Acupuncture
A s s o c i a t e s

Bellevue: 15100 SE 38th Street Suite 305B Bellevue, WA 98006
Marysville: 1519 9th St. Suite 103 Marysville, WA 98270

New Patient Intake Form

DATE:___________________

Name: SS#: Birthday: / /

Marital Status: _________________ Age: _________ ❑Male ❑Female Ht Wt

Address: City: Zip:

Best Contact Phone #: 1.(_______)__________________ 2.(________)___________________

Emergency Contact (Name & Phone) Occupation/Employer:

Referred by

Have you had Acupuncture before? ❑ Yes ❑ No

Reason for today's visit How Long have you had this condition?

Does it bother your: ❑ Sleep ❑ Work ❑ Other (What?)

What seemed to make it **better** or **worse**?

Is this related to Auto Accident or work injury? If Auto, PIP or PI? DOA:_______________

If work related, L&I or company liability?

Are you currently under the care of physician? ❑ Yes ❑ No If yes, for what?

Who is your physician?(Name & Phone):

Current Medications(any allergies):

Other concurrent therapies:

Please check ✔ if YES to any of following Medical condition:

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are significant part of your medical history.)

❑AIDs/HIV	❑ Epilepsy	❑ Pacemaker	❑ Thyroid Disorders	❑ pregnant
❑ Alcoholism	❑Heart Disease	❑ Seizure	❑Tuberculosis	❑ Whooping Cough
❑ Allergies	❑ Hepatitis	❑ Stroke	❑ Trauma	❑ Other (Specify)
❑ Asthma	❑ Herpes	❑ Surgery (List)		
❑ Cancer	❑ High Blood Pressure	____________	____________	____________
❑ Diabetes	❑ Multiple Sclerosis	____________	____________	____________

YOUR LIFESTYLE

❑ Alcohol
❑ Tobacco
❑ Marijuana
❑ Drugs
❑ Stress
❑ Occupational Hazards
❑ Regular Exercise
Type: Frequency:
Type: Frequency:

GENERAL SYMPTOMS

❑ Poor appetite
❑ Heavy appetite
❑ Prefer cold drinks
❑ Prefer hot drinks
❑ weight gain or loss
❑ Poor sleep
❑ Heavy sleep
❑ Dream disturbed sleep
❑ Fatigue
❑ Lack of strength
❑ Bodily heaviness
❑ Cold hands or feet
❑ Poor circulation
❑ Shortness of breath
❑ Fever
❑ Chills
❑ Night sweats
❑ Sweat easily
❑ Muscle cramps
❑ Vertigo or dizziness
❑ Bleed or bruise easily
❑ Peculiar taste (describe)
____
____
____

HEAD/EYES/EARS/NOSE/THROAT

❑ Glasses
❑ Eyestrain
❑ Eye pain
❑ Red eyes
❑ Itchy eyes
❑ Spots in eyes
❑ Poor vision
❑ Blurry vision
❑ Night blindness
❑ Glaucoma
❑ Cataracts
❑ Teeth problems
❑ Grinding teeth
❑ TMJ
❑ Facial pain
❑ Gum problems
❑ Sores on lips or tongue
❑ Dry mouth
❑ Excessive saliva
❑ Sinus problems
❑ Excessive phlegm
❑ Color of phlegm
____
❑ sore throat
❑ Lumps in throat
❑ Enlarged thyroid
❑ Nose bleeds
❑ Ringing in ears
❑ Poor hearing
❑ Earaches
❑ Headaches
❑ Concussions
Other head or neck problems
____
____
____

RESPIRATORY

❑ Tightness in chest
❑ Cough
Productive?___________________
Wet or dry?___________________
❑ Bronchitis
❑ Pneumonia
❑ Color of phlegm
____
❑ Shortness of breath
❑ Asthma/wheezing

CARDIOVASCULAR

❑ High blood pressure
❑ Blood clots
❑ Low blood pressure
❑ Fainting
❑ Chest pain
❑ Difficult breathing
❑ Tachycardia
❑ Irregular heartbeat
❑ Palpitations

GASTROINTESTINAL

❑ Nausea
❑ Vomiting
❑ Acid regurgitation
❑ Gas
❑ Hiccup
❑ Bloating
❑ Bad breath
❑ Diarrhea
❑ Constipation
❑ Laxative use
❑ Black stools
❑ Bloody stools
❑ Mucous in stools
❑ Intestinal pain/cramp
❑ Itchy anus
❑ Burning anus
❑ Rectal pain
❑ Hemorrhoid
❑ Anal fissures

Bowel movements:
Frequency_______________ Texture/form_______________
Color__________________ Odor____________________

MUSCULOSKELETAL

❑ Neck/shoulder pain
❑ Muscle pain
❑ Upper back pain
❑ Low back pain
❑ Joint pain
❑ Rib pain
❑ Limited range of motion
❑ Limited use
Other (describe)
____

SKIN/HAIR

❑ Rashes
❑ Hives
❑ Ulcerations
❑ Eczema
❑ Psoriasis
❑ Acne
❑ Dandruff
❑ Itching
❑ Hair loss
❑ Change in hair
❑ Fungal infection
❑ Change in skin texture
Other hair or skin problems
____
____

NEUROPSYCHOLOGICAL

❑ Seizures
❑ Numbness
❑ Tics
❑ Poor memory
❑ Depression
❑ Anxiety
❑ Irritability
❑ Easily stressed
❑ Abuse survivor
❑ Considered suicide
❑ Attempted suicide
❑ Seeing therapist
Other (specify)
____
____

GENITO-URINARY

❑ Pain on urination
❑ Frequent urination
❑ Urgent urinaiton
❑ Blood in urine
❑ Unable to hold urine
❑ Incomplete urination
❑ Venereal disease
❑ Bedwetting
❑ Wake to urinate
❑ Increased libido
❑ Decreased libido
❑ Kidney stone
❑ Impotence
❑ Premature ejaculation
❑ Nocturnal emission

GYNECOLOGY

❑ Age menses began
____
❑ Length of cycle
____
❑ Duration of flow
____
❑ Irregular periods
❑ Painful periods
❑ PMS
❑ Vaginal discharge
(color)_______________
❑ Vaginal sores
❑ Vaginal odor
❑ Clots
❑ Breast lumps
#Pregnancies__________
births_______________
Premature births________
Age at Menopause_______
Date of last PAP
____
Date last period began
____

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee f6r your request. Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or e-mail a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgement

Patient Name(s) ____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledgment of your receipt of our policy by signing this Notice.

Patient Signature______________________________Date_______________

Instructions to the NAET patient before beginning the treatment

1. Patients should be encouraged to read *Say Good-bye To Illness* before they begin the NAET treatments.
2. Please do not wear any perfume, perfumed powder, strong smelling deodorant hair spray, or after shave, eat strong smelling herbs like raw garlic, etc., when you come to the clinic for treatments.
3. There is no smoking allowed in (or around) the office. Please do not wear clothes that smell like smoke or paint. Other patients could react to these smells.
4. Please wash your hands before and after the treatment. After the treatment, if the patient cannot wash his/her hands, vigorous subbing of the hands for 30 seconds will be sufficient.
5. Do not exercise for 6 hours after the treatment.
6. Avoid exposure to extreme hot or cold temperature after the treatment.
7. Please take a shower before you come for a treatment, and wear freshly washed clothes to avoid smell of herbs, spices, perspiration, etc. from your body or clothes. This can cause irritation and reactions in other allergic patients.
8. Do not bathe or shower until 6 hours after the treatment.
9. Do not eat or chew gum or candy during treatment.
10. Do not cross your hands or feet during the first 20 minutes after the treatment.
11. Do not read or touch other objects during the 20 minutes following the stage 1 spinal manipulation treatment because contact with other substances during this period could cause your treatment to fail.
12. Wear minimum or no jewelry when you come for a treatment. Avoid wearing large crystals or large diamonds.
13. Remember to check with your doctor for the item you treated, after 25 hours, and at least within one week to make sure you have completed the treatment. If you did not complete the treatment, your symptoms due to the incomplete treatment may continue for a long time, sometimes for weeks. Eventually the symptoms will wear of if you did not repeat the treatment for the unfinished allergen.
14. To insure maximum progress with your treatments maintain your own treatment and food diary in the NAET guide book at the section for record keeping in the book. If you need help to record your treatments, please ask your practitioner.
15. You may need to take extra precaution while you get treated for environmental substances: (mineral mix, metals, water, leather, formaldehyde, fabric, wood, mold, mercury, newspaper, maker ink, chemicals, flowers, perfume, etc.).

Apart from staying away from the item, you may also need to wear mask, gloves, socks and shoes even to bed, full gowns, scarf, earplugs, covering your head, ear, and forehead, etc., if you are highly sensitive to the allergens.

16. Always eat before you come for the treatment. You should not take NAET treatments and acupuncture when you are hungry.
17. Do not eat heavy meals after the NAET or acupuncture treatments.
18. Drink a glass of water before the NAET treatment. Energy moves better in a well hydrated body. Drink lots of water (4-6 glasses/day) after NAET and acupuncture treatments to help flush out the toxins produced during the treatment.
19. Please do not stop any other treatment you are on: medication, therapy, chiropractic treatments, massages etc. It is good for your body to have a general body massage immediately before the NAET or 6 hours after the NAET treatments.

Massages can help to improve the energy flow through the energy pathways. If you are taking lots of vitamins and herbs, or any particular drug, you may continue them as before if you think that they are helping you. But when you get treated for the food containing a particular vitamin, herb, or substance, at certain times you may be asked to stop using it for 25 hours following that particular treatment.

20. NAET treatment will not interfere with any other treatment. In fact, if you can keep your body free of toxin accumulation (stool softeners, laxatives, to prevent constipation, and colonics or high enemas once or twice a month to eliminate the toxic build up), and keeping your symptoms under control with whatever method you are using. NAET treatment will be a lot easier.

Acupuncture Associates

Bellevue	Marysville	Puyallup
15100 SE 38th St. Ste.305B	1519 9th. St. Ste.103	13909 Meridian E #A2
Bellevue, WA 98006	Marysville, WA 98270	Puyallup, WA 98373

CONSENT FORM FOR NAET

I, ____certify that Jyun Shimizu, D.Ac., L.Ac. does not claim to cure any illness or disease with NAET (Nambudripad's Allergy Elimination Techniques).
I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (Allopathic, chiropractic, kinesiological, and acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.
I understand that I am (my dependent) to continue all medications and other treatment modalities as they have prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my dependent) get a life-threatening reaction from the allergen I (my dependent) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am treating with NAET treatments.
This way essential NAET treatments can be completed without interruption and once I (my dependent) complete the essential NAET treatments for my (my dependent's) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.
I understand that for 25 hours after the treatment I (my dependent) am to avoid eating, touching, breathing and coming within 5 feet or more as it was instructed by my practitioner of the substance(s) that I (my dependent) have received treatment. If I (my dependent) come in contact with the substance(s) for which I (my dependent) am being treated, I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction.
I understand that I (my dependent) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my dependent) have cleared for the substance(s). I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) come in contact with them if I (my dependent) did not clear them completely. If I (my dependent) did not clear them completely, I (my dependent) may require to repeat the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.
Patients with seizure, severe bleeding disorders, pace makers or pregnancy should inform practitioners prior to any treatment.
x__________(your initial) I am fully aware that the clinic allows a specific amount of time for my treatment and that if I arrive late my treatment will be adjusted to fit into that time schedule. I also understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment. Late arrivals and appointments missed without proper notice will be billed at the current rates.
I have read or have had read to me the above statements and have had opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

Signature of Patient or Signature of person authorized to consent / Date Signature of Witness / Date

Office Policies and Authorization for Treatment

I, ________________________________, understand that acupuncture is an energetic form of therapy based on the regulation of energy, and is not intended to replace conventional medical treatment. I assume full responsibility for consulting with appropriate physician since I understand that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Acupuncture Associates, to perform the following specific procedures:

Acupuncture procedures involving insertion of special needles through the skin into the underlying tissue at specific points on the surface of the body, as well as other techniques as specifically described in the Washington State Law for Licensed Acupuncturists, such as moxibustion, cupping, electroacupuncture and acupressure.

I recognized the potential benefits and risks of the above procedures included reactions as described below:

> Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention, or elimination of the presenting problem.
> Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruised, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given me by Acupuncture Associates, regarding cure or improvement of my condition.

I hereby release Acupuncture Associates, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

FEE:

I understand that fee for treatment is payable at the time of service unless I am receiving testament via a medical plan which recognizes Acupuncture Associates, as a Preferred provider. In such an event, payment shall be provided as per the terms of the plan. If it is found I am not eligible for coverage of testament by my medical plan, I assume full responsibility for paying Acupuncture Associates any money owed for treatment.

MISSED APPOINTMENT:

I will give 24 hours notice if I need to cancel an appointment. I understand without that advance notice, the time reserved for me is my responsibility and will be charged to me as a missed appointment. Missed appointments are charged at the same rates as regular appointment. Insurance companies do not pay for missed appointments so I understand that any appointments missed are my financial responsibility. Exceptional circumstances will be considered regarding this policy.

______________________________ ______________________

Signature of Patient Date

______________________________ ______________________

Signature of Person Authorized to consent Date

Acupuncture Associates

PROFESSIONAL FEE SCHEDULE

Acupuncture Associates of Bellevue/Eastgate
15100 SE 38th St. Suite 305B
Bellevue, WA 98006

Service	Fee
New Patient Consultation/Examination Consulting based on patient's symptom, Tongue and pulse diagnosis	**\$45.00 - \$90.00**
Established Patient Consultation/Examination	**\$25.00 - \$65.00**
Acupuncture Treatment	**\$50.00 - \$75.00**
Electro Acupuncture Treatment	**\$60.00 - \$90.00**
Infra-red (TDP) Heat Treatment	**\$25.00**
Return Check Charge	**\$20.00**
Missed Appointment Charge	**\$40.00**
NAET Fee First Office Visit Charge	**\$125.00**
NAET Return Office Visit Charge	**\$75.00**

If I am covered by insurance, I am responsible for any balance not paid within 90 days.

Any call to your insurance company regarding benefits made by Acupuncture Associates of Bellevue/ Eastgate is done as a courtesy and is not a guarantee of payment.

I am still responsible for coordination of my insurance.

Acupuncture total charge, billed to insurance ranges from \$80.00 - \$175.00 per visit.

Date ______________________________
Signature ________________________________