

Welcome to Edgewood Natural Health

Patient Name	_____	Date of Birth	_____
Mail Address	_____	Home Phone	_____
City & ZIP	_____	Work Phone	_____
Occupation	_____	Cell Phone	_____
Employer	_____	E-Mail	_____

How did you find us? _____

What concerns would you like treated?

What other treatments have you received?

Other Concerns & Medical Conditions

Hospitalizations Injuries & Surgeries

Medications Herbs & Supplements

Caffeine _____ Tobacco _____

Alcohol _____ Drugs _____

Allergies _____

Diet Restrictions _____

Exercise Routine _____

Please review and check all of the symptoms below that apply to you.

TEMPERATURE	<input type="checkbox"/> Feverishness	<input type="checkbox"/> Hot flushes	<input type="checkbox"/> Chills	<input type="checkbox"/> Cold Hands / Feet
	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Excess Sweating		
HEAD	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness / Vertigo	<input type="checkbox"/> Jaw Problems	<input type="checkbox"/> Dental Problems
	<input type="checkbox"/> Eye pain / strain	<input type="checkbox"/> Dry or itchy eyes	<input type="checkbox"/> Spots / Floaters	<input type="checkbox"/> Poor vision
	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Ear discomfort	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Sinus problems
	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Dry mouth / throat	<input type="checkbox"/> Mouth sores	
DIGESTIVE	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Constant hunger	<input type="checkbox"/> Weight change	<input type="checkbox"/> Anorexia / bulimia
	<input type="checkbox"/> Cravings	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea / vomiting
	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Fatigue after meals	<input type="checkbox"/> Bloating / gas	<input type="checkbox"/> Abdominal pain
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Laxative use
	<input type="checkbox"/> Bloody or black stool	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Cramping	
HEART & RESPIRATORY	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Anemia	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Heart disease
	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Blood clots
	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Coughing	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Pacemaker / Defib.
SKIN & HAIR	<input type="checkbox"/> Hives / Rashes	<input type="checkbox"/> Itching	<input type="checkbox"/> Ulcers / sores	<input type="checkbox"/> Tumors / growths
	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Acne	<input type="checkbox"/> Eczema / psoriasis
UROGENITAL	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Dark / cloudy urine
	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Waking to urinate	<input type="checkbox"/> Urinary stones	<input type="checkbox"/> Blood in urine
	<input type="checkbox"/> Low sex drive	<input type="checkbox"/> Excess sex drive		
NEUROLOGICAL	<input type="checkbox"/> Seizures	<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Tremors	<input type="checkbox"/> Muscle twitching
	<input type="checkbox"/> Stroke	<input type="checkbox"/> Areas of weakness	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Poor coordination
PSYCHOLOGICAL	<input type="checkbox"/> Easily stressed	<input type="checkbox"/> Irritability / Anger	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Unclear thinking	<input type="checkbox"/> Mental illness
SLEEP / ENERGY	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hard to fall asleep	<input type="checkbox"/> Fitful sleep	<input type="checkbox"/> