Welcome! I look forward to working with you to achieve your goals through the use of Acupuncture & Chinese Medicine. The following are Office Policies to be aware of; these policies are subject to change. Policy updates are sent via email, but the most current version can always be found on the website. *Please keep this page for your records.*

NON-DISCRIMINATION
The office / treatment room is located at the center of a private residence. You are entering a family space where the amazing diversity of the human experience - race, gender expression, sexual orientation, religious tradition, relationship structure, etc. - is embraced with LOVE. Welcome!

ACCESSIBILITY
- Refrain from using perfume, scented moisturizer, or any other heavily scented products
- The house is not wheelchair accessible

If you have specific accessibility needs, please email to discuss these prior to scheduling.

PAYMENTS & CANCELLATIONS
Payment is due at the time of service by CASH, CHECK, or CREDIT CARD unless otherwise agreed to by both parties in writing. Advance payment is always welcome. With notice, receipts for Acupuncture & Chinese Medicine sessions can be provided for health flex accounts or insurance reimbursements. Insurance does not cover Qigong Instruction or other services and is not guaranteed for Acupuncture treatments; please confirm coverage with your provider.

CANCELLATIONS
Cancellations and non-emergency rescheduling must occur at least 24 HOURS prior to an appointment to avoid fees. Same day cancellations, missed appointments, and late arrivals will be charged the full amount. Cancellations due to extreme weather or emergencies are excused from this policy; please contact the office as soon as possible.

PRIVACY
HIPAA, the Health Insurance Portability and Accountability Act of 1996, protects all "individually identifiable health information" held or transmitted in any form, whether electronic, paper, or oral. This means that from our first private conversation, any shared information is protected. If you want to share your protected health information with another health care provider, a family member, or other loved one, I need your written authorization to do so.

Conversations held via telephone, cell phone, internet, email, and/or fax are inherently non-confidential and are used by both parties with the full understanding of risk. Liability for any breach in privacy that may occur while using these devices will not be assumed by this office or practitioner.

Let me know if you have any questions – I look forward to meeting you soon!

CATHERINE LUMENELLO, PLLC
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~ Fill out the remaining SEVEN pages and bring them to your appointment ~

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE 1: _____ PHONE 2: _____

EMAIL: _____

PARENT / GUARDIAN (IF UNDER 18) _____

EMERGENCY CONTACT _____ PHONE _____

REFERRED BY _____

PRIMARY HEALTH CONCERNS: *Please answer in regards to your Highest Priority Conditions (three maximum).*

	1	2	3
Brief DESCRIPTION of your Concern			
DURATION of Condition			
Were you prescribed MEDICATIONS? *(include dosage)*			
Other Treatments you have tried			
What HELPS? *(heat, cold, meds, etc)*			
What HURTS?			
Treatment GOALS			

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ DATE OF BIRTH _____

INFORMED CONSENT

Payments & Cancellations

I have been informed regarding the payment and cancellation policies of this office and/or practitioner, including payment at the time of service. I am fully responsible and agree to pay for the treatments and services received, as well as any cancellation fees incurred.

Privacy

I understand that conversations with this office and/or my practitioner via telephone, cell phone, internet, and fax are inherently non-confidential. I agree to hold this office and/or my practitioner free from any liability in regards to breaches in privacy that may occur when using these devices.

Chinese Medicine: Diagnosis & Treatment

I hereby request and consent to Chinese Medicine diagnosis and treatment, including the performance of Acupuncture and other procedures within the scope of the practice of Acupuncture, on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the named acupuncturist, including those working at the clinic or office listed or any other office or clinic, whether listed this form or not.

I understand that methods of treatment may include, but are not limited to, Acupuncture, Moxibustion, Cupping, Electrical Stimulation, Tui-Na (Chinese massage), Gua Sha, Chinese Herbal Medicine, Medical Qigong, and Nutritional Counseling. I understand that Herbs may need to be prepared and/or consumed according to the instructions provided orally and in writing, and that they may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of Herbs. I have been informed that Acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of Moxibustion and Cupping, or when treatment involves the use of heat lamps. Bruising is also a common side effect of Cupping and Gua Sha. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The Herbs and Nutritional Supplements that have been recommended (which are from plant, animal and mineral sources) are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking Herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some Herbs may be inappropriate during pregnancy; I will immediately notify my practitioner if I am or if I become pregnant, or if I am trying to conceive.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above information, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

SIGNATURE: _____ TODAY'S DATE: _____

If under 18, Parent / Guardian must sign above, and print name here: _____

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ TODAY'S DATE _____

How many hours do you WORK per week? _____ Do you like your job? ☐ YES ☐ NO

How would you rate your STRESS level on a scale of 0 - 10, with 10 being the highest: _____

What regular ACTIVITES do you do in order to manage stress?

