Queenpin Acupuncture
1731 Grandin Road
Roanoke, VA 24015
540.685.2718

Katie Clifton, L.Ac.

Name: _____ Birthdate: _____ Age:_____

Address:_____
_____

Email:_____ Phone:_____

Occupation:_____

Marital Status: S/M/D/W/Cohabitating Referred by:_____

Emergency contact name:_____ Phone:_____
_____

Have you ever received acupuncture before? _____ If so, by whom?_____

Reason for seeking acupuncture:_____
_____
_____

How and when did this condition start?
_____
_____

Have you received previous treatment for this condition?_____

By whom?_____

What was the result/diagnosis?_____

Has the condition gotten: Better/Worse/Stayed the same

Other healthcare providers:_____
_____

Do you have any of the following: Surgical Implants / Heart Monitor

Positive for: AIDS/HIV Hepatitis Pregnancy or suspected pregnancy

Are you fearful of needles?_____

Do you have any allergies/sensitivities to any medicines or any other substances? If so, please list:_____
_____
_____

Please list all the medications, vitamins, and nutritional supplements that you have taken in the past 3 months:_____
_____
_____

Please list any hospitalizations or surgeries:
_____
_____

Are you currently experiencing any family stress? Y/N

In the past year have you experienced any significant loss? (Death of a loved one or pet, job loss, miscarriage, divorce or separation, significant move, etc.)
_____
_____

Intuitively, what do you feel is causing your current symptoms? _
_____
_____

What are your expectations for your course of treatment?
_____
_____

How soon do you expect to get results and what is your goal?
_____
_____

Do you think your healing will require lifestyle changes? Y/N If so, do you believe you will be able to make them?
_____

Please share any additional information you feel is relevant to your case:

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Please check any conditions that you currently have. Underline any you've had in the past:

Diabetes ☐ Glaucoma ☐ Heart Trouble ☐ High blood pressure ☐ Cancer ☐
Vein Trouble ☐ Asthma ☐ Jaundice ☐ Tuberculosis ☐ Bleeding Tendencies ☐
Mumps ☐ Pneumonia ☐ Allergies ☐ Polio ☐ Kidney Disease/Stones ☐
Measles ☐ HIV/AIDS ☐ Rheumatic Fever ☐ Nervous Disorder ☐ Chicken Pox ☐ Meningitis ☐ Hepatitis ☐ Multiple Sclerosis ☐ High Fever ☐ Antibiotic Use ☐ Thyroid Medication ☐
Steroid Medication ☐ Other ☐ _____

Please check if you are **currently** experiencing the following:

GENERAL: Tremors/Tics ☐ Headache ☐ Migraine ☐ Fever ☐ Sweats ☐ Fainting ☐
Dizziness ☐ Convulsions ☐ Fatigue ☐ Loss of Sleep ☐ Anxiety ☐ Depression ☐ Weight Loss ☐ Forgetfulness ☐ Confusion ☐ Numbness ☐ Paralysis ☐ Chronic Chilliness ☐
Chronic Stress ☐ Irritability/Touchiness ☐ Weak Fingernails ☐ Intense Thirst ☐ Sensations of Heaviness in Limbs ☐

EYES, EARS, NOSE, THROAT: Failing/Diminished Vision ☐ Eye Pain ☐ Blurry Vision ☐
Floaters ☐ Poor Night Vision ☐ Light Sensitivity ☐ Red Eyes ☐ Eye Inflammation ☐
Glaucoma ☐ Cataracts ☐ Deafness ☐ Earache ☐ Hearing Loss ☐ Tinnitus/Ringing in Ears ☐
Ear Discharge ☐ Dry Eyes ☐ Nose Bleeds ☐ Nasal Drainage ☐ Loss of Smell ☐ Sore Throat ☐
Hoarseness ☐ Dry Throat/Mouth/Nose ☐ Difficulty Swallowing ☐ Loss of Taste ☐ Dental Decay ☐ Gum Inflammation ☐ Frequent Colds ☐ Enlarged Thyroid ☐ Enlarged Glands ☐
Sinus Infection ☐

SKIN: Skin Eruptions ☐ Clammy Skin ☐ Spontaneous Sweating ☐ Dryness ☐ Bruise Easily ☐
Boils ☐ Rashes ☐ Sensitive Skin ☐ Hives/Allergies ☐ Swelling/Edema ☐ Mouth Ulcers ☐
Damp/Greasy Skin/Hair ☐ Acne ☐

