



Marya Deda L.Ac., Dipl.O.M., L.M.T

Jade Acupuncture
1920 NW Lovejoy Street
Portland, OR 97209
503-358-3772 cell 503-417-1774 clinic

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

SS# _____ Home # _____ Work # _____

Gender _____ DOB _____ Ht _____ Wt _____ Age _____

Email _____ Emergency contact _____ Phone _____

Employer _____ Occupation _____

If patient is a minor, signature of parent or guardian _____

Living situation: alone w/partner w/friends w/children # children _____

Who can I thank for referral _____

Major complaint(s) _____

Other treatment received for this _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.) _____

Are there others in your family with the same condition? _____

Is this related to a work injury? _____ Car accident? _____ Date injured? _____

Medications you now take _____

Vitamins, supplements, herbs, remedies _____

Have you previously sought other complimentary health care? _____ (please check which)

- Naturopathy Shiatsu Massage/Body work Chiropractic Acupuncture Osteopathy

Family Health History

- Diabetes Stroke Asthma Back Problems
 Cancer High Cholesterol Allergies Other _____
 Heart Disease High Blood Pressure Alcoholism

Personal Health History (include dates)

Major illnesses _____

Major surgeries _____

Other significant trauma _____

Have you been treated for any other health condition in the past year? yes no

If yes, please explain _____

Allergies (drugs, chemicals, foods) _____

Do you smoke? yes no

Check any of the following disease you have had

- Appendicitis Malaria Arthritis Heart Disease
 Tuberculosis Diabetes Anemia STDs
 Cancer Epilepsy Pleurisy Low Back Pain
 High Cholesterol Mental Disorder Goiter Eczema
 Pneumonia Measles Influenza Other _____
 Rheumatic Fever Mumps Alcoholism _____
 Mononucleosis Chicken Pox Whooping Cough _____

Musculo-Skeletal

- Back Pain Neck Pain Walking Problems Hip Pain
 low/upper/middle Arm Pain Pained/Clicking Jaw Foot/Ankle Pain
 Shoulder Pain Joint Pain/Stiffness Wrist/Hand Pain Sciatic Pain

Nervous System

- Numbness Confusion/Depression Cold/Tingling Extremities Poor Memory
 Dizziness/Vertigo Fainting Irritability Loss of Sleep
 Forgetfulness Convulsions Headaches/Migraines Anxiety/Panic Attacks

Cardio-vascular

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Lung Problems/Congestion | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pressure in Chest | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Palpitations at Rest |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Swelling ankles/hands |

Gastro-Intestinal

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appetite excessive/poor | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Black/Bloody Stool | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Colitis/Irritable Bowel | <input type="checkbox"/> Crohn's |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Loose Stool | <input type="checkbox"/> Acid Reflux/GERD |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Frequency of bowel movements _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas/Bloating after meals | <input type="checkbox"/> Bad Breath | |
| | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hernia | |

EENT

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Stuffed Nose | <input type="checkbox"/> Allergies |

Skin

- | | | | |
|---------------------------------|--|---|---|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Fever | <input type="checkbox"/> Skin Discoloration |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Itch without eruption | <input type="checkbox"/> Loss of Hair | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Acne | <input type="checkbox"/> Fungal Infection | |

Respiratory

- | | | | |
|-----------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Production of Phlegm |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Difficulty Breathing w/ Laying Down |

Genito-Urinary

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Herpes | <input type="checkbox"/> Excessive libido |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Night urination what time? _____ |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Copious flow | <input type="checkbox"/> how often? _____ |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Burning urination | |

Gynecological/Reproductive

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Age of first menses _____ | <input type="checkbox"/> Date of last PAP _____ | <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Date of last menses _____ | <input type="checkbox"/> Number of pregnancies _____ | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis |
| | | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids |
| | | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue |

Fees and Policies

I, _____ (client) understand that my insurance is an agreement between the insurance company and myself. Insurance billing is a courtesy that this office extends to our patients. I understand that Marya Deda, LAc, LMT, will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance company. I agree to accept full responsibility for all amounts not paid for by my insurance company and agree to pay Marya Deda, LAc, LMT, for all services provided to me which the insurance company denies due to their usual and customary policy or for other reasons. I understand that balances are due net 30 days.

I further understand that returned checks carry a service charge of \$25.00 per check, and I agree to pay Marya Deda, LAc, LMT, the total amount due of said returned check, service charge, plus her costs of collection.

Cancellation Policy:

I, _____ (client) agree that if I am unable to keep an appointment, I will give 24 hours notice. I also understand that there is **a full office fee for missed or cancelled appointments without 24 hours notice**. I understand that this fee is my responsibility. Cancellation due to illness will not be charged.

Signed _____ Date _____

Consent

Massage/Shiatsu:

Massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. There may be certain side effects such as muscle soreness and the aggravation of symptoms existing prior to treatment. _____

Acupuncture:

Acupuncture is the insertion of needles through the skin at certain points on the body to treat bodily dysfunction or disease, to modify or prevent pain, and to normalize the body's physiological functions. Certain adverse side effects may include local bruising, minor bleeding, fainting, pain or discomfort, and/or possible aggravation of symptoms existing prior to the acupuncture treatment. _____

Moxibustion:

Moxibustion is the application of heat to the skin at certain points on the body to treat bodily dysfunction or disease. There is a risk of burning or scarring. _____

Chinese Herbs:

Chinese Herbs are plants, insects, and minerals from the Oriental materia medica to treat bodily dysfunction or disease. Patients must follow the directions for administration and dosage. Certain adverse side effects may include changes in bowel

movement, abdominal pain or discomfort, and possible aggravation of symptoms existing prior to herbal treatment. Please call acupuncturist if any adverse side effects occur. _____

Electro-Acupuncture:

Electro-acupuncture is the addition of an electric current used with the acupuncture needles. Possible adverse reactions include mild shock, pain or discomfort, or possible aggravation of symptoms existing prior to treatment. _____

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

HIPPA Consent

I, _____, consent to the use or disclosure of my protected health information by Marya Deda, L.Ac., LMT, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Marya Deda, L.Ac., LMT. I understand that diagnosis or treatment of me by Marya Deda, L.Ac., LMT, may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the health care operations of the practice. Marya Deda, L.Ac., LMT, is not required to agree to the restrictions that I may request, however, if Marya Deda, L.Ac., LMT, agrees to a restriction that I request, that restriction is binding.

“Protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

Marya Deda, L.Ac., LMT reserves the right to leave a message on the patient’s home answering machine/recorder or private cell phone. As the patient I consent to this right.

I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (print)

Description of Personal Representative Authority

Date