



New Moon Family Acupuncture has relocated to the



906 South Cowley
Spokane, WA 99203

Cowley is located Northeast of Sacred Heart, on the same street as St. Luke's rehab and Inland Imaging. The center is on the NW corner of 9th and Cowley. It is red brick building with a ramp in front.

Informed Consent for Acupuncture

Rebekah Giangreco, EAMP, is a licensed acupuncturist in the state of Washington. She earned her Master of Science in Acupuncture from the Northwest Institute of Acupuncture and Oriental Medicine (NIAOM) where she completed all her didactic and clinical training. Rebekah also has her Bachelor of Science in Applied Psychology from Eastern Washington University. She has been designated a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine, and is an Acupuncture Detoxification Specialist.

I, the undersigned hereby authorize Rebekah Giangreco, EAMP, to administer care on my behalf using the following procedures to stimulate my body's healing process. Your acupuncturist will explain all procedures indicated for your treatment and obtain your verbal consent prior to the administration of procedure.

- | | | |
|-----------------------|---------------------------|--|
| • Acupuncture | • Cupping | • Nutritional and Lifestyle counseling |
| • Acupressure | • Dermal Friction/Gua Sha | • Sonopuncture/Sound Therapy |
| • Electro-Acupuncture | • Shiatsu/Chinese Massage | • NAET |
| • Moxibustion | • Plum Blossom | |

If you are Pregnant or Think That You May be Pregnant
If You Have A Severe Bleeding Disorder
If You Have A Pacemaker
PLEASE MAKE SURE THESE CONDITIONS ARE KNOWN PRIOR TO TREATMENT.

I recognize that there are possible benefits to these procedures including painless and drugless relief from my presenting symptoms and improved balance of energy, which may lead to prevention or elimination of the presenting problem.

I realize that no guarantees have been given to me by Rebekah Giangreco, EAMP, regarding cure or improvement of my condition.

I am aware that there are potential side effects, which occur in a small percentage of patients, such as discomfort at the site of needle insertion, bruising, dizziness, weakness or temporary aggravation of pre-existing symptoms. I also recognize that these procedures carry the rare but potential risks of needle breakage or infection.

With this knowledge, I voluntarily consent to the above procedures and hereby release Rebekah Giangreco, EAMP, from any and all liability which may occur in connection with the previously mentioned procedures, except for failure to perform the procedures with appropriate medical care.

SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN

DATE

PRINTED NAME OF THE ABOVE SIGNED

SIGNATURE OF WITNESS

DATE

NEW MOON

FAMILY ACUPUNCTURE

ANCIENT MEDICINE FOR THE MODERN FAMILY

Welcome and Policies

Welcome! Thank you for choosing acupuncture and oriental medicine to enhance your personal wellbeing. I look forward to working with you as you strive towards wellness in your life. I want to assure you that acupuncture is safe and, by and large painless. Most people experience it with an overall sensation of relaxation and wellbeing. To help serve you better, I've listed some guidelines and office policies. Please sign the client acknowledgment below and bring this form with you to your first treatment.

- Please eat 1 to 2 hours prior to your appointment.
- Please fill out the enclosed forms and bring them with you on your first appointment.
- Please come in 15 minutes before your appointment to complete your Health History Questionnaire if you have not already done so.
- Please wear loose fitting clothes if possible.

Appointment and Fee Information:

Your first appointment will last approximately 90 minutes; return visits are usually about 45 to 60 minutes. This time will be spent interviewing you regarding your medical history and primary complaint, conducting a physical examination based on Traditional Chinese Medicine (TCM), and performing a course of treatment.

If payment is received at time of service, my fees are \$150 for first office calls and \$75 for return office calls.

I offer community clinics for a sliding scale of \$20-40, with a \$10 first office call chart set-up fee.

If I am a preferred provider for your insurance plan and you have acupuncture benefits, I will bill your insurance directly. Please contact your insurance company to determine how many visits you have coverage for and your financial responsibility.

Cancellation and Lateness Policy:

If you are unable to keep your appointment for any reason, I ask that you call at least 24 hours in advance to cancel or reschedule the appointment. Otherwise you will be charged 50% of the fee for the missed appointment. If you are twenty or more minutes late, your appointment will be canceled and you will be charged \$25 for the appointment.

Client Acknowledgement:

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I authorize Rebekah Giangreco, L.Ac. to release to my insurance company or companies any and all information to process any claim. I further authorize that payment(s) be made directly to Rebekah

SIGNATURE OF CLIENT

DATE

Health History Questionnaire

Please take the time to accurately fill out this form; all information provided will help guide our treatment strategy. Feel free to ask questions, all information provided will be kept confidential.

Name: _____ Today's Date: _____ Age: _____

Date of Birth: _____ Height: _____ Weight: _____ Occupation: _____

Address: _____

Best number to leave a message: _____ E-Mail: _____

Primary Physician: _____ Phone: _____

Contact In case of Emergency: _____ Phone: _____

Please identify your primary health concerns in the order of severity:

Health Concern	Onset	Known Cause	Previous Treatment(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What do you hope to accomplish by seeking out treatment with acupuncture and oriental medicine?

To what extents do the health concerns affect your daily activities (work, sleep, sex...)?

If you have been given a diagnosis for your health concern(s), please describe the diagnoses below and indicate who made the diagnosis.

Please list any therapies you are currently utilizing to remedy your condition. Include prescription and other medications if applicable.

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FAMILY ACUPUNCTURE

ANCIENT MEDICINE FOR THE MODERN FAMILY

Please list all other medications or supplements you have taken over the last three months:

Medication/supplement	Reason for taking	Dosage/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> STD's _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> HIV _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____ | |

Personal Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> STD's _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> HIV _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____ | |

Gynecological History

Age of first period: _____ Date of Last Period: ___/___/___ Current Contraception: _____
 Are you currently pregnant? Yes No Maybe Due Date _____
 Age Peri-menopause began: _____ Ended: _____
 Are you on Hormone Replacement Therapy? _____
 Other gynecological information: _____

Are any of the following applicable to you?

- Surgeries – types and date (s): _____
- Significant Trauma – auto accidents, falls, etc.: _____
- Significant Dental Work – types and date (s): _____
- Occupational Stress – Chemical, physical, psychological: _____
- Your Birth history (forceps, prolonged labor, twin, premature): _____
- Childhood illnesses (anything predominant – measles, mumps, chickenpox): _____
- Vaccination history: _____

Please describe your exercise program: _____

Do you have allergies (drug, food, chemical, airborne, etc.)? _____

Please describe reactions: _____

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ANCIENT MEDICINE FOR THE MODERN FAMILY

Habits – please indicate usage per day/week/year

Cigarettes: _____ Per _____

Sugar: _____ Per _____

Coffee: _____ Per _____

Tea: _____ Per _____

Cola: _____ Per _____

Drugs: _____ Per _____

Alcohol: _____ Per _____

Other: _____ Per _____

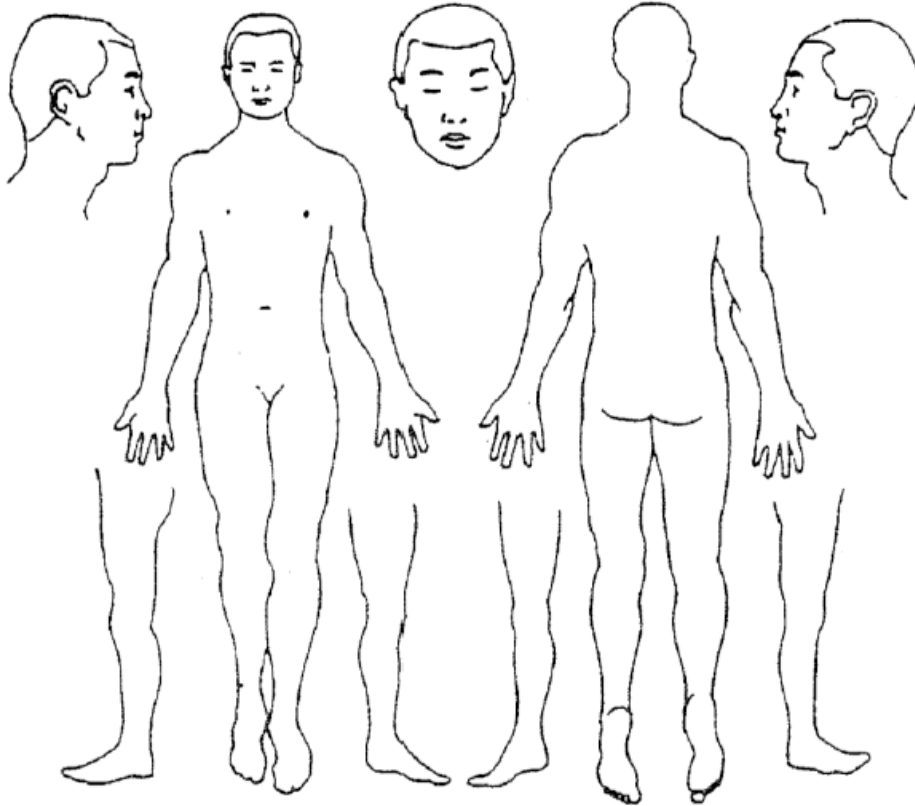
Please describe your average daily diet/routine:

Morning: _____

Afternoon: _____

Evening: _____

Indicate painful or distressed areas below:





ANCIENT MEDICINE FOR THE MODERN FAMILY

Questions to Ask Your Insurance Provider

Please check with your insurance plan regarding your acupuncture benefits, this will prevent any surprises with your bill.

Following are some questions that you should ask your insurer to help clarify your benefits.

1. Do you have acupuncture benefits?
2. Must the deductible be met before insurance benefits cover the cost of acupuncture treatment? How much is the deductible? Has it been met?
3. How many visits per year are covered?
4. Is a brief office visit (code 99211), Massage (97124), Infrared (97026) or Cupping (97139) included in your acupuncture benefits or will they be covered elsewhere as an extra and/or with a different deductible.

NEW MOON

FAMILY ACUPUNCTURE

ANCIENT MEDICINE FOR THE MODERN FAMILY

I, Rebekah Giangreco L.Ac., M.Ac. of New Moon Family Acupuncture, am dedicated to protect your privacy rights and the confidential information entrusted by you to me. I am committed to ensure that your health information is never compromised. If these policies and practices are amended, as happens from time to time, you will be informed of any changes that may affect you.

Protecting Your Personal Healthcare Information

I use and disclose the information I collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment and healthcare operations. Your personal health information will never be given to anyone, even family members, without your written consent. You, of course, may give written authorization to me to disclose your information to anyone you choose, for any purpose.

My office and electronic systems are secure from unauthorized access. My privacy policy and practices apply to all former, current and future patients. You can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

I will only request personal information needed to provide the health care, implement payment activities and conduct normal healthcare practice operations which comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history and health records. While most of the information will be

collected from you, I may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Protected Health Information

I am obligated to provide information to law enforcement and governmental officials under certain circumstances. I may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards.

Patient Rights

You have the right to request copies of your healthcare information and to request a list of instances in which I have disclosed your protected information for uses other than stated above. All such requests must be in writing and I may charge for your copies in an amount allowed by law. If you believe your rights have been violated, I urge you to notify me immediately. You can also notify the US Department of Health and Human Services.

Patient Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices for New Moon Family Acupuncture. This notice describes the types of uses and disclosures for my protected health care information that might occur during my treatment, payment for services or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights, responsibilities as well as the duties of New Moon Family Acupuncture with respect to my protected health care information.

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

- Any member of my immediate family Yes No
- Spouse or Significant Other (please specify) _____ Yes No
- Other (please specify) _____ Yes No

SIGNATURE OF PATIENT (OR REPRESENTATIVE, INCLUDING RELATIONSHIP)

DATE

Clinic Rules

1. **All cell phones and pagers must be turned off in the treatment room.**
2. Please do not wear any perfume, perfumed powder, strong smelling deodorant, hair spray, or after shave when you come to the clinic for treatments.
3. There is no smoking allowed in (or around) the office. Please do not wear clothes that smell like smoke or paint. Other patients could react to these smells.
4. Do not vigorously exercise for 6 hours after the treatment.
5. Avoid exposure to extreme hot or cold temperature after the treatment. (Tanning beds, Walk-In Coolers...)
6. Please take a shower before you come for a treatment, at least don't arrive dirty or excessively sweaty.
7. Do not bathe or shower until 6 hours after the treatment.
8. Do not eat or chew gum or candy during treatment.
9. Always eat before you come for the treatment. You should not receive acupuncture treatments when you are hungry or thirsty.
10. Drink lots of water after treatments, and regularly. The amount of water taken daily should be $\frac{1}{2}$ your body weight in ounces. (i.e. 200 lb person should drink 100 oz of water.)
11. Please do not stop any other treatment you are on: medication, therapy, chiropractic treatments, massages etc. If you are taking vitamins or herbs or any particular drug, you may continue them as before if you think that they are helping you. Under no circumstance are you to ever stop taking a prescribed medication unless the health care professional who prescribed the medication authorizes the change.

SYMPTOM SURVEY FORM
(Restricted to Professional Use)

PATIENT _____ DOCTOR _____ DATE _____

AGE _____ PHONE (_____) _____ VEGETARIAN ____ Yes ____ No

INSTRUCTIONS: Circle the number that applies to you. If symptom doesn't apply, leave blank. Use (1) for MILD symptoms (occurs once or twice a month), (2) for MODERATE symptoms (occurs several times a month), and (3) for SEVERE symptoms (you are aware of it almost constantly).

GROUP ONE

- | | | |
|-----------------------------------|--|-----------------------------------|
| 1 - 1 2 3 Acid foods upset | 8 - 1 2 3 Gag easily | 15 - 1 2 3 Appetite reduced |
| 2 - 1 2 3 Get chilled, often | 9 - 1 2 3 Unable to relax; startles easily | 16 - 1 2 3 Cold sweats often |
| 3 - 1 2 3 "Lump" in throat | 10 - 1 2 3 Extremities cold, clammy | 17 - 1 2 3 Fever easily raised |
| 4 - 1 2 3 Dry mouth-eyes-nose | 11 - 1 2 3 Strong light irritates | 18 - 1 2 3 Neuralgia-like pains |
| 5 - 1 2 3 Pulse speeds after meal | 12 - 1 2 3 Urine amount reduced | 19 - 1 2 3 Staring, blinks little |
| 6 - 1 2 3 Keyed up - fail to calm | 13 - 1 2 3 Heart pounds after retiring | 20 - 1 2 3 Sour stomach frequent |
| 7 - 1 2 3 Cuts heal slowly | 14 - 1 2 3 "Nervous" stomach | |

GROUP TWO

- | | | |
|---|---|---|
| 21 - 1 2 3 Joint stiffness after arising | 29 - 1 2 3 Digestion rapid | 37 - 1 2 3 "Slow starter" |
| 22 - 1 2 3 Muscle-leg-toe cramps at night | 30 - 1 2 3 Vomiting frequent | 38 - 1 2 3 Get "chilled" infrequently |
| 23 - 1 2 3 "Butterfly" stomach, cramps | 31 - 1 2 3 Hoarseness frequent | 39 - 1 2 3 Perspire easily |
| 24 - 1 2 3 Eyes or nose watery | 32 - 1 2 3 Breathing irregular | 40 - 1 2 3 Circulation poor, sensitive to cold |
| 25 - 1 2 3 Eyes blink often | 33 - 1 2 3 Pulse slow; feels "irregular" | 41 - 1 2 3 Subject to colds, asthma, bronchitis |
| 26 - 1 2 3 Eyelids swollen, puffy | 34 - 1 2 3 Gagging reflex slow | |
| 27 - 1 2 3 Indigestion soon after meals | 35 - 1 2 3 Difficulty swallowing | |
| 28 - 1 2 3 Always seems hungry; feels "lightheaded" often | 36 - 1 2 3 Constipation, diarrhea alternating | |

GROUP THREE

- | | | |
|---|---|--|
| 42 - 1 2 3 Eat when nervous | 49 - 1 2 3 Heart palpitates if meals missed or delayed | 53 - 1 2 3 Crave candy or coffee in afternoons |
| 43 - 1 2 3 Excessive appetite | 50 - 1 2 3 Afternoon headaches | 54 - 1 2 3 Moods of depression - "blues" or melancholy |
| 44 - 1 2 3 Hungry between meals | 51 - 1 2 3 Overeating sweets upsets | 55 - 1 2 3 Abnormal craving for sweets or snacks |
| 45 - 1 2 3 Irritable before meals | 52 - 1 2 3 Awaken after few hours sleep - hard to get back to sleep | |
| 46 - 1 2 3 Get "shaky" if hungry | | |
| 47 - 1 2 3 Fatigue, eating relieves | | |
| 48 - 1 2 3 "Lightheaded" if meals delayed | | |

GROUP FOUR

- | | | |
|--|--|--|
| 56 - 1 2 3 Hands and feet go to sleep easily, numbness | 63 - 1 2 3 Get "drowsy" often | 68 - 1 2 3 Bruise easily, "black and blue" spots |
| 57 - 1 2 3 Sigh frequently, "air hunger" | 64 - 1 2 3 Swollen ankles worse at night | 69 - 1 2 3 Tendency to anemia |
| 58 - 1 2 3 Aware of "breathing heavily" | 65 - 1 2 3 Muscle cramps, worse during exercise; get "charley horses" | 70 - 1 2 3 "Nose bleeds" frequent |
| 59 - 1 2 3 High altitude discomfort | 66 - 1 2 3 Shortness of breath on exertion | 71 - 1 2 3 Noises in head, or "ringing in ears" |
| 60 - 1 2 3 Opens windows in closed room | 67 - 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion. | 72 - 1 2 3 Tension under the breastbone, or feeling of "tightness" worse on exertion |
| 61 - 1 2 3 Susceptible to colds and fevers | | |
| 62 - 1 2 3 Afternoon "yawner" | | |

SYMPTOM SURVEY FORM – Page 2

GROUP FIVE

- | | | |
|--|---|---|
| 73 - 1 2 3 Dizziness | 82 - 1 2 3 Worrier, feels insecure | 90 - 1 2 3 History of gallbladder attacks or gallstones |
| 74 - 1 2 3 Dry Skin | 83 - 1 2 3 Feeling queasy; headache over eyes | 91 - 1 2 3 Sneezing attacks |
| 75 - 1 2 3 Burning feet | 84 - 1 2 3 Greasy foods upset | 92 - 1 2 3 Dreaming, nightmare type bad dreams |
| 76 - 1 2 3 Blurred vision | 85 - 1 2 3 Stools light-colored | 93 - 1 2 3 Bad breath (halitosis) |
| 77 - 1 2 3 Itching skin and feet | 86 - 1 2 3 Skin peels on foot soles | 94 - 1 2 3 Milk products cause distress |
| 78 - 1 2 3 Excessive falling hair | 87 - 1 2 3 Pain between shoulder blades | 95 - 1 2 3 Sensitive to hot weather |
| 79 - 1 2 3 Frequent skin rashes | 88 - 1 2 3 Use laxatives | 96 - 1 2 3 Burning or itching anus |
| 80 - 1 2 3 Bitter, metallic taste in mouth in mornings | 89 - 1 2 3 Stools alternate from soft to watery | 97 - 1 2 3 Crave sweets |
| 81 - 1 2 3 Bowel movements painful or difficult | | |

GROUP SIX

- | | | |
|---|---|---|
| 98 - 1 2 3 Loss of taste for meat | 101 - 1 2 3 Coated tongue | 104 - 1 2 3 Mucous colitis or "irritable bowel" |
| 99 - 1 2 3 Lower bowel gas several hours after eating | 102 - 1 2 3 Pass large amounts of foul-smelling gas | 105 - 1 2 3 Gas shortly after eating |
| 100 - 1 2 3 Burning stomach sensations, eating relieves | 103 - 1 2 3 Indigestion ½- 1 hour after eating; may be up to 3 - 4 hrs. | 106 - 1 2 3 Stomach "bloating" after eating |

