Dr. Katie Gaffney, OMD, LAc
Acupuncture and Herbal Medicine
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Patient Information

Name _____

Address _____

Primary phone _____ Text ok? Yes No

Email Address _____

Age _____ DOB _____/_____/_____ Gender _____

Emergency Contact _____
Name Phone # Relationship

Primary Care Provider name _____

INFORMED CONSENT TO TREATMENT AND CARE

Treatments may include acupuncture, moxibustion, fire cupping, electrical stimulation on the needles, gua sha (scraping), herbal medicine, lab work and nutritional counseling. The treatments selected are at the discretion of the acupuncturist. Any modality chosen will be explained in full to the patient before it is performed and the patient has the right to deny any treatment. Acupuncture and the other treatment modalities are all generally safe methods of treatment, but there are some risks and possible side effects. Please review table on the next page.

Treatment modality	Risks
Acupuncture	**Mild and more common:** - Minor bleeding, bruising at needle site - Temporary soreness, numbness, or tingling at needle site **Moderate and occasional:** - dizziness, fainting - Nerve damage **Severe and very rare:** - Infection - Organ puncture, particularly lung puncture (pneumothorax) - Uterine contractions/spontaneous miscarriage - Needle break/imbedment requiring surgical removal
Fire cupping	bruising, bleeding, blisters, burning, scarring
Moxibustion	burning, scarring
Herbal medicine	Toxic in excessive doses Possible side effects: nausea, gas, stomach ache, vomiting, headache, diarrhea, bleeding, rashes, hives, tingling of tongue

To help reduce risk of some of the side effects, lie still during treatment and inform the acupuncturist immediately about any pain caused by the needles. Come to treatment well nourished and hydrated. Treatment while under the influence of alcohol or recreational drugs is not permitted or safe.

With herbal medication, it is the responsibility of the patient to follow dosing guidelines provided by the acupuncturist. Consult the acupuncturist as soon as possible if any negative side effects are experienced. There are no refunds on herbal formulas even if the desired result is not obtained or the patient experiences side effects.
The patient accepts full responsibility to follow up with all medical advice given. By signing below, the patient consents to the treatment procedures with acknowledgement of the risks.

PREGNANCY
Some Oriental Medicine techniques, acupuncture points, and herbs are contraindicated with pregnancy. The acupuncturist must be made aware of any possible pregnancy. It is the responsibility of the patient to disclose this information.

TREATMENT OF MINORS
During the treatment of patients under the age of 18, the patient's legal guardian is required to be present in the treatment room for the entire treatment on every visit.

PRIVACY POLICY
The acupuncturist may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The acupuncturist may use the patient's phone number or email address to contact the patient regarding appointment reminders,

insurance items and any information pertaining to the patient's clinical care. The patient has the right to request that the acupuncturist restricts how it uses or discloses any PHI to carry out TPO. The acupuncturist will, only through a patient completing a specific and separate Authorization for Release of Information form, or in compliance with a legal subpoena, furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

PAYMENT & CANCELLATION POLICY

Full payment is expected at time of service. The first appointment is $95, return appointments are $75. Herbal formulas are an additional fee and vary in cost. Insurance is not accepted. Failure to provide 24 hours notice for a cancel will result in the patient's account being charged a $25 fee. Failure to show up for an appointment without any notice will result in a $50 fee. Arriving more than 15 minutes late for an appointment may result in not being seen and a no show fee.

By signing below, I acknowledge that I have read all of the above, I understand the risks, and I consent to treatment and the related terms.

_____

Patient (or guardian) signature Date

Medications	Dose	Used for

Supplements/herbs	Dose	Used for

New patient intake

Reason for visit today *

Primary health concerns *

What treatment/diagnostic modalities are you interested in today?

- [ ] Acupuncture
- [ ] Herbal medicine
- [ ] Ordering lab work
- [ ] Cupping

Pain

Where do you have pain?

If you have pain, what actions cause you to feel pain?

- [ ] Walking
- [ ] Standing
- [ ] Sitting
- [ ] Rotation/twisting
- [ ] flexing neck to chin
- [ ] extending neck (chin to sky)
- [ ] Bending forward
- [ ] bending backward
- [ ] holding weight
- [ ] lifting leg
- [ ] curling toes
- [ ] extending/lifting toes
- [ ] rotating bent arm (waiving, pouring)
- [ ] at night when resting in bed
- [ ] going upstairs
- [ ] going downstairs

If you have pain, what are the qualities of the pain?

- [ ] dull ache
- [ ] throbbing
- [ ] sharp
- [ ] burning
- [ ] tingling
- [ ] shooting/radiating

History

What major surgeries have you had?

Do you have any PERSONAL history of cancer? What type?

Do you have a history of stroke? *

- ○ Yes
- ○ No

Any history of serious infectious disease?

Current

Any diagnosed autoimmune disorders?

Any bleeding or clotting disorder or any anti-coagulant medication?

Any allergies?

Any artificial body parts, implants, or medical devices?

Are you pregnant? If so, how many weeks?

Any special requests or accommodations required during the treatment?

Diet

Do you feel you eat a healthy diet (ie. minimal sugar, fast food, & processed foods, balanced carb/protein/fat, plenty of fresh fruits & veggi *

- ○ Yes, completely
- ○ Mostly
- ○ Somewhat
- ○ No, poor diet

Are you vegan or vegetarian?

Are you regularly (more than once a week) partaking in any of the following: *

- ☐ Soda
- ☐ Alcohol
- ☐ recreational drugs
- ☐ Coffee
- ☐ Smoking cigarettes
- ☐ None
- ☐ Energy drinks
- ☐ smoking weed

Are there any foods that you intentionally avoid/restrict?

Digestive health

Symptoms

- ☐ bloating
- ☐ acid reflux
- ☐ vomiting
- ☐ excessive burping and/or flatulence
- ☐ bad breath
- ☐ trouble swallowing
- ☐ poor smell or taste
- ☐ constipation
- ☐ abdominal pain
- ☐ poor appetite
- ☐ weight gain
- ☐ bleeding gums
- ☐ lack of saliva
- ☐ itchy anus
- ☐ diarrhea
- ☐ intestinal cramping
- ☐ nausea
- ☐ weight loss
- ☐ hemorrhoids
- ☐ trouble chewing

For any digestive symptoms marked above, how long have you been experiencing these symptoms?

Do these digestive symptoms improve with healthy eating?

- ☐ Yes
- ☐ somewhat
- ☐ No
- ☐ Haven't tried

Have these digestive symptoms been unresponsive to previous treatments, protocols, supplements?

- ☐ Yes
- ☐ somewhat
- ☐ No
- ☐ Haven't tried

How many bowel movements do you typically have per week? *

Intolerance or difficulty digesting any of the following food groups?

- ☐ fats
- ☐ carbs
- ☐ protein

Any diagnosed digestive disorders?

Mental/emotional health

- [ ] Anger
- [ ] Chronic stress
- [ ] Grief
- [ ] Procrastination
- [ ] PTSD
- [ ] Eating disorder
- [ ] Phobias
- [ ] Depression
- [ ] Bipolar disorder
- [ ] Shock
- [ ] Brain fog
- [ ] Trauma
- [ ] Personality disorder
- [ ] Anxiety
- [ ] Chronic worry
- [ ] Fear
- [ ] OCD
- [ ] Addiction
- [ ] ADHD

Skin

Any diagnosed skin disorders?

- [ ] Acne
- [ ] Psoriasis
- [ ] Alopecia
- [ ] Eczema
- [ ] Rosacea
- [ ] Lichen sclerosis
- [ ] Hives
- [ ] Vitiligo

Skin quality

- [ ] dry
- [ ] rash
- [ ] plaques
- [ ] oily
- [ ] itching
- [ ] flaking
- [ ] cracks
- [ ] blisters
- [ ] weeping

Check all current medical conditions not already mentioned

- [ ] Asthma
- [ ] Migraines
- [ ] Osteoporosis
- [ ] Tinnitus
- [ ] Fibromyalgia
- [ ] Seizures
- [ ] Thyroid disorder
- [ ] Paralysis
- [ ] Neuropathy
- [ ] Infertility
- [ ] Anemia
- [ ] Heart disease
- [ ] Arthritis
- [ ] Diabetes
- [ ] Headaches
- [ ] Vision problems
- [ ] Tremors
- [ ] Chronic cough
- [ ] Prostatitis
- [ ] Allergic rhinitis
- [ ] Autoimmune disorder
- [ ] Kidney disease
- [ ] Dementia
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Hearing problems
- [ ] Traumatic brain injury
- [ ] Vertigo
- [ ] Peri or menopausal symptoms
- [ ] Sexually transmitted disease
- [ ] Recurrent infections

How does your body temperature typically feel? *

- [ ] Usually hot
- [ ] Usually cold
- [ ] Moderate
- [ ] Fluctuating to extremes

Typical energy level *

- [ ] Great
- [ ] Terrible
- [ ] Moderate
- [ ] Fluctuates to extremes

Typical sleep quality (select all that apply) *

- [ ] Always great
- [ ] Always terrible
- [ ] Fluctuates
- [ ] Trouble falling asleep
- [ ] Trouble staying asleep
- [ ] Averaging 7+ hrs/night
- [ ] Averaging 6-7 hrs/night
- [ ] Averaging 5-6 hrs/night
- [ ] Averaging less than 5 hrs/night

For women: date of last period? (Or just year if post menopause)

For menstruating women: check all symptoms/conditions

- [ ] irregular cycle
- [ ] heavy bleeding
- [ ] severe pain
- [ ] clots
- [ ] uterine fibroids
- [ ] ovarian cysts