RESPIRATORY & CARDIOVASCULAR: Chronic Cough ☐ Spitting Up Phlegm ☐ Excessive Mucus ☐
Sneezing ☐ Chest Pain ☐ Difficulty Breathing ☐ Wheezing ☐ Asthma ☐
Rhinitis/Sinusitis ☐ Chest Tightness/Heaviness ☐ Palpitations ☐ Irregular Heartbeat ☐
High Blood Pressure ☐ Low Blood Pressure ☐ Stroke ☐ Poor Circulation☐ Varicose Veins ☐ Hardening of Arteries ☐ High Cholesterol ☐ Shortness of Breath ☐

GENITOURIINARY: Frequent Urination ☐ Scanty Urine ☐ Blood in Urine ☐ Urinary Tract Infections ☐ Painful Urination ☐ Difficult Urination ☐ Cloudy Urination ☐ Bed

Wetting □ Incontinence □ Burning Urination □ Dribbling □ Urgency with Urination □ Night Urination □ Concentrated Urine □

FEMALE: Painful Menstrual Cycle □ Early Periods □ Heavy Bleeding □ Lack of Blood □ Late Menses □ Watery/Thin Blood □ Pale Blood □ Clotting □ Water Retention □ Breast Pain□ Abnormal Bleeding □ Hot Flashes □ Vaginal Discharge □ Vaginal Burning □ Infertility □ Hormone Replacement Therapy □ PMS □ Rib Pain/Distention □ Prolapsed Uterus/Organs □ Soft Nodules or Masses □ Cysts □ Polycystic Ovaries □
Other_____
Are you currently on birth control? Y/N If so, what are you using?_____
Age you started menses:_____ Menopause Age:_____
Are you Pregnant Y/N/Maybe If yes, how many weeks?_____
Are you experiencing reduced libido (sexual energies)? Yes/No
# of Pregnancies:_____ # of Children:____ Abortions:_____ Miscarriages:_____
Please list any surgeries involving: Ovaries Uterus Tubes Vagina Breast

MALE: Reduced Libido (sexual energy) □ Premature Ejaculation □ Seminal Emission □ Impotence □ Discharges □ Urgent Urination □ Genital Pain □ Prostate Problems □

GASTROINTESTINAL: Poor Appetite □ Excessive Hunger/Cravings □ Gas/Bloating □ Belching □ Nausea □ Vomiting □ Hunger Without Desire to Eat □ Lack of Taste Discrimination □ Abdominal Pain □ Colitis □ Constipation □ Diarrhea □ Irregular Bowel Movements □ Loose Stools □ Hemorrhoids □ Worms/Parasites □ Liver Trouble □ Gall Bladder Trouble □ Irritable Bowel Heartburn/Acid Reflux □ Weight Gain □ Weight Loss □ Emaciation □ Desire to Eat Strange Things □ Feeling Cold in the Abdomen □

MUSCULO-SKELETAL: Stiff Neck □ Pain Between Shoulders □ Mid-Backache □ Lower Back Pain □ Lower Back Weakness □ Foot Trouble □ Hernia □ Arthritis □ Sore Muscles □ Weak Muscles □ Sciatica □ Spinal Curvature □ Knee Pain □ Knee Weakness □ Bone Disorders □ Cold Hands/Feet □

FAMILY HISTORY: Asthma □ Allergies □ Cancer □ Diabetes □ Digestive Problems □ Emotional Problems □ Heart Disease □ High Blood Pressure □ Seizures □ Stroke □ Substance Abuse □ Other:_____

LIFESTYLE:

Do you exercise? Y/N
Please indicate the level of habit and frequency of the following:

	Heavy	Moderate	Light	None
Coffee	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Stress	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Other	_____	_____	_____	_____

DIET:
(circle one) omnivore carnivore vegetarian vegan raw foods paleo other:_____
Breakfast: _____
Lunch: _____
Dinner: _____
Between Meals: _____

Are you now on (or have undertaken) a restricted diet? Please describe and indicate when/why: _____

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Patient Rights

Your Rights as a Patient: The Commonwealth of Virginia Board of Medicine regulates the practice of Oriental Medicine; all practitioners are required to be licensed through this system. You are entitled to receive information about the methods of care, if known, and fee structure. You have the right to know the risks, as well as the benefits, of any therapy, procedure performed, medicinal agent, healing supplement, herb or any other recommendations made by a health care practitioner. All invasive procedures require documented informed consent. You are also entitled to information regarding the health care provider's degrees, credentials and licenses. You have the right to seek a second opinion from another practitioner or terminate care at any time. Understand that VA law states, "No practitioner may guarantee the outcome or cure". You should know that in a professional relationship, sexual intimacy is never appropriate and should be reported to your state Medial Grievance Board. It is important that you understand that information provided by you during care is confidential and except in certain circumstances of which you should be informed.

Confidentiality: Matters regarding your health care will be kept confidential except in the following circumstances: you sign a release from giving permission to release information to a specific individual or agency; child abuse; patient or client is in imminent danger to self or others; subpoena of records. In addition, it may be appropriate to consult your primary care medical doctor, particularly in circumstance where a medical doctor is monitoring physical symptoms or a change in medication may be needed. *In this circumstance, your signature below constitutes your giving permission for such consultations.*

Fee and Payments:

Initial Pediatric Appointment	$50
Follow Up Pediatric Appointment	$40
Initial Adult Appointment	$80
Sliding Scale Fees for Follow Up Appointments Based on total household income:	
Under - $30,000	$45
$35,000 - $40,000	$50
$40,000 - $45,000	$55
$45, 000 - $50,000	$60
$55,000 – Above	$65

Payments are due at the time of service. Returned checks will incur a $30 fee. Since I have reserved our appointment time for you, it is my policy to charge a 50% cancelation fee for cancellations received less than 24 hours notice except in cases of emergencies. If you have financial concerns,

please discuss them with me prior to that becoming an obstacle to your healing progress – I am happy to work out arrangements to make this work within your personal budget. Please understand that this office does not bill to any insurance company and that the responsibility falls upon you to collect from any company that will reimburse for services rendered here.

Continuity of Care/ Termination of Care: Your responsibility in a therapeutic relationship is to keep your appointments and follow through with guidance and recommendations that take reasonable steps toward a goal of health. It is always your right to terminate care at any time; however, I strongly encourage you to discus this decision with me. I am delighted in your decision to better your health and am willing to discus your progress and your status with you on an on-going basis. Please understand acupuncture works best as a cooperative process. Feel free to talk about your needs and concerns with me at any time.

I understand the above rights and responsibilities in the therapeutic relationship.

_____	_____	_____
Printed Name	Signature	Date

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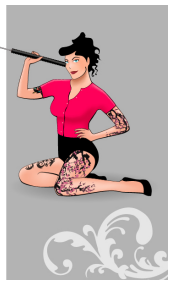

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental Medicine on me (or the patient named below, for whom I am legally responsible) by Katie Clifton, L.Ac.

I understand there are some risks to treatment, including but not limited to bruising of the skin and/or slight bleeding. If moxabustion or heat therapies are used there is a risk of possible burn and/or scarring. This includes therapy administered by both the acupuncturist in her office and myself, the patient/guardian, if applicable, when using moxabustion therapy at home. The risk of infection is small since this office uses only sterile, disposable needles.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of Oriental Medicine and I understand the results are not guaranteed.

I do not anticipate the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment which she fells at the time is in my best interest, based upon the facts then known, during the course of the procedure.

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

_____ _____

Patient's Signature (or Patient Representative) *Date*
Please indicate relationship is signing for patient.

_____ _____

Acupuncturist *Date*

Consent to NADA/ 4 Gates Treatment

Treatment Description
NADA / 4Gates is a specialized form of acupuncture and is performed by placing one to five thin, sterile, single-use needles in your ears, hands, and/or feet. The needles are generally left in place for 35 – 45 minutes. Treatment time may need to be altered for clinical or training purposes.

Voluntary
I hereby voluntarily consent to be treated by acupuncture, and in particular the NADA/ 4 Gates protocol. I understand I may be treated with needles and/or small seeds/tacks taped to my ears.

I have not been guaranteed any success concerning the uses and effects of NADA/4 Gates. I understand I am free to discontinue treatment at anytime.

Possible Side Effects/Reactions
I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed physician.

Medical Referral
I understand if there is a worsening of my ailment or condition or if a new ailment or condition arises, that I should consult a licensed physician. I also understand that if I am currently under a physician's care I should continue as long as my physician and I deem it necessary and that my NADA/ 4 Gates providers do not recommend altering medications or other therapies without first consulting my personal physician or provider.

Infectious Disease/Clean Needle Procedures
I understand that infectious diseases may be carried through the air, through physical contact, and through body fluids. I understand that NADA/ 4 Gates practitioners follow the prescribed national standards of Universal Precautions to guard against the spread of infection through the use of sterilized, prepackaged, disposable single-use needles.

I further understand that I am responsible for cleaning my ears prior to NADA/ 4 Gates treatment.

_____

Printed Name Signature

_____

Phone number Email Date