GROUP SEVEN

- | | | |
|--|---|--|
| (A) | | (E) |
| 107 - 1 2 3 Insomnia | | 150 - 1 2 3 Dizziness |
| 108 - 1 2 3 Nervousness | | 151 - 1 2 3 Headaches |
| 109 - 1 2 3 Can't gain weight | | 152 - 1 2 3 Hot flashes |
| 110 - 1 2 3 Intolerance to heat | | 153 - 1 2 3 Increased blood pressure |
| 111 - 1 2 3 Highly emotional | | 154 - 1 2 3 Hair growth on face or body (female) |
| 112 - 1 2 3 Flush easily | | 155 - 1 2 3 Sugar in urine (not diabetes) |
| 113 - 1 2 3 Night sweats | (C) | 156 - 1 2 3 Masculine tendencies (female) |
| 114 - 1 2 3 Thin, moist skin | 137 - 1 2 3 Failing memory | |
| 115 - 1 2 3 Inward trembling | 138 - 1 2 3 Low blood pressure | (F) |
| 116 - 1 2 3 Heart palpitates | 139 - 1 2 3 Increased sex drive | 157 - 1 2 3 Weakness, dizziness |
| 117 - 1 2 3 Increased appetite without weight gain | 140 - 1 2 3 Headaches, "splitting or rending" type | 158 - 1 2 3 Chronic fatigue |
| 118 - 1 2 3 Pulse fast at rest | 141 - 1 2 3 Decreased sugar tolerance | 159 - 1 2 3 Low blood pressure |
| 119 - 1 2 3 Eyelids and face twitch | | 160 - 1 2 3 Nails weak, ridged |
| 120 - 1 2 3 Irritable and restless | (D) | 161 - 1 2 3 Tendency to hives |
| 121 - 1 2 3 Can't work under pressure | 142 - 1 2 3 Abnormal thirst | 162 - 1 2 3 Arthritic tendencies |
| | 143 - 1 2 3 Bloating of abdomen | 163 - 1 2 3 Perspiration increase |
| (B) | 144 - 1 2 3 Weight gain around hips or waist | 164 - 1 2 3 Bowel disorders |
| 122 - 1 2 3 Increase in weight | 145 - 1 2 3 Sex drive reduced or lacking | 165 - 1 2 3 Poor circulation |
| 123 - 1 2 3 Decrease in appetite | 146 - 1 2 3 Tendency to ulcers, colitis | 166 - 1 2 3 Swollen ankles |
| 124 - 1 2 3 Fatigue easily | 147 - 1 2 3 Increased sugar tolerance | 167 - 1 2 3 Crave salt |
| 125 - 1 2 3 Ringing in ears | 148 - 1 2 3 Women: menstrual disorders | 168 - 1 2 3 Brown spots or bronzing of skin |
| 126 - 1 2 3 Sleepy during day | 149 - 1 2 3 Young girls: lack of menstrual function | 169 - 1 2 3 Allergies – tendency to asthma |
| 127 - 1 2 3 Sensitive to cold | | 170 - 1 2 3 Weakness after colds, influenza |
| 128 - 1 2 3 Dry or scaly skin | | 171 - 1 2 3 Exhaustion – muscular and nervous |
| 129 - 1 2 3 Constipation | | 172 - 1 2 3 Respiratory disorders |
| 130 - 1 2 3 Mental sluggishness | | |
| 131 - 1 2 3 Hair coarse, falls out | | |
| 132 - 1 2 3 Headaches upon arising wear off during day | | |
| 133 - 1 2 3 Slow pulse, below 65 | | |
| 134 - 1 2 3 Frequency of urination | | |
| 135 - 1 2 3 Impaired hearing | | |

SYMPTOM SURVEY FORM – Page 3

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 - 1 2 3 Apprehension	200 - 1 2 3 Very easily fatigued	213 - 1 2 3 Prostate trouble
174 - 1 2 3 Irritability	201 - 1 2 3 Premenstrual tension	214 - 1 2 3 Urination difficult or dribbling
175 - 1 2 3 Morbid fears	202 - 1 2 3 Painful menses	215 - 1 2 3 Night urination frequent
176 - 1 2 3 Never seems to get well	203 - 1 2 3 Depressed feelings	216 - 1 2 3 Depression
177 - 1 2 3 Forgetfulness	204 - 1 2 3 Menstruation excessive and prolonged	217 - 1 2 3 Pain on inside of legs or heels
178 - 1 2 3 Indigestion	205 - 1 2 3 Painful breasts	218 - 1 2 3 Feeling of incomplete bowel evacuation
179 - 1 2 3 Poor appetite	206 - 1 2 3 Menstruate too frequently	219 - 1 2 3 Lack of energy
180 - 1 2 3 Craving for sweets	207 - 1 2 3 Vaginal discharge	220 - 1 2 3 Migrating aches and pains
181 - 1 2 3 Muscular soreness	208 - 1 2 3 Hysterectomy/ovaries removed	221 - 1 2 3 Tire too easily
182 - 1 2 3 Depression; feelings of dread	209 - 1 2 3 Menopausal hot flashes	222 - 1 2 3 Avoids activity
183 - 1 2 3 Noise sensitivity	210 - 1 2 3 Menses scanty or missed	223 - 1 2 3 Leg nervousness at night
184 - 1 2 3 Acoustic hallucinations	211 - 1 2 3 Acne, worse at menses	224 - 1 2 3 Diminished sex drive
185 - 1 2 3 Tendency to cry without reason	212 - 1 2 3 Depression of long standing	
186 - 1 2 3 Hair is coarse and/or thinning		
187 - 1 2 3 Weakness		
188 - 1 2 3 Fatigue		
189 - 1 2 3 Skin sensitive to touch		
190 - 1 2 3 Tendency toward hives		
191 - 1 2 3 Nervousness		
192 - 1 2 3 Headache		
193 - 1 2 3 Insomnia		
194 - 1 2 3 Anxiety		
195 - 1 2 3 Anorexia		
196 - 1 2 3 Inability to concentrate; confusion		
197 - 1 2 3 Frequent stuffy nose; sinus infections		
198 - 1 2 3 Allergy to some foods		
199 - 1 2 3 Loose joints		

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row.

MALES
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

BP SIT _____ BP STAND _____

PULSE SIT _____ PULSE STAND _____

SALIVA PH _____ BLOOD TYPE _____

Patient Information

Your Name _____ Birthdate _____ M F
Address (mailing) _____ (City) _____ (State) _____ (Zip Code) _____
Telephone (home) _____ (work) _____ (cell phone) _____
E-Mail _____ Status: Single Married Partnership
Employed?: Yes No/Student No Yes Employer/School Name _____
Primary Health Care Provider _____ (title) _____ Telephone _____
Who may I thank for referring you to my office? _____ Telephone _____

Health Insurance Information

Name of Insured _____ Birthdate _____ M F
Relationship to patient: self spouse partner dependent Insured's ID # _____
Insured's Address _____ Telephone _____
Insurance Plan Name _____ Policy _____ Group _____
Insured's Employer _____ Telephone _____
Is there another health benefit plan? No Yes Name _____
Plan Name _____ Group _____ ID Number _____
Is your condition related to: employment auto accident other accident Date _____
Claim Number _____ Guarantor _____
Claims Representative _____ Telephone Number _____
Address (where to send claims) _____

Emergency Contact

Name _____ Relationship _____ Telephone _____

Patient Acknowledgement

The above information is true and correct. I agree to keep New Moon Family Acupuncture current with any changes to the above. I authorize the release of information concerning my treatment to my insurance company, legal advisor and/or referring health care provider. I also authorize payment directly to this office for professional services rendered and am personally responsible for any unpaid balance.

SIGNATURE OF PATIENT (OR REPRESENTATIVE, INCLUDING RELATIONSHIP)

DATE