The Wellness Tree - Carrie J. Graves

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a Florida Medical Board Acupuncture Physician employed or contracted with our office.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin 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.

Chinese Herbs: I understand that substances from the Oriental 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 my 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.

Cupping: I understand that cupping is a modality used to increase circulation, relax muscle tissues, and alleviate pain. As a result this may lead to a discoloration of the skin in the form of a bruising that is temporary. I understand that I may refuse this treatment.

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.

Acupuncture Injection Therapy/Trigger Point Injections: I understand that injection therapy is the injection of herbs, homeopathics, and other nutritional supplements in the form of sterile substances into acupuncture points by means of hypodermic needles but not intravenous therapy to promote, maintain, and restore health; for pain management and palliative care; for acupuncture anesthesia; and to prevent disease.

I understand that there may be other treatment alternatives, including treatment offered by other specialists and healthcare providers. I hereby voluntarily agree to accept acupuncture treatments. I also understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

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.

Printed Name ________________________________ **Signature:** ____________________________________

DOB: _______ **Date:** _______ How did you hear about our office? ______________________________________

Street Address: ________________________________ City:________________ State: ______ Zip:___________

Email Address: ____ Phone: ________________________________

Primary Care Provider: ________________________________ Other Physician: ___________________________

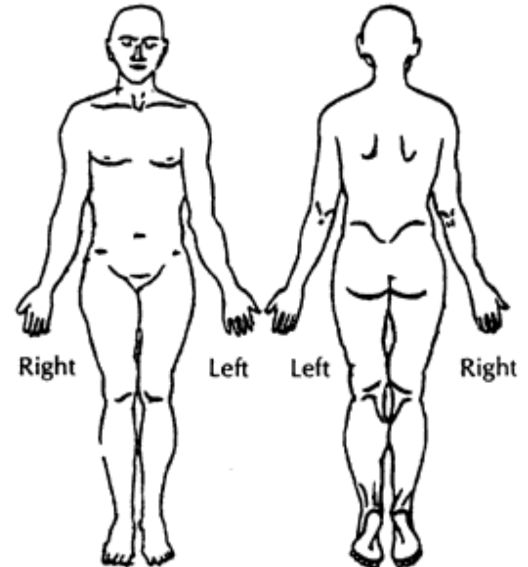
The Wellness Tree - Health History

Dr. Carrie J. Graves - Doctor of Oriental Medicine, Acupuncture Physician **Date** ________

Have you had acupuncture before? Y / N Have you sought treatment for this condition before? Y / N

Chief Complaint

On a scale from 1-10 (10 being the worst) please rate your chief complaint(s) and how long it has been bothering you



Condition

1 : ____

2: ____

3: ____

4 : ____

5 : ____

Please list all **prescription medications**, doses, conditions, and how long you have been taking the medication.

Medication	Dose (ex: 20mg, 2x daily)	Condition	Prescribed date (ex: August 2010)

Please list all **supplements and vitamins**, doses, conditions, brand, and how long you have been taking the medication

Medication	Brand	Dose (ex: 20mg, 2x daily)	Condition	Prescribed date (ex: August 2010)

With acupuncture and herbal therapies, dosages of medications may need to be adjusted **as my condition improves**. I understand that any changes in medication and/or doses will be done gradually and under the care of all my physicians. I will notify my prescribing practitioner of changes in dose or medication.

Signature________________________________ Date_________

General Health Information:

Please indicate if you or a family member has had or currently has any of the conditions below (parents, siblings, grandparents, children)

Allergies ○ Self ○ Family	Seizures ○ Self ○ Family	Kidney Disease ○ Self ○ Family
Arthritis ○ Self ○ Family	Heart Disease ○ Self ○ Family	Mental Illness ○ Self ○ Family
Bleeding disorder ○ Self ○ Family	Hepatitis ○ Self ○ Family	Stroke ○ Self ○ Family
Cancer ○ Self ○ Family	High Blood Pressure ○ Self ○ Family	Infectious Disease ○ Self ○ Family
Diabetes ○ Self ○ Family	HIV/AIDS ○ Self ○ Family	
Do you have a **PACEMAKER?** ○ Yes ○ No	Are you on **Blood Thinners?** ○ Yes ○ No	Are you **Pregnant** or trying to get pregnant? ○ Yes ○ No

Surgeries and Major Trauma (List type and date)

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Allergies and Known Reactions

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Lifestyle & Nutrition - check which substance you use and how often	**Lifestyle & Nutrition -** check which substance you use and how often
○ Alcohol ______________	○ Stress : None Low Med High
○ Caffeine ______________	○ Sleep Total Hours: __________
○ Marijuana _____________	○ Sleep Quality: Poor Good
○ Sugar_________________	○ Hours per Week Working _______
○ Tobacco_______________	○ Hours per Week Commuting _______
○ Soft Drinks ____________	○ Hours per Day Sitting _______
○ Fast Food _____________	○ Hazardous Materials ________________________________

Diet - Please describe a typical day

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Beverages ____

INSTRUCTIONS: fill in only the circles which apply to you.

● ○ ○ MILD symptoms (occurs rarely)
○ ● ○ MODERATE symptoms (occurs several times a month)
○ ○ ● SEVERE symptoms (occurs almost constantly or daily)

Musculoskeletal

○ ○ ○ Joint Pain
○ ○ ○ Muscle Weakness
○ ○ ○ Pain
○ ○ ○ Cold hands/feet
○ ○ ○ Numbness/Tingling

Other: ______________________

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Head, eyes, ears, nose, & throat

○ ○ ○ Dizziness
○ ○ ○ Concussions
○ ○ ○ Headaches
○ ○ ○ Migraines
○ ○ ○ Eye Strain
○ ○ ○ Cataracts
○ ○ ○ Ringing in Ears
○ ○ ○ Night Blindness
○ ○ ○ Nose Bleeding
○ ○ ○ Sinus Pressure
○ ○ ○ Grinding Teeth
○ ○ ○ Mouth Sores

Other: ______________________

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Respiratory

○ ○ ○ Cough
○ ○ ○ Wheezing
○ ○ ○ Bronchitis
○ ○ ○ Pneumonia
○ ○ ○ Chest Pain
○ ○ ○ Phlegm in Chest
○ ○ ○ Asthma

Other: ______________________

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Cardiovascular

○ ○ ○ High Blood Pressure
○ ○ ○ Low Blood Pressure
○ ○ ○ Chest Pain
○ ○ ○ Palpitations
○ ○ ○ Dizziness when Standing
○ ○ ○ Irregular Heartbeat
○ ○ ○ Varicose Veins
○ ○ ○ Mitral Valve Prolapse

Other: ______________________

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Gastrointestinal

○ ○ ○ Nausea
○ ○ ○ Diarrhea
○ ○ ○ Constipation
○ ○ ○ Gas
○ ○ ○ Bloating
○ ○ ○ Acid Reflux
○ ○ ○ Bad Breath
○ ○ ○ Hemorrhoids
○ ○ ○ Gallbladder problems
○ ○ ○ Parasites
○ ○ ○ Abdominal Pain

Other: ______________________

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Genito-urinary

○ ○ ○ Painful Urination
○ ○ ○ Frequent Urination
○ ○ ○ Dribbling Urine
○ ○ ○ Night Urination
○ ○ ○ Kidney Stones
○ ○ ○ Genital Pain
○ ○ ○ Genital Itching
○ ○ ○ Frequent Infections

Other: ______________________

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Neuropsychological

○ ○ ○ Anxiety
○ ○ ○ Depression
○ ○ ○ Bad Temper
○ ○ ○ Irritability
○ ○ ○ Overthinking

Other: ______________________

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Skin

○ ○ ○ Rashes
○ ○ ○ Hives
○ ○ ○ Itching
○ ○ ○ Acne
○ ○ ○ Dandruff
○ ○ ○ Oily Skin
○ ○ ○ Dry Skin

Other: ______________________

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Men

○ ○ ○ Prostate Problems
○ ○ ○ Erectile Dysfunction
○ ○ ○ Fertility Problems
○ ○ ○ Painful/swollen testicles

Other: ______________________

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Women

○ ○ ○ Frequent Infections
○ ○ ○ Endometriosis
○ ○ ○ Hot Flashes
○ ○ ○ Ovarian Cysts
○ ○ ○ Irregular Periods
○ ○ ○ Moodiness

Age of first period ____________
Date of Last Period ___________
Duration of bleeding __________
Cycle Days __________

○ ○ ○ Cramps
○ ○ ○ Clot

Number of births _____
Miscarriages _____
Abortions _____

OFFICE POLICIES

Welcome to our Practice! We have implemented certain office policies and procedures to ensure safety and the highest level of care.

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1. We do not dispense any herbal medicine or supplement to people who are not active patients within the last year.

2. We are available for communication primarily via phone and secondarily via e-mail. Please do not text, instant message, Facebook, Twitter, or otherwise attempt communication, as these may not be received and your medical confidentiality cannot be guaranteed. Likewise, if you e-mail and do not receive a return e-mail within 24 hours, please call the office; phone is the most reliable route of communication for our office.

3. Our physician is available for communication with active patients for quick questions that can be answered briefly. If you have a more complex question or lengthy explanation, or if your question requires an in-depth answer, we may ask that you schedule an appointment, either in-office or on-phone.

4. We try to return phone calls and e-mails within a few hours, but sometimes that is not possible. We do not have full-time receptionists and will make every attempt to return your phone call as soon as possible.

5. We do not practice emergency medicine. If you have an emergency, please call 911 or report to your local emergency room or urgent care clinic. If you have an urgent situation that you think does not require an emergency room visit, and you think our office may be able to help, please phone us. We will do what we can for you, but if your situation worsens or if you do not hear back from us within a time-frame that is appropriate for your situation, please call 911 or report to your local emergency room or urgent care.

6. We keep your health information private. If you would like a copy of our Privacy Practices, please let us know.

FINANCIAL POLICIES

Full Payment is due at time of service
Payment Methods Accepted: Cash, Check, Visa, Mastercard, Discover & American Express are accepted.

We do offer a $5 discount for cash and check

Returned Checks: Each returned check will incur a fee of $35.
Cancellations or Missed Appointments: We require a notice of 24 hours if you need to cancel an appointment, or you will be billed for a full treatment.

If you have a **Health Savings Account**: Acupuncture treatment is allowable under all HSA's. You will need to check with your specific HSA to find out if herbal medicine prescribed by a health professional is an allowable expense.

If your Health Insurance Policy Covers Acupuncture: We do not do insurance billing. At your request, we will provide you a superbill/receipt form which contains all the procedure & diagnostic codes prudent to your visit. You can submit a copy of this form to your insurance company for them to reimburse you directly.

If you are an Auto Injury Patient: Unfortunately, Florida PIP no longer covers acupuncture or massage therapy services. If You are a Medicare Patient: At this time, Medicare does not cover acupuncture services.

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I have read and agree to the above Office and Financial Policies

Signature______________________________ Date_________