Do you EXERCISE? ☐ YES ☐ NO

If YES, what type and how often? _____

Do you MEDITATE or PRAY? ☐ YES ☐ NO

If YES, what type and how often? _____

How many hours do you SLEEP each night? _____ At what TIME? _____

Do you experience: ☐ Difficulty falling asleep ☐ Interrupted sleep ☐ Waking too early
☐ Waking up groggy, not well-rested ☐ Vivid dreams ☐ Nightmares

How would you rate your ENERGY level on a scale of 1-10, with 10 being the highest: _____

Any particular time of day your energy is HIGHER _____ LOWER _____

Do you typically FEEL : ☐ Hot ☐ Cold ☐ Both ☐ Often thirsty ☐ Dry mouth/throat

How many MEALS do you eat each day? _____ At what TIMES? _____

How many SNACKS do you eat each day? _____ At what TIMES? _____

Do you get FOOD CRAVINGS? ☐ YES ☐ NO

If YES, for what? _____

Do you drink WATER? ☐ YES ☐ NO

If YES, how much and when? _____

Do you use any of the following on a regular basis?

☐ SODA How often? _____

☐ ALCOHOL How often? _____

☐ CAFFEINE How often? _____

☐ TOBACCO How often? _____

☐ MARAJUANA How often? _____

☐ RECREATIONAL DRUGS How often? _____

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ TODAY'S DATE _____

How many BOWEL MOVEMENTS do you have in a day or week? _____

Are they: ☐ Well-formed ☐ Easy to pass ☐ Difficult to pass ☐ Sticky
☐ Loose ☐ Small pebbles ☐ Dark / Black ☐ Pale /Tan

List any SURGERIES or major Incidents (accidents, abuse history, etc.), and the DATE of occurrence:

1 _____

2 _____

3 _____

4 _____

5 _____

List ALL Prescriptions, OTC Medications, and/or Supplements you take regularly, including any already listed above under Primary Health Concerns. *Use a separate sheet of paper if needed.*

	MEDICATION	DOSE	TREATMENT FOR?
1			
2			
3			
4			
5			

Please indicate if the following pertain to you:

☐ Blood-Thinning Medication

☐ Pacemaker

FOR MEN

Are you SEXUALLY ACTIVE? ☐ YES ☐ NO How often? _____

Any history of STD's / STI's? ☐ YES ☐ NO If yes, list: _____

Date of your last PROSTATE EXAM (if applicable): _____

Any concerns with urinary difficulty (past or present), sexual function, or libido: ☐ YES ☐ NO

If YES, please describe:

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ TODAY'S DATE _____

GENERAL MEDICAL HISTORY *Check any that occur regularly, or are major health contributors.*

DIGESTIVE

☐ Diabetes
☐ Hypoglycemia
☐ Hyperglycemia
☐ Food Allergies
☐ Poor Appetite
☐ Excessive appetite
☐ Low energy after a meal
☐ Belching
☐ Acid Reflux
☐ Gallstones
☐ Nausea
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids
☐ Colitis / Diverticulitis
☐ Thirst / Dry Mouth

RESPIRATORY

☐ Asthma
☐ Allergies – environmental
☐ Skin Condition
☐ Frequent Colds/Flu
☐ Cough
☐ Shortness of Breath
☐ Poor sense of Smell

CARDIOVASCULAR

☐ Blood Pressure: HIGH / LOW
☐ Heart Palpitations
☐ Chest pain / tightness
☐ Varicose Veins
☐ Heart Disease
☐ Cholesterol Concerns
☐ Blood-clotting Disorder
☐ Strokes
☐ Dizziness/Fainting

IMMUNE SYSTEM

☐ Sweat Easily
☐ Temperature Sensitivity
☐ Weather/Seasonal Sensitivity
☐ Thyroid Condition
☐ Cancer
☐ HIV/AIDS
☐ Hepatitis
☐ Herpes
☐ Chronic Fatigue
☐ Other Chronic Disease:

PSYCHOLOGICAL

☐ Stress
☐ Anxiety
☐ Obsession / Excess Worry
☐ Mental Restlessness
☐ Claustrophobia
☐ Depression
☐ Easily Angered / Frustrated
☐ Difficulty making Decisions
☐ Loneliness
☐ Grief / Sadness / Regret
☐ Poor Memory: SHORT term
☐ Poor Memory: LONG term
☐ Substance Abuse
☐ Suicidal
☐ Other Concern:

GENITO-URINARY

☐ UTI: Acute
☐ UTI: Chronic
☐ Libido: POOR
☐ Libido: HIGH
☐ Urination Concerns
☐ Men: Prostate Concern

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ TODAY'S DATE _____

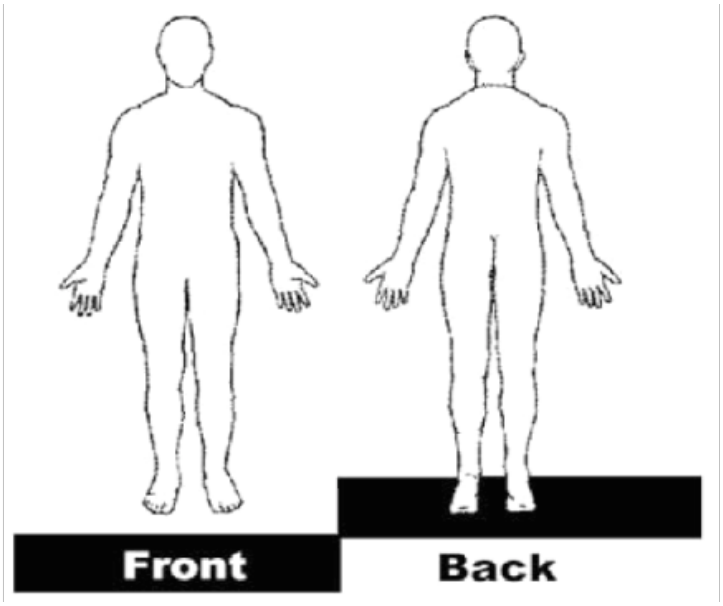
MUSCULOSKELETAL

☐ Muscle Pain	☐ Numbness	☐ Sciatica
☐ Muscle Cramps	☐ Stiffness	☐ Arthritis
☐ Muscle Weakness	☐ Fibromyalgia	☐ Broken Bone/Cartilage

SPECIFIC AREAS OF PAIN OR TENSION: *Check all that apply*

☐ Head / Face	☐ Abdomen	☐ Fingers
☐ Eyes	☐ Pelvis/Hips	☐ Legs
☐ Teeth/Jaw	☐ Back: Upper / Middle / Low	☐ Knees
☐ Neck	☐ Arms	☐ Ankles
☐ Shoulders	☐ Elbows	☐ Feet
☐ Chest/Breasts	☐ Wrists / Hands	☐ Toes

Using the diagram → Please indicate where you feel pain or discomfort.



Please describes the nature of your PAIN in as much detail as you can:
(ie. sharp stabbing, constant, intermittent, dull achy etc…)

Does this PAIN affect your sleep or your daily activities? To what degree?

OTHER CONCERNS

☐ Inflammation	☐ Twitches/Tremors	☐ Brittle Hair
☐ Edema	☐ Headaches	☐ Hair Loss
☐ Fatigue	☐ Migraines	☐ Brittle Nails
☐ Insomnia	☐ Ear Ringing	☐ Sense of Heaviness
☐ Epilepsy/Seizures	☐ Poor Hearing	☐ Dark Circles under Eyes

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ACUPUNCTURE & CHINESE MEDICINE

NAME _____ TODAY'S DATE _____

FOR WOMEN

Are you SEXUALLY ACTIVE? ☐ YES ☐ NO How often? _____

Any history of STD's / STI's? ☐ YES ☐ NO If yes, list: _____

Do you use BIRTH CONTROL? ☐ YES ☐ NO What kind? _____

Are you currently PREGNANT? ☐ YES ☐ NO How many weeks? _____

# of TOTAL Pregnancies _____ # of Births _____ # of Miscarriages/Abortions _____

Start Date of your last Menstrual cycle: _____ At what age did your Menses begin? _____

Average # of days (from Day 1) between cycles: _____ With flow for _____ days.

		Before	Day 1 – 2	Day 3 – 4	Day 5 +	After
COLOR	Pale / Light					
	Bright Red					
	Dark Red					
	Brown / Purple					
CONSISTENCY	Normal					
	Watery					
	Thick					
# of Pads or Tampons	1 – 3					
	4 – 7					
	8 +					
Uterine CRAMPING	Mild					
	Moderate					
	Severe					
CLOTS	Small - *Confetti*					
	Medium - *Dimes*					
	Large - *Quarters*					
Emotional Upset						
Breast Pain/Swelling						
Bloating						
Insomnia						
Fatigue						

Do you regularly experience any of the following BEFORE / DURING / AFTER your Menstrual Cycle?

☐ Low Back Pain ☐ Diarrhea ☐ Constipation ☐ Nausea ☐ Headache

☐ Appetite Changes ☐ Food Cravings ☐ Hemorrhoids ☐ Down-bearing sensation

Do you regularly experience any of these other gynecological symptoms:

☐ Vaginal dryness ☐ Profuse /odorous vaginal discharge ☐ Yeast infections ☐ UTI's

Have you ever been diagnosed with any of the following?

☐ Fibroids ☐ Endometriosis ☐ Ovarian Cysts ☐ Fibrocystic Breasts

☐ Polycystic Ovary Syndrome ☐ Pelvic Inflammatory Disorder

Please list any other gynecological / sexual concerns you may have: