Miranda Taylor, M.TCM. EAMP, L.Ac., High Point Health pllc dba Jade River Acupuncture
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New Patient Information & Health History

Date: ___/___/___

Patient's Name (Last, First, M.I.)	****DOB** (mm/dd/yyyy) **Sex**(M/F/O)	**Patient Status**: Single ☐ Married ☐ Other ☐ **Employed** ☐ **Student**: F-Time ☐ P-Time ☐	
Patient's Address (No. Street)	**Relation to Insured**	**Patient's Employer/Occupation**	
City **State**	**Zip Code**	**Home/Cell Phone** (10 digit)	**Work/Cell/Other Phone**
Insured's Name (Last, First, M.I.)	****DOB** (mm/dd/yyyy) **Sex**(M/F/O)	**Insured's Employer:**	
Insured's Address (No. Street)	**Phone** (10 digit)	**Describe Health of Partner:**	
City **State**	**Zip**	**Number of Children, if any:** _____	
Patient's e-mail address:		**Names/Ages/Concerns** (add paper if needed)	

Insurance Company (I will copy your card front & back**) or Auto Ins. adjuster name & phone:**

Auto Accident? Y N **U.S. State** **Injury Date** **Injury Claim Number**

Are you presently being treated for a medical condition? Please describe. _____

What health issue(s) do you want treated? When did issue(s) begin? Have you been given a diagnosis? If so, what? Please describe as fully as possible, on separate sheet - if needed - for all your health concerns. _____

What treatments have you tried already? What were the results?_____

To what extent does this problem interfere with your daily activities?

How severe is (are) your problem(s) right now? (Please mark the scale below):

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below):

No problem Moderate Worst Imaginable

Your Past Medical History (please indicate with **date(s)** on the line:

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____

Surgeries (type and date), Other Significant Trauma (auto accidents, falls, etc. and date):

_____

_____

Significant Dental Work (type and date): _____

_____

Birth History (prolonged labor, forceps delivery, caesarian section, etc, when YOU were born):

_____

(How) Do You Take Care Of Your Spirit? _____

Family Medical History (other family members besides yourself):

☐ High Blood Pressure	☐ Alcoholism	☐ *Cancer:*	☐ Allergies (other family):
☐ Heart Disease	☐ Seizures	*Who? What kind?* _____	
☐ Arteriosclerosis	☐ Asthma	☐ Stroke	☐ Diabetes

Occupational Stress (chemical, physical, npsychological, etc.): _____

_____

Do you exercise regularly? Y or N Please describe: _____

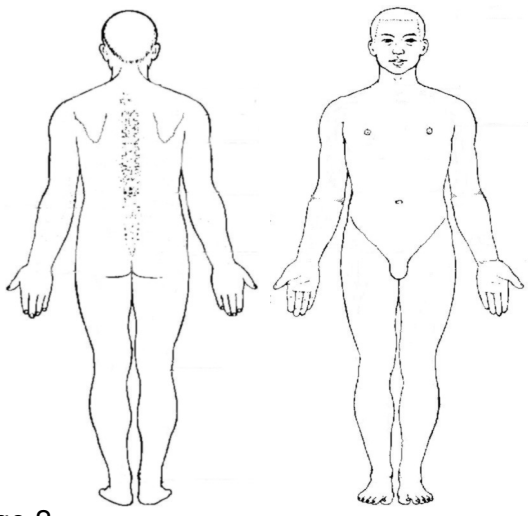
_____

Please list any other problems you would like to discuss: _____

How do you feel about the following areas in your life? Please circle appropriate description and indicate any problems you may be experiencing.

Partner or significant other:	great good fair poor bad	_____
Family:	great good fair poor bad	_____
Diet:	great good fair poor bad	_____
Sex:	great good fair poor bad	_____
Self:	great good fair poor bad	_____
Work:	great good fair poor bad	_____

Please indicate Painful or Distressed Areas on diagram of body below:



What are Your Treatment Goals?

- ☐ Temporary relief of symptoms, such as pain control.
- ☐ Eliminate root or cause of problem, if possible.
- ☐ Lessen/eliminate habits which contribute(d) to condition.
- ☐ Maintenance care (to keep in good health).

On the following page, please check any boxes of acute symptoms you have had in the past 2 weeks. Please also check long-term chronic conditions that you still have, and include dates, if requested:

Patient Name: _____ Date: _____

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema (swelling)
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches…
  *When:*_____

  Where: _____
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

_____

Cardiovascular

- ☐ Arteriosclerosis/Stints
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

Gastrointestinal

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

*Other stomach or intestinal problems:*_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?

☐ Yes ☐ No

How often? _____
What color is your urine?

_____

*Other genital or urinary system problems?*_____

Pregnancy and Gynecology

of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Average Length of full cycle:
e.g. 23-34 days_____
Average Length of menses:
e.g 3-7 days_____
Last menses start date:

_____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  Year: _____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

Other pain / lack of movement?

_____

Neuropsychological

- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?

☐ Yes ☐ No

Patient Name: _____ Date: _____

Last Physical Date: _____ Doctor: _____ Results: _____

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

_____

What medicines have you taken within the last 2 months? (include prescriptions, vitamins, over-the-counter drugs, herbs, etc.) Please attach addition pages for longer lists: _____

_____

What allergies do you have? What are your reactions to chemicals, foods, drugs, animals etc?_____

_____

Any animals you or your family members are in close contact with:

_____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please circle or add comments:

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	
Coffee:	☐	☐	☐	☐	
Herbal or blackTea:	☐	☐	☐	☐	
Tobacco:	☐	☐	☐	☐	
Sleep:	☐	☐	☐	☐	
Appetite:	☐	☐	☐	☐	
Energy Level:	☐	☐	☐	☐	
Prescribed med's:	☐	☐	☐	☐	
Vitamins:	☐	☐	☐	☐	
Food Intake:	☐	☐	☐	☐	
Teeth problems:	☐	☐	☐	☐	
OTC/illegal/drugs:	☐	☐	☐	☐	
Salt Intake:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Stress Level:	☐	☐	☐	☐	

FOOD Required: Your dietary intake, in detail. **Everything you ate in the past 24 hours**:

Morning: .....

Afternoon: .....

Evening: .....

Before bed: .....

Between meals: .....

Local person to call in case of an emergency? Name & Phone:_____

Sometimes other professionals can help me provide better care for you. If you would like me to consult with any of your **other** health care professionals, I will need to have you sign an agreement form before I consult with them. Would this be helpful?
Yes --- No If Yes: please ask front desk for "authorization for release of information" form.

Permission, Authorization & Informed Consent for Treatment at High Point Health pllc, dba Jade River Acupuncture

Miranda R. Taylor, WA State East Asian Medicine Practitioner license AC 00002224

Purpose of treatment: The purpose of treatment is to resolve your complaint, i.e., the reason you are seeking treatment. The clinic provides diagnosis and treatment to promote health and treat organic and/or functional disorders. Miranda Taylor is licensed in WA since 2003 with a Bachelor of Science in biology with extensive chemistry coursework, and a 4 year Master's degree in Traditional Chinese Medicine.

Nature of treatment: High Point Health pllc dba Jade River Acupuncture provides East Asian Medicine as well as Nutrition Response Testing(SM). The scope of East Asian Medicine practice includes acupuncture, electro-acupuncture, moxibustion, acupressure, cupping, Gua Sha (dermal friction), infrared, sonopuncture (sound stimulation), laserpuncture, point injection therapy (aquapuncture) as well as dietary advice and health education based on East Asian medical theory. It also includes herbal, vitamin, and nutritional supplements; breathing, relaxation, and exercise techniques; Qi Gong, East Asian massage, and Tui Na; plus heat and cold therapies.

Nutrition Response Testing involves a Nutrition Response Testing health analysis and use of kinesiology (body reflexes) to inform Chinese medicine recommendations and to develop a natural health improvement program. The program can include dietary guidelines, nutritional supplements and life-style recommendations in order to assist the patient in improving his or her health. Note that Nutrition Response Testing is not for the treatment or "cure" of any disease. Nutrition Response Testing is a safe, non-invasive method of analyzing the body's physical and nutritional needs, and determining which deficiencies or imbalances could contribute to health problems.

Benefits of treatment: Acupuncture and East Asian Medicine procedures and nutrition have been used effectively to treat disease for hundreds of years. The Wold Health Organization lists over 40 conditions that can be effectively treated by acupuncture. These include muscular-skeletal injuries, digestive difficulties, respiratory diseases, women's health issues, etc. However, this record does not allow a guarantee of any individual course of treatment.

Nutrition Response testing does not promise or guarantee the results of treatment with this modality or any natural health, nutritional, or dietary programs recommended by Miranda Taylor. I understand that Nutrition Response Testing is a means by which the body's natural reflexes are used to determine possible nutritional imbalances so that safe natural programs can be developed and modified for the purpose of bringing about a more optimum state of health. I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" any specific disease, including conditions such as cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

Risks of treatment: East Asian Medicine procedures have been shown to be relatively safe. There are some uncommon but potential risks, which include discomfort during and after treatment, "needle sickness" which includes dizziness or fainting that might occur if the patient has not eaten shortly before the treatment; localized but minor bruising or swelling; minor burns from moxibustion, infection (rare with the use of disposable needles); broken needles; and temporary aggravation of symptoms that existed prior to treatment.

With Nutrition Response Testing, risks are minimal. Occasional aggravation of symptoms can occur if the body is detoxing rapidly, but special appointments should be made to quickly remedy them.

NOTE: Please notify Miranda if you experience any adverse effects from your treatment. She will be glad to work with you to overcome any adverse effects immediately, if they arise at all.

Patient Name: _____ Date: _____

Special Situations: You must inform Miranda if you have severe bleeding disorder, wear a pacemaker, or have any other electronic medical device on your body. Because some herbs and acupuncture points are contra-indicated during pregnancy, notify Miranda if you are pregnant or if you might become pregnant.

Confidentiality of medical records: Your medical records are not released to anyone or any organization without your written consent. If data from this clinic are used in research, all identities and individual records are kept confidential.

Required consultations: Washington State law requires acupuncturists to receive a written diagnosis or to consult with a primary care provider (MD, DO, ND,PA, ARNP) before treating patients with any of the following potentially serious disorders: cardiac conditions, including uncontrolled hypertension; acute abdominal symptoms; acute, undiagnosed neurological changes; unexplained weight loss or gain in excess of 15% of body weight within three months; suspected fracture or dislocation; suspected systemic infection; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history or diagnosis. This consultation requires your authorization; if you refuse the authorization or do not provide a recent diagnosis from the physician, you will have to sign a waiver so that treatments may continue.

Consent: By signing below, you request and consent to the performance of acupuncture, East Asian medicine treatments, and/or Nutrition Response Testing treatments. You are free to withdraw your consent and stop treatment at any time. Your signature indicates that you have read and understand the preceding information in this document and that if you have any questions, you will ask Miranda before signing.

You hereby release High Point Health pllc dba Jade River Acupuncture from any and all liability that may occur in connection with your treatments, except for the failure to perform the procedures with appropriate medical care. Your signature also indicates your understanding that you are ultimately responsible for all financial obligations for treatments.

Patient/Guardian's Name (please print): _____

Patient/Guardian's Signature: _____ Date: _____

Cancellation Policy Consent:

High Point Health dba Jade River Acupuncture enforces a strict cancellation policy. You will be charged the full amount for your scheduled appointment time if canceling or rescheduling is done less than 24 hours before your appointment. Thank you for your time and understanding.

I (please print name) _____ have read the Cancellation Policy and acknowledge that I can be charged the full amount and that I am responsible for payment for my scheduled appointment if I cancel or reschedule with less than 24 hours notice.

Patient/Guardian's Signature: _____ Date: _____