Ashland Holistic Health

325 A St., Ste #1 ASHLAND OR 97520
PH (541) 482.1650 www.ashlandholistichealth.com

THANK YOU FOR FILLING THIS OUT SO WE MAY BETTER SERVE YOU! *Today's Date:___/___/___*

Name _____(_____) Male___ Female___ Age:___ Birth Date ___/___/___
LAST FIRST (prefer to be called)

Mailing Address _____ City _____State ____ Zip _____

Home Address (if different) _____

Phone #s: Cell _____ Home _____ Work _____

E- mail _____

Occupation _____ Employer _____

Employment Status: ___Full-time ___Part-time ___Retired ___Unemployed ___Student ___Other _____

Relationship Status: ___Single ___Married ___Divorced ___Widowed

Name of Partner/Spouse/Parent _____ Their Occupation _____

EMERGENCY CONTACT: Name _____ Phone # _____

Do you have Acupuncture Insurance? ___No ___Yes Ins. Co. _____

Whom may we thank for referring you? _____

Main Health Issue(s) you wish to address _____

_____

What was initial cause? _____

How long have you had this/these condition(s)?_____

Is it getting worse? ___Yes ___No Does it bother your: ___Sleep ___Work ___Other _____

What seems to make it better? _____ What seems to make it worse? _____

Other therapies you have tried or are trying to help this condition _____

Have you had acupuncture before? ___Yes ___No Chinese Medicine? ___Yes ___No

Please tell the story of this condition ***(use the back side of this page if necessary)*****:**_____

_____

_____

In general, I feel my overall health is: ___Excellent ___Good ___Fair ___Poor

Rate on a scale of 1 ***(poor)*** **to 10** ***(great)*****:** ___ Sleep ___ Energy Level ___ Appetite ___ Digestion

Elimination regular? ___Yes ___No Any gas, bloating or other discomfort after eating: ___Yes ___No

Recent significant life events? (divorce, relocation, job change, death in family, etc.) _____

_____

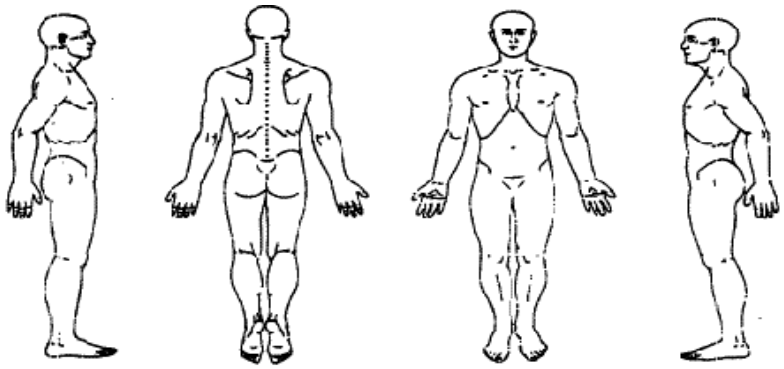
I commonly cope with stressful periods by _____

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? _____

Any foreign residence or travel in last two years? _____

Circle on the diagram any areas of pain or injury

Pain: ___dull ___sharp ___stabbing ___throbbing ___cramping ___burning ___limited range of motion ___limited use



Area/Description of Symptoms	**Pain Level: 0-10 (10 as highest)**	**Frequency**

Current /Recent Health Care Providers

Name	Dates	Care Provided

Accidents/Injuries - *briefly describe*

MORE than 5 years ago_____

LESS than 5 years ago_____

Allergies

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc. _____

Medications - *Please list all prescription and over-the-counter medications you are using*

Medication	What it's for	For how long?	Strength	Dose	Frequency

Supplements/Herbs **Were these recommended by: ___practitioner ___self ___both**

Supplement/Herb	Brand Name	Potency (mg, IU, etc)	Dose	Frequency

Sample of day's menu:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Water and fluids _____

Dietary preferences/restrictions _____ Cravings? _____

Favorite food? _____ Favorite flavor? _____ Do you eat meals regularly? ___Yes ___No

Physical exercise: ___Avid ___Regular ___Sporadic ___Rare ___Not now Type _____

Tobacco: how much? _____ how long?_____(previously? how much? _____ how long? _____)

Mark the following "1" if current "2'" if past

___ asthma	___ ringing in ears	___ palpitations	___ migraines
___ bronchitis	___ sciatica	___ tightness in chest	___ frequent headaches
___ pneumonia	___ frequent urination	___ rheumatic fever	___ frequent depression
___ frequent cold/flu	___ dribbling urine	___ heart problems	___ jaundice
___ Epstein-Barr	___ painful urination	___ poor sleep	___ hepatitis
___ chronic fatigue	___ scanty urination	___ hypoglycemia	___ hemorrhoids
___ mononucleosis	___ blood in urine	___ severe mood swings	___ eye problems
___ HIV positive	___ prostate problems	___ diabetes	___ photophobia
___ AIDS	___ no/low sex drive	___ overweight	___ dizziness
___ allergies	___ impotence/frigidity	___ underweight	___ stroke
___ sinus congestion	___ afternoon persp/fever	___ eating disorder	___ varicose veins
___ colitis	___ night sweats	___ gum/teeth problems	___ drug addiction
___ Crohn's	___ hearing problem	___ lots of fillings	___ alcoholism
___ diverticulitis	___ memory difficulty	___ TMJ	___ epilepsy
___ parasites	___ concussion	___ frequent anger	___ heartburn/acid indigestion
___ anxiety	___ frequent frustration	___ bloating	___ arthritis ___ gas

WOMEN'S HEALTH

MENSTRUAL PERIODS - *Please complete this section to the best of your ability even if you no longer menstruate.*

Since age _____ Regular? ___Yes ___No Flow lasts _____ days Length of cycle _____

Color of blood: ___light red ___dark red ___brownish ___other:_____ ___light ___heavy ___clots

Date of last menses_____ ___PMS ___breast distention ___moodiness ___bloating ___other:_____

___Menstrual cramps (which days)?_____

HISTORY - ***Mark the following "1" if current "2" if past***

___ hysterectomy	___ pain with intercourse	___ fibroids	___ breast reconstruction
___ D&C	___ dryness with intercourse	___ irregular bleeding	___ lumpectomy
___ tubal ligation	___ interstitial cystitis	___ breast implants	___ mastectomy
___ ablation	___ yeast infections	___ breast lumps (please describe _____)	
___ irregular PAP smear	___ pain during ovulation	___ fibrocystic breasts	

___ vaginal discharge (color _____ frequency/when _____ amount _____)

Date of last PAP smear _____ Results _____

PREGNANCY/BIRTH CONTROL

Are you pregnant now? ___Yes ___No Do you think you may be? ___Yes ___No

Number of pregnancies: _____ Number of children _____

Terminations? _____ Miscarriages? _____ Tubular pregnancies? _____

Difficulty in conceiving? _____

_____

_____

Birth control method(s): _____

_____

MENOPAUSE

No menses since: _____

Experiences/symptoms you are currently feeling/having or had in the past during menopause? _____

_____

FEE POLICY

- Payment may be made by cash, check, Visa, Master, or Discover; returned checks are subject to a $25 fee
- We require 24-hr. notice for appointment cancellation and reserve the right to charge for appointments canceled without said notice
- We want everyone to be able to receive necessary treatment. If unusual circumstances or hardship prevents you from continuing treatment, please speak with our Office Manager.

Client / Representative NAME (Printed)	Client / Representative SIGNATURE	Date

INSURANCE ELIGIBILITY

I, the undersigned, do hereby authorize payment directly to this office for all the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance, and also responsible for monitoring my own insurance benefit usage.
I hereby authorize Jenn Collins, L.Ac. and Jenny Riegg L.Ac. and Ashland Holistic Health to release all information necessary to secure these benefits. I authorize the use of this signature on all my insurance submissions.

Client / Representative NAME (Printed)	Client / Representative SIGNATURE	Date

INFORMED CONSENT STATEMENT

Jenn Collins, L.Ac., and Jenny Riegg L.Ac. are Oregon Licensed Acupuncturists, both holding a Masters of Science in Oriental Medicine as well as national certification in acupuncture through the National Commission for Certification of Acupuncturists.

Under Oregon law, acupuncture is defined as an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by stimulation of specific points by insertion of needles, with scope of practice including traditional and modern Oriental medical and acupuncture techniques of diagnosis & evaluation, use of an extensive herbal pharmacopoeia, vitamins, minerals, dietary advice, as well as Oriental massage, exercise and related therapeutic methods.

Jenn Collins, L.Ac. and *Jenny Riegg L.Ac.* are not medical doctors. They do not claim to diagnose, treat or cure any medical conditions or pathologies nor prescribe medicine nor in any way represent themselves as so doing. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not for your care is your right, and acupuncturists at Ashland Holistic Health assume no responsibility for your decision in this matter.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that:

- *no claims are made for acupuncture, herbal medicine, nutritional or dietary recommendations to treat or cure any medical condition*
- *all information given is for educational purposes only*
- *there is no implied or stated guarantee of success or effectiveness of any specific treatment plan or guidelines*
- *I am free to act upon or disregard the recommendations of Jenn Collins, L.Ac. and*
- *Jenny Riegg L.Ac. as I so choose.*
-
- *I hereby release Jenn Collins, L.Ac., Jenny Riegg L.Ac. and Ashland Holistic Health from any and all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints.*

I hereby affirm that I consent and agree to the above statements of my own free will and request to engage the services of Jenn Collins, L.Ac. and Jenny Riegg L.Ac.

to participate in a professional relationship with her pursuant to the statements herein.

Client / Representative NAME (Printed)	Client / Representative SIGNATURE	Date

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Client / Representative NAME (Printed) Client / Representative SIGNATURE Date

PRIVACY POLICY

This notice will remain in effect until it is replaced or amended by changes in law.

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.

We receive personal information and health information in several ways: from you, from other healthcare providers, and from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship, we will likely use and disclose health information by submitting the authorization in writing. Disclosures will be made to any personal representation you choose to have your protected health information.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing
This office will not use your health information for marketing communication without your written authorization. This office may send birthday cards, newsletters and appointment reminders by telephone, post cards, or letters.

Disclosure
This office may use or disclose your Protected Health Information when required by law.

Client Rights
- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of your healthcare information that this office has disclosed.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- Upon written request you have the right to amend your Protected Health information.
- You have the right to receive all notices in writing.

If you have any questions, complaints or want more information, please contact our Office Manager at the phone number/address listed at the top of this page. You may submit a written complaint to the U.S. Department of Health and Human Services.

I, the undersigned, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. A copy of these Privacy Policies may be obtained upon request.

_____ _____ _____

Client / Representative NAME (Printed) Client / Representative SIGNATURE Date