Wellspring Medical Associates PC
11 Sewall Street Marblehead MA 01945
781.639.0037

- ✓ **Medical history:** Your past medical history is very important. Please disclose any pacemakers, surgeries, metal rods or plates, medications, or other known illnesses.

- ✓ **Medications**: Please continue to take your prescription medications as directed by your doctor.

- ✓ **Pregnancy:** Please share the news before your session begins. It is vital information for an optimal treatment.

- ✓ **Appointments:** Please arrive on time. This insures that you receive a full treatment.

- ✓ **Course of Treatment:** Acupuncture usually involves more than one treatment. It is referred to as a Course of Treatment. The number of treatments and the spacing between the treatments greatly influences the overall success of this medicine.

- ✓ **Cancellations:** Please carefully consider your need to cancel an appointment as it may affect your response to the Course of Treatment.

- ✓ **Missed appointments:** You are responsible for the related fee for any missed appointment. An appointment will be considered "missed" if you have not notified the office 24 hours prior to your scheduled appointment.

- ✓ **Fees:** Initial appointment fee is $75.00 and each subsequent treatment is $75.00, payable in cash, by check, Master Card/Visa or Debit card. Payment is due at the end of each session. If you have insurance that covers acupuncture, please check with your insurer about reimbursement procedures. **NOTE: Acupuncture treatment qualifies for re-imbursement under most Flexible Spending plans.**

- ✓ **Clothing:** You may want to wear or bring loose fitting clothing. Many of the acupuncture points we use are located from the elbows out and the knees down. Fresh sheets are provided for your privacy and comfort.

- ✓ **Activities:** Please avoid **strenuous** activities or exercise after your treatment. If possible, plan your activities so that you do not have to be working at peak performance for a couple of hours after treatment.

- ✓ **Your Response:** Try to keep a mental or written record of your response to treatment. Everyone responds differently and your feedback helps direct each subsequent treatment.

- ✓ **Confidentiality:** Absolutely no information is given without your consent. Exceptions include court orders and insurance companies (when you have waived your right to confidentiality with them).

- ✓ **Consent:** I have read the above with understanding and consent to the terms of treatment with Wellspring Medical Associates PC.

_____ _____ _____

(Signature) (Printed name) (Today's date)

Health History

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If you have questions, please ask.

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Name:_____ DOB:_____ Date of First Visit:_____

Address:_____Town _____Zip_____Phone:_____

E-mail_____Emergency: Name & number_____

Physician Name:_____Phone_____

Height:_____Weight: _____Reason for Seeking Acupuncture:_____

When did this begin?_____Have you been given a diagnosis?, what?_____

What kinds of treatments have you tried:_____

Does it interfere with your daily activities(work, sleep, sex)?_____

Significant Illnesses: Cancer Diabetes Hepatitis High Blood *Pressure VD HIV* EBV Heart Disease Rheumatic Fever Thyroid Disease Seizures Auto immune Diseases Candida Significant Traumas: (Auto accidents, falls, etc (circle any that apply). Allergies Other_____

Surgeries (list)_____

Medications taken within the last two months, include vitamins, herbs, homeopathic remedies, etc.:

_____

_____

Have you ever taken or had injections of steroids.? (cortisone) If so, when and for how long?_____

_____

Occupational Stress:(Chemical, physical, psychological,.etc):_____

_____

Do you exercise regularly?_____ Describe:_____

Have you ever been on a restricted diet:_____What kind ?_____

Please describe an average day's meals:

Morning Afternoon Evening

_____

_____

Coffee, tea, or other caffeine _____How much?_____Alcohol per week?_____
Do you smoke, chew or snuff tobacco? _____ How much?_____
Medications/drugs for non medical purposes _____ How much?_____

Family Medical History: (circle)

Diabetes Cancer High Blood Pressure Mental Illness Alcoholism

Heart Disease Seizures Asthma Allergies Auto immune Diseases Stroke Arthritis Alzheimer's

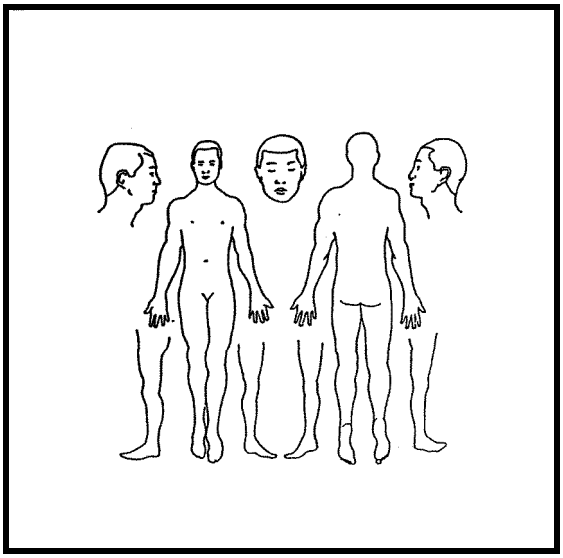
Other: _____

Personal:
Are you currently experiencing any significant family stress? _____

In the **past year**, have you experienced any significant loss ? (death of loved one or pet, job loss, miscarriage, divorce or separation, etc?) _____
Have you experienced a significant life event where you felt completely overwhelmed ?_____
_____
Do you feel actively supported by your family and friends ?_____
Do you own pets ? _____ Do you consider your home life to be stressful ?_____
Comments: Please feel free to add any other information you would like to discuss:_____
_____
_____
_____

Musculoskeletal:

Please indicate painful or distressed areas:
x = little xx = moderate xxx = strong



Emotional State: Rate the frequency with which you experience the following emotions:

(1 =Never, 2=Occasionally, 3=Frequently, 4=Regularly)

____Grief ____Sadness ____Depression _____Worry ____Anxiety
_____Anger ____ Irritability ____Obsession _____ Pensiveness ____Fear

Circle any thing on this list that you have experienced in the **last three months.**

Blurred vision
Floaters
Poor night vision
Weak fingernails
Palpitations
Insomnia
Poor memory
Weakness of the limbs
Feverish sensation on palms and soles
Abdominal pain better with warmth
Abdominal pain better with pressure
Loose stool with odor
Loose stool with burning sensation
Bruise easily
Incontinence
Low back, pain or weakness
Knee, hip or ankle pain
Pain or weakness that's better w/ rest
Night urination
Symptoms improve with steroid medications
Symptoms improve with thyroid medications
Uterine bleeding
Vaginal discharge
Pitting edema
Diarrhea
Frequent or copious urination
Excess Sweating
Nasal discharge

Difficulty inhaling
Symptoms are worse with stress
Symptoms are worse pre-menstrually
Anger, irritability, labile emotions, moodiness
Rib side pain
Nausea with a bitter taste
Low-grade headache – temple or crown
Light sensitivity
Seeing auras
Symptoms worse with stimulation like touch or noise
Loud tinnitus
Tremors
Tics
Dizziness
Convulsions
Numbness
Paralysis
Cough
Wheeze
Cough that is worse when laying down
Muzzy headed
Non-pitting edema
Sensation of heaviness
Lack of taste discrimination
Symptoms worse in the morning
Thirst with little desire to drink
Scanty clear urination
Hemorrhoids

Circle it any of these apply:

Premature labor
Threatened miscarriage
Miscarriage
Infertility

Primary onset dysmenorrhea
Primary onset bone disorder (scoliosis etc.)
Primary onset developmental disorder
Premature aging

Consent to Treatment Form - Acupuncture

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Wellspring Medical. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important part of my heath care plan.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body to treat bodily dysfunction or diseases, relieve pain, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a moderate risk of blistering and a minimal risk of scarring from its use. I understand that I may refuse this type of therapy.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that my feedback will direct the course of this type of treatment and it will be discontinued should it become too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: a mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that my feedback will direct the course of this type of treatment and that the intent is not to cause discomfort. The treatment will be discontinued should it become uncomfortable.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, in combination with or in lieu of acupuncture.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X_____ _____ X_____

Patient's Signature Date Explained by me and signed in my presence