Melissa Yaden EAMP, LMT, AP | 1233 Lawrence St Suite 102 Port Townsend, WA 98368
360-434-0670 | Northwesthealingtree@gmail.com | www.healingtreeacupuncture.com

Healing Tree Acupuncture & Ayurveda New Patient Information

Name _____ Today's Date _____

Street Address _____ Unit _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Receive Healing Tree Acupuncture & Ayurveda's Newsletter: Yes: No:

Birth Date (include year) _____ Age _____

Gender _____ Height _____ Weight _____

Occupation _____ Employer _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____ Phone _____

Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____

Name _____ Phone _____

Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of **24 hours notice**. Failure to do so will result in being charged $50 missed appointment fee to your account.

☐ **I understand the cancellation policy.**

Signature:_____ Date: _____/_____/_____

Health History:

Have you had acupuncture before? _____ If so, for what reason? _____

Have you had Ayurvedic treatment before? _____ If so, for what reason? _____

Main issue(s) you are seeking treatment for and length of time experiencing each: _____

_____

_____

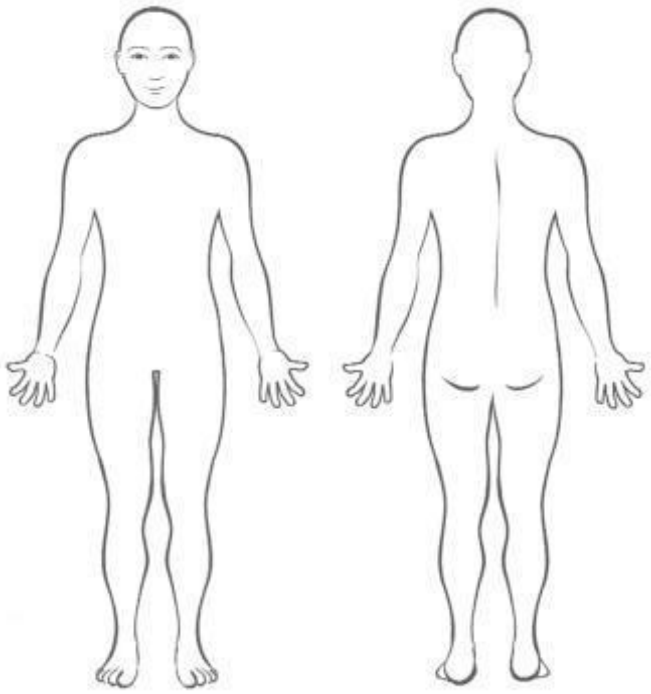
_____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable): _____

_____

_____

Please mark any areas of pain or discomfort:



Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

_____

_____

_____

_____

_____

_____

Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
sweating easily during the day	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair	☐	☐

Please elaborate:

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Please elaborate:

_____

_____

_____

_____

_____

_____

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐			

Please elaborate:

_____

_____

_____

_____

_____

_____

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Please elaborate:

_____

_____

_____

_____

_____

_____

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections	☐	☐
bacterial vaginosis	☐	☐			

Please elaborate:

_____

_____

_____

_____

_____

_____

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

Please elaborate:

_____

_____

_____

_____

_____

_____

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

Please elaborate:

_____

_____

_____

_____

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_____

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Are you currently pregnant or breastfeeding? _____

Have you been through menopause? Age? _____

Did you experience a difficult menopause?

_____

_____

_____

_____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

Please elaborate on any of the above:

_____

_____

_____

_____

_____

_____

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

_____

_____

_____

_____

_____

_____

Lifestyle:

Current medications/herbs/supplements (please list brands/dosages and how long you have been taking each):

_____

_____

_____

_____

_____

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

_____

_____

_____

_____

_____

_____

How much water, caffeinated drinks, and alcohol do you drink per day?

_____

_____

_____

_____

Current exercise routine:

_____

_____

_____

_____

Are you currently taking any of the following medications? *(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen	Aleve/Naproxen	Prednisone/Prednisolone
Celebrex/Celecoxib	Bayer/Aspirin	Acetaminophen/Tylenol

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

_____

Family Medical History:

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

What are your goals for your health?

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.

Healing Tree Acupuncture & Ayurveda Consent Form

Melissa Yaden EAMP, LMT, AP (AC60185523, MA60198889)

I.
Informed Consent for Treatment
Please read the information carefully, and ask your Practitioner if there is anything you do not understand.

Melissa Yaden EAMP, LMT, AP is a graduate from Bastyr University with a masters in acupuncture and oriental medicine, and in conjunction with Bellevue massage school, a certificate of completion for massage therapy. Melissa is nationally certified by the NCCAOM, and certified with FSMTB. Melissa has also furthered her training in Ayurvedic wellness practitioner and bodywork through Kerala Ayurveda Academy. In addition to her formal training, Melissa also has furthered her education in sound healing with Tibetan singing bowls, five element acupuncture, craniosacral therapy, manual ligament therapy, flower essences, and aromatherapy. A session with Melissa may include, but is not limited to the following:

Acupuncture needles to stimulate acupuncture points and meridians
Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points/ meridians
Moxibustion (direct and indirect)
Acupressure, acutonics, singing bowls(sound vibration)
Cupping
Bleeding, use of lancets
Dermal friction technique (gua-sha)
Inferred
Laser-puncture, point injection therapy
Qi gong techniques
Breathing, relaxation and East Asian Medicine Exercise treatments
Massage (East Asian massage "tui na", Ayurvedic oil and marma massage, Swedish, sports, and deep tissue)
Craniosacral therapy
Heat/cold application
Ayurvedic diet and lifestyle advice
Dietary and health education based on East Asian Medicine Theory, including herbs, vitamin/mineral, dietary/ nutritional supplements. The herbal advice/prescription is based on Chinese and Ayurvedic Medicine.

Acupuncture is very safe, adverse side effects are very rare. Side effects can occur in small percentage of patients, and may include the following: minor pain during or
following treatment in the insertion area or meridian, minor burning, bruising or bleeding, broken needles, fainting, and drowsiness. In some patients, symptoms can worsen after the treatment, if this occurs with you, contact your acupuncturist as promptly as possible.

Herbal medicine is very safe, and used traditionally in Chinese medicine and Ayurvedic medicine, although some are toxic in large doses. There are also some herbs inappropriate during pregnancy. Some possible side effects of taking herbal medicine are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, tingling of the tongue. I will notify my Practitioner regarding any side effect mentioned or not above, and if I think I may be pregnant.

Apart from routine medical details that will be discussed during your intake, it is important that you let your acupuncturist know:
If you have ever experienced fainting, or are sensitive or nervous about needles
If you have a pacemaker, or any other electrical implants.
If you have any bleeding disorder, or on any anti-coagulants (blood thinners)
If you have a damaged heart valve, or have any other particular risk of infection
If you are or think you might be pregnant
If you have a serious condition and are not being treated by a Primary Health Care Physician, please refer to the Serious Condition Form and sign your name there as well.

Statement of consent:

I confirm that I have read and understood the above information and the notice of privacy practices.
I consent to receive acupuncture/massage/Ayurvedic treatment. I understand that I can refuse treatment or an element of a treatment at any time. I acknowledged no guarantees have been given regarding the outcome of my treatment(s). I release Melissa Yaden EAMP, LMT, AP from all liability which may occur in connection with the above mentioned procedure.

II.
Office Policies:
FEE:
I understand that fee for treatment is payable at the time of service, I assume full responsibility for paying Melissa Yaden EAMP, LMT, AP any money owed for treatment.

III.
MISSED APPOINTMENT:
I will give 24 hour notice if I need to cancel my appointment. I understand that without advanced notice, the time reserved for me is my responsibility and will be charged $50.00 missed appointment fee. Insurance companies do not pay for missed appointments, so I understand that any appointments missed are my final responsibility. Exceptional circumstances will be considered regarding this policy.

IV.
Notice of Privacy Practices:
I acknowledge that I have received, and made aware of the privacy practices policy, and are welcome to have a copy upon request. If you have any questions or concerns don't hesitate to ask, thank you.

By signing I acknowledge that I have read and understand the Articles I-IV in this document

Signature: _____

Date: _____

Printed Name: _____

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal
medical and financial information with your insurance company and with Worker's Compensation (and your
employer as well in this instance), or with other medical practitioners. We will obtain your authorization before
disclosing any information.

Safeguards in place at our office include:

• Limited access to facilities where information is stored.
• Policies and procedures for handling information.
• Requirements for third parties to contractually comply with privacy laws.
• All medical files and records (including email, regular mail, telephone, and faxes sent)
are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:
• About your financial transactions with us (billing transactions).
• From your medical history, treatment notes, all test results, and any letters,
faxes, emails or telephone conversations to or from other health care
practitioners.
• From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).
In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you -e.g. your name, address, Social Security number, etc.).
We value our relationship with you and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours.

Sincerely,

Melissa Yaden EAMP, LMT, AP
www.healingtreeacupuncture.com
360-434-0670