒ Muscle weakness
- ❒ Shoulder pain
- ❒ Knee pain
- ❒ Foot/ankle pains
- ❒ Hip pain

Any other joint or bone problems? _____

Neuropsychological

- ❒ Seizures
- ❒ Areas of numbness
- ❒ Concussion
- ❒ Bad temper
- ❒ Dizziness
- ❒ Lack of coordination
- ❒ Depression
- ❒ Easily susceptible to stress
- ❒ Loss of balance
- ❒ Poor memory
- ❒ Anxiety

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Medication

Please list any medications, vitamins and/or herbs that you take on a regular basis, or have taken within the past two months:

	Type	Dosage	Times/Day
Medications			
Vitamins			
Herbs			

Occupational stress (chemical, physical, psychological, etc.)
Do you have a regular exercise program? If yes, please describe.
Do you smoke? If yes, how much?
Please describe any use of drugs for non-medical purposes.

Patient name _____ Date _____

Diet

Please describe, with as much detail as possible, what you eat and drink on a typical day:

Breakfast	Lunch	Dinner

Snacks	Beverages

Do you ever crave certain foods, such as those that are (circle any or all that apply):

sweet sour spicy salty high in fat high in carbohydrates

Other _____

Do you have a preference for hot or cold beverages?

Have you ever been on a restricted diet? If yes, what kind?

How much caffeinated coffee, tea, or cola do you drink per week?

How much water do you drink per day? How much alcohol do you drink?

What is your favorite season of the year? During which season do you feel your best? Your worst? Please describe.

Comments: Please describe any other problems you would like to discuss (use the reverse side if necessary):

_____

_____

_____

Consent to Treatment

I, _____, hereby authorize Serra May Plourde, Lic. Ac. to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Needle Insertion - This technique involves insertion of various styles and sizes of sterile, disposable needles into the body at various depths and locations. On rare occasion, slight bruising may occur upon the removal of a needle.

2. Heat treatments - This refers to either moxabustion or a conventional heat lamp, both of which are used to promote circulation. Moxabustion or mugwart (Arthemesa vulgaris) is an herb that is used by either a) applying it to the top of the needle (referred to as indirect moxa), b) holding a moxa pole above the skin (also an indirect application), or c) applying it directly on the skin with salve that serves as a barrier to protect the skin. The heat lamp emits a continuous warming effect that is placed over various areas of the body. The heat generated from the moxabustion may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.

3. Cupping - This is a type of deep massage that uses glass or plastic cups placed, using suction, on muscular areas that have pain or tension. The cups are either left stationary or slid with massage oil back and forth to cover larger areas of need. This technique may temporarily leave a red or purple mark in the area treated that can last for 1-5 days. This is a normal response to the technique.

4. Gwa Sha - This is another type of massage that uses a Chinese ceramic spoon with massage oil to help relieve neck, shoulder and back pain. This technique may leave red or purple bruising and tenderness to the area treated that can last from 1-5 days. This is a normal response to the technique.

5. Electrical stimulation - This technique uses slight electrical impulses to stimulate already inserted needles in order to help un-block more stubborn blockages.

6. Expression of blood - A small lancet is inserted quickly into the skin and a few drops of blood are expressed from an acupoint. This is sometimes used to improve the circulation of a meridian.

I have been informed that I have the right to refuse any form of treatment. I understand the objective of the treatment and have been informed of the possible risks and consequences involved in the treatment. I have been informed that I have the opportunity to ask questions that pertain to the treatment. I also understand there is always a possibility of an unexpected complication and that no guarantee can be made with regard to the results of the treatment.

Patient signature: _____

Printed name: _____ Date: _____

Acupuncturist signature: _____ Date: _____

Provider-Patient Contact Consent Form

I, _____ , DOB _____/_____/_____, consent and agree that Serra May Plourde, MAc., Lic. Ac. may contact me and leave voice messages as outlined below. These messages can include appointment information, billing information, and any pertinent treatment information. I understand that if I choose the option for callback information only, a message will be left solely with a first name, and callback telephone number. I am aware that restrictions placed on where messages can be left may impact the ability of Serra May Plourde to contact me in a timely manner.

I wish to be contacted in the following manner (check off one box for each phone number):

Home Telephone Number and/or Answering machine number: _____-_____-_____

- ❒ I consent to messages with detailed information as outlined above (no restrictions)
- ❒ Leave messages with first name and callback number only (restricts the message)
- ❒ Do not leave messages at my home telephone number

Work Telephone Number and/or Answering Machine Number: _____-_____-_____

- ❒ I consent to messages with detailed information as outlined above
- ❒ Leave messages with first name and callback number only
- ❒ Do not leave messages at my work telephone number

Mobile Telephone Number and/or Answering Machine Number: _____-_____-_____

- ❒ I consent to messages with detailed information as outlined above
- ❒ Leave messages with first name and callback number only
- ❒ Do not leave messages at my mobile telephone number

Address Where Private Health Information Can Be Mailed To You:

Street: _____

City, State, Zip: _____

I request and consent that Serra May Plourde, MAc., Lic. Ac. may contact and leave messages with the following person(s) as indicated:

Name: _____ Relationship: _____

Phone: _____-_____-_____ ❒ I designate this person as my emergency contact

❒ Leave detailed messages ❒ Leave callback information only

Name: _____ Relationship: _____

Phone: _____-_____-_____ ❒ I designate this person as my emergency contact

❒ Leave detailed messages ❒ Leave callback information only

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken relying on this consent.

_____ _____

Signature of Patient/Guardian Date

Revised 02-03-2004

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