Acupuncture Registration / Health History

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID No. _____

Patient Name _____
First

_____
Middle *Last*

Address _____

_____

City _____ State _____ Zip _____

E-mail _____

Sex: ❍ M ❍ F Age _____

Birth Date _____ SS No. _____

❍ Married ❍ Widowed ❍ Single ❍ Minor

❍ Separated ❍ Divorced ❍ Partnered for ____ years

Patient Employer / School _____

Occupation _____

Employer / School Address _____

Employer / School Phone (____) _____

Spouse's Name _____

Birth Date _____ SS No. _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE INFORMATION

Primary Insurance Co. _____

Group No. _____ ID No. _____

Subscriber's Name _____

Birth Date _____ SS No. _____

Relationship to Patient _____

Is patient covered by secondary insurance? ❍ Yes ❍ No

Secondary Insurance Co. _____

Group No. _____ ID No. _____

Subscriber's Name _____

Birth Date _____ SS No. _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and / or my dependents(s), have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. Petrie all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of patient, parent, guardian or personal representative

_____
Please print name of patient, parent, guardian or personal representative

_____ _____
Date *Relationship to Patient*

PHONE NUMBERS

Cell Phone _____ Home Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

ACCIDENT INFORMATION

Is condition due to an accident? ❍ Yes ❍ No Date _____

Type of accident ❍ Auto ❍ Work ❍ Home ❍ Other

To whom have you made a report of your accident?

❍ Auto Insurance ❍ Employer ❍ Workers Comp ❍ Other

Attorney name (if applicable) _____

MEDICATIONS | ALLERGIES | VITAMINS / HERBS / MINERALS

_____ | _____ | _____

_____ | _____ | _____

_____ | _____ |

_____ | _____ |

Pharmacy Name _____

Pharmacy Phone (_____) _____

American Health & Wellness Center

13300-B Franklin Farm Road
Herndon, VA 20171
Ph: (703) 787-7463
www.amhwell.com

SYMPTOM SURVEY

Please "check" the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
❍ excessive appetite	❍ insomnia	❍ cough	❍ low back pain	❍ eye problems
❍ loose stool/diarrhea	❍ palpitations	❍ shortness of breath	❍ knee problems	❍ jaundice
❍ digestive problems,	❍ cold hands and feet	❍ decreased sense of smell	❍ hearing impairment	❍ difficulty digesting oily foods
❍ vomiting	❍ nightmares	❍ nasal problems	❍ ear ringing	❍ gall stones
❍ belching, burping	❍ mentally restless	❍ skin problems	❍ kidney stones	❍ light-colored stool
❍ heartburn/reflux	❍ laughing for no reason	❍ claustrophobia	❍ decreased sex drive	❍ soft or brittle nails
❍ stomach bloating	❍ chest pains	❍ colitis/diverticulitis	❍ hair loss	❍ easily angered
❍ obsession in work	❍ poor memory	❍ constipation	❍ urinary problems	❍ difficult relationships
❍ blood in stool	❍ sadness	❍ allergies	❍ dental problems	❍ difficulty making decisions
❍ lack of appetite	❍ depression	❍ asthma	❍ fatigue	❍ dizziness
❍ hemorrhoids	❍ Anxiety	❍ get sick easily	❍ edema	❍ headaches
❍ easily bruised				
❍ I usually feel warm	❍ I usually feel chilled			

KIDNEY YIN XU

- ❍ Do you have lower back weakness, soreness or pain?
- ❍ Do you have ringing in your ears?
- ❍ Is your hair prematurely gray?
- ❍ Do you have dark circles under your eyes?
- ❍ Do you have night sweats?
- ❍ Are you prone to hot flashes?
- ❍ Would you describe yourself as "afraid" frequently?
- ❍ Do you have dizziness?
- ❍ Do you have knee problems?

For Women only:

- ❍ Do you have vaginal dryness?
- ❍ Is your mid-cycle cervical mucus scanty or missing?

KID YANG XU

- ❍ Is your back sore or weak?
- ❍ Are your feet cold, especially at night?
- ❍ Are you typically colder than those around you?
- ❍ Is your libido low?
- ❍ Are you often fearful?
- ❍ Do you wake up at night or early in the morning because you have to urinate?
- ❍ Do you urinate frequently, and is the urine diluted and/or profuse?
- ❍ Do you have early morning loose, urgent stools?

For Women only:

- ❍ Do you have low back pain pre-menstrually?
- ❍ Do you have profuse vaginal discharge?
- ❍ Do you feel cold cramps during your period that respond to a heating pad?

SPLEEN QI-XUE-YANG XU

- ❍ Are you often fatigued?
- ❍ Do you have poor appetite?
- ❍ Is your energy low after a meal?
- ❍ Do you feel bloated after eating?
- ❍ Do you crave sweets?
- ❍ Do you have loose stools, abdominal pain, or digestive problems?
- ❍ Are your hands and feet cold?
- ❍ Are you prone to feeling sluggish?
- ❍ Are you prone to heaviness or grogginess in the head?
- ❍ Do you have varicose veins?
- ❍ Are you prone to worry?
- ❍ Have you been diagnosed with low blood pressure?
- ❍ Do you sweat a lot without exerting yourself?
- ❍ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- ❍ Are you often sick, or do you have allergies?
- ❍ Have you ever been diagnosed with hypothyroid or anemia?
- ❍ Do you have hemorrhoids or polyps?

For Women only:

- ❍ Is your menstruation thin, watery, profuse, or pinkish in color?
- ❍ Are you more tired around ovulation or menstruation?
- ❍ Do you ever spot a few days before your period comes?
- ❍ Have you ever been diagnosed with uterine prolapse?
- ❍ Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

BLOOD DEFICIENCY

- ❍ Do you have dry, flaky skin?
- ❍ Are you prone to getting chapped lips?
- ❍ Are your fingernails or toenails brittle?
- ❍ Is your hair brittle or dry?
- ❍ Do you have diminished nighttime vision?
- ❍ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

For Women only:

- ❍ Do you get dizzy or light-headed around your period?
- ❍ Are you losing hair on your head?
- ❍ Are your menses scant or late?

BLOOD STASIS

- ❍ Do you experience periodic numbness of your hands and feet, especially at night?
- ❍ Do you have varicose or spider veins?
- ❍ Do you have red cherry spots (hemangiomas) on your skin?
- ❍ Do you have chronic hemorrhoids?
- ❍ Do you have dark spots in your eyes?
- ❍ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

For Women only:

- ❍ Does your menstrual blood contain clots?
- ❍ Have you been diagnosed with endometriosis or uterine fibroids?
- ❍ Do you have piercing or stabbing menstrual cramps?
- ❍ your menstrual flow ever brown or black in color?
- ❍ Do you feel mid-cycle pain around your ovaries?
- ❍ Do you have painful, unmovable breast lumps?

LIVER QI STAGNATION

- ❍ Are you prone to emotional depression?
- ❍ Are you prone to anger and/or rage?
- ❍ Are your pupils usually dilated and large?
- ❍ Do you have difficulty falling asleep at night?
- ❍ Do you experience heartburn or wake up with a bitter taste in your mouth?

For Women only:

- ❍ Do you become irritable pre-menstrually?
- ❍ Do you feel bloated or irritable around ovulation?
- ❍ Does it feel as if ovulation lasts longer than it should?
- ❍ Are your breasts sensitive/sore at ovulation?
- ❍ Do you experience pain or discharge from your nipples?
- ❍ Do you have a lot of pre-menstrual breast distension or pain?
- ❍ Do you become bloated pre-menstrually?
- ❍ Are your menses painful?
- ❍ Do you feel your menstrual cramps in the external genital area?
- ❍ Is your menstrual blood thick and dark, or purplish in color?

HEART [ANY DISORDER]

- ❍ Do you wake up early in the morning and have trouble getting back to sleep?
- ❍ Do you have heart palpitations, especially when anxious?
- ❍ Do you have nightmares?
- ❍ Do you seem low in spirit or lacking vitality?
- ❍ Are you prone to agitation or extreme restlessness?
- ❍ Do you fidget?
- ❍ Do you sweat excessively, especially on your chest?

EXCESS HEAT

- ❍ Are your mouth and throat usually dry?
- ❍ Are you often thirsty for cold drinks?
- ❍ Do you often feel warmer than those around you?
- ❍ Do you wake up sweating or have hot flashes?

For Women only:

- ❍ Do you breakout with red acne, especially pre-menstrually?
- ❍ Do you have a short menstrual cycle?
- ❍ Do you have vaginal irritation?

DAMPNESS

- ❍ Do you feel tired and sluggish after a meal?
- ❍ Do you have cystic or pustular acne?
- ❍ Do you have urgent, bright, or foul-smelling stools?
- ❍ Are you overweight?
- ❍ Do you have a wet, slimy tongue?
- ❍ Does your body feel like a barometer? Can you sense when it will rain?

For Women only:

- ❍ Does your menstrual blood contain stringy tissue or mucus?
- ❍ Are you prone to yeast infections and vaginal itching?
- ❍ Do you have fibrocytic breasts?

FOR WOMEN

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow_____

Check All that Apply:

Color of flow: ❍ pale/light red ❍ red ❍ bright red ❍ dark red ❍ dark red/brown ❍ dark red/purple

Number of pads you use per day: ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day

Pain and Cramping: ❍ No ❍ Yes ❍ mild ❍ moderate ❍ severe

❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

Amount of flow:

❍ even throughout

❍ clots ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

❍ spotting ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

❍ light ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

❍ heavy ❍ 1st day ❍ 2nd day ❍ 3rd day ❍ 4th day ❍ Before flow ❍ After flow

Other symptoms related to menses: ❍ Discharge ❍ PMS ❍ Headache ❍ Swollen Breasts

❍ Constipation ❍ Diarrhea ❍ Nausea ❍ Increased Appetite

❍ Insomnia ❍ Mood Swings ❍ Decreased Appetite

Have you ever been diagnosed with: ❍ endometriosis ❍ ovarian cysts ❍ PID ❍ fibrocystic breasts

❍ fibroids ❍ polycystic ovary syndrome ❍ STD: _____

Fertility Information: Number of IVF procedures _____ Number of IUI procedures _____

Has a physician diagnosed a difficulty with fertility due to:

❍ Female Factor ❍ Male Factor ❍ Unexplained

❍ Other _____

INFORMED CONSENT FOR ORIENTAL AND CHIROPRACTIC MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments, chiropractic, and other procedures within the scope of the practice of Oriental and chiropractic medicines, for the purposes of demonstration for students only, on me, or on the patient named below, for whom I am legally responsible, by the doctor of Oriental medicine named below and/or other doctors of Oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

There are some risks to treatment, including but not limited to some bruising of the skin and or/ slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to applicable state legal requirement.

I have had an opportunity to discuss with the doctor named below the nature and purpose of Oriental and chiropractic medicine. I understand that results are not implied nor guaranteed.

I DO NOT EXPECT THE DOCTOR TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND COMPLICATIONS. I WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGMENT WHICH THE DOCTOR FEELS AT THE TIME IS IN MY BEST INTEREST, BASED UPON THE FACTS THEN KNOWN, DURING THE COURSE OF THE PROCEDURE.

I UNDERSTAND THAT I HAVE THE CHOICE TO ACCEPT OR REJECT THE PROPOSED DIAGNOSTIC PROCEDURE OR TREATMENT, OR ANY PART OF IT, BEFORE OR DURING THE DIAGNOSIS OR TREATMENT.

I understand that the doctor is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT'S NAME (print) _____

PATIENT SIGNATURE: _____ DATE: _____
(Or Patient Representative – Indicate relationship if signing for patient)

❍ I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

DOCTOR'S SIGNATURE:_____ DATE: _____

PROTOCOL FOR MOXIBUSTION TREATMENT

Purpose: In recognition of the risks involved with moxibustion treatment; including but not limited to a risk of burn and/or scarring and the risk of infection if burning occurs, the following procedure is to be followed when applying moxibustion.

1. All patients must be informed of the risks, benefits, and alternatives to moxibustion, prior to treatment. All attending physicians must go over the "Informed Consent for Moxibustion Treatment" form with each patient, prior to treatment.

2. All patients must understand and sign the "Informed Consent for Moxibustion Treatment" form prior to treatment.

3. All moxibustion in the office is to be performed by the attending physician.

The only exception to the above rule follows:
The patient may perform moxibustion on him/herself under the doctor's direct line-of-sight supervision, as part the process of teaching the patient the procedure for home self-application.

INDIRECT MOXA is to be applied only until the patient's skin becomes red and warm to the touch, sufficient to achieve the desired level of therapeutic action. The attending physician will continually monitor the temperature of the patient's skin to insure against inadvertent burning.

MOXA POLES are to be to be closely monitored, and held a minimum of 1 inch from the skin at all times. The attending physician must continually monitor the temperature of the patient's skin, in order to adjust or remove the moxa pole as necessary.

MOXA ON NEEDLE is to be closely monitored. Line-of sight is not sufficient. The attending physician must be within close proximity, to remove the moxa if the patient is in danger of being burned, by the moxa getting too hot, falling off the needle, or any other mishap.

MOXA ON SALT, GINGER, OR ACONITE is to be closely monitored. Line-of sight is not sufficient. The attending physician must be within close proximity, to remove the moxa if the patient is in danger of being burned, by the moxa getting too hot, falling off the medium, or any other mishap.

MOXA INSTRUMENTS are to be closely monitored during application. The attending physician must continually monitor the temperature of the patient's skin and the moxa instrument, in order to remove it if the patient is in danger of being burned.

MOXA BOXES are to be closely monitored during application. The attending physician must continually monitor the temperature of the patient's skin and the moxa box, in order to remove it if the patient is in danger of being burned.

DIRECT MOXA After informing the patient of the procedure, the attending physician must apply the direct moxa, as is medically necessary, while closely monitoring the patient and the procedure. Burns are to be cared for as described below.

CARE FOR MOXA BURNS

- Small moxa burns are to be kept clean and covered with a sterile dressing. Patients are to be advised of the signs of infection, and instructed to seek emergency medical care, should any signs of infection develop.

- Any moxa burns which are large or severe are to be treated with standard first aid treatment. Patients with such burns are to be immediately referred to a qualified Western medical professional (i.e. M.D., D.O., C.N.P., N.P.) for prompt treatment. If necessary, the attending physician should accompany, and escort the patient to a qualified practitioner for appropriate care.

INFORMED CONSENT FOR MOXIBUSTION TREATMENT

I hereby request and consent to the performance of the moxibustion treatments, which I have initialed below, on me (or on the patient named below, for whom I am legally responsible) by the doctor of Oriental medicine named below and/or other doctors of Oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

There are some risks to moxibustion treatment, including but not limited to a risk of burn and/or scarring. The risk of infection is also present if burning occurs.

❍ I Understand That All Moxibustion Includes The Application Of Heat to acupuncture points, and other areas of my body, by manipulating a burning herb, in various ways, to allow the heat to warm and penetrate my skin. I understand that this procedure may result in burns and scarring.

Patient's Initials_____ Date: _____

❍ I Agree To Treatment With Indirect Moxa. I understand that this treatment includes the application of burning moxa near my skin. I understand that this procedure is not intended to result in burns and scarring, but that burning and scaring is a definite possibility.

Patient's Initials_____ Date: _____

❍ I Have Been Instructed To Apply Indirect Moxa To Myself. I have been instructed in this procedure, by my doctor, and I understand the instructions. I realize that this procedure includes the application of burning moxa near my skin. I understand that this procedure is not intended to result in burns and scarring, but that burning and scaring is a definite possibility.

Patient's Initials_____ Date: _____

❍ I Agree To Treatment With Direct Moxa. I understand that this includes the direct application of burning moxa to my skin and often results in burns and scarring. In fact, burning and scarring may even be part of the therapeutic action, and may be intentional, on the part of the doctor.

Patient's Initials_____ Date: _____

I have had an opportunity to discuss with the doctor named below the nature and purpose of this moxibustion treatment. I understand that results are not guaranteed.

I DO NOT EXPECT THE DOCTOR TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND COMPLICATIONS. I WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGMENT WHICH THE DOCTOR FEELS AT THE TIME IS IN MY BEST INTEREST, BASED UPON THE FACTS THEN KNOWN, DURING THE COURSE OF THE PROCEDURE.

I UNDERSTAND THAT I HAVE THE CHOICE TO ACCEPT OR REJECT THE PROPOSED PROCEDURE OR TREATMENT, OR ANY PART OF IT, BEFORE OR DURING THE TREATMENT.

PATIENT'S NAME (print) _____

PATIENT SIGNATURE: _____ DATE: _____
(Or Patient Representative – Indicate relationship if signing for patient)

❍ I have discussed the above information with the patient, including the risks, benefits, and alternatives to the proposed treatment.

DOCTOR'S SIGNATURE:_____ DATE: _____

DIRECTIONS FOR SELF-TREATMENT AT HOME WITH MOXA

PLEASE READ ALL THESE INSTRUCTIONS THROUGH THOROUGHLY BEFORE USING MOXA ON YOUR SELF.

There are risks involved with moxibustion treatment. The risks include, but are not limited to, A risk of burn and/or scarring, and the risk of infection if burning occurs. The following procedure is to be followed when applying moxibustion.

4. All patients must be informed of the risks, benefits and alternatives to moxibustion prior to treatment. An attending physician must go over the "Informed Consent for Moxibustion Treatment" form with each patient, prior to instruction for moxa use, or purchase of moxa from this office

5. All patients must understand and sign the "Informed Consent for Moxibustion Treatment" form prior to treatment, instruction for use, or purchase of moxa from this office.

6. Patients must demonstrate, to the attending physician's satisfaction, the ability to perform moxibustion on him/her self prior to any purchase of moxa in the office.

USING MOXA AT HOME All moxa is to be applied only until your skin becomes sufficiently red, and/or warm to the touch, to achieve the desired level of therapeutic action. Your doctor will instruct you in this. You must continually monitor the temperature of your skin, to insure against inadvertent burning. In order to prevent inadvertent burns, do not use moxa on areas that are numb or have any lack of feeling.

USING THE MOXA POLE/STICK Moxa Poles (sticks) are to be to be closely monitored, and held a minimum of 1 inch from the skin at all times. You must continually monitor the temperature of your skin, in order to adjust or remove the moxa pole as necessary.

Light one end of the moxa pole with a lighter, the way you would light an incense stick. When it's well-lit, blow out the flame. It will smoke and, when you blow on this end now, it should glow red at the tip. The tip of the moxa stick is now Very Hot and could burn you if you are not careful, so please be careful.

Once the moxa stick is lit, bring it to about an inch from the skin for only about one second, and then move it to about six inches above the skin for about two seconds. Repeat this one-second-close-two-seconds-far "pecking" motion for about five minutes or until your skin becomes sufficiently red and/or warm as you have been shown.

If at any time your skin should get too hot, remove the moxa stick far from your person.

Moxa Poles can be a little tricky to put out, so it is recommended that you put a few drops of water on the burning tip of the pole just sufficient to put it out completely. If you are judicious in the amount of water used, the pole should be dry enough by the next day to be lit again. If not, you can carefully cut off the damp tip and relight it.

CARE FOR MOXA BURNS

- All moxa burns are to be treated as burns, with standard first aid treatment.
- Small moxa burns where there is no broken skin are to be kept clean and covered with a sterile dressing. Should any signs of infection develop, you are advised to seek emergency medical care from a qualified Western medical professional (i.e. M.D., D.O., C.N.P., N.P.)
- For Burns that are Severe, Large, Or Break the Skin the Patient Should Immediately Seek a Qualified Western Medical Professional (i.e. M.D., D.O., C.N.P., N.P.) for Emergency Treatment.

AMERICAN HEALTH AND WELLNESS CENTER
PAYMENT AGREEMENT

Your insurance policy requires the payment of co-pays and deductible amounts from you at the time of service. Your insurance company also requires that American Health and Wellness Center collect your copay or un-met deductible amount. Not adhering to these terms could be a violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

We verify benefits as a courtesy to you. However, American Health and Wellness Center does not accept any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

Some insurance policies do not cover all of our therapies. Your treatment plan is between you and Dr. Petrie. If he believes you would need these therapies to improve health, you would be responsible this portion of the payment .

Our front office staff can accept payment from you in the form of cash, check or credit card. As a courtesy, we will bill you're your insurance company for their portion of the bill. Feel free to ask questions of us as you receive "Explanation of Benefits" (EOB) from your insurance provider.

Please verify that you understand your financial responsibility by signing and dating this form and let us know if we can assist you in any other way.

Patient Signature: _____

Print Name: _____ Date: _____

Staff Initials: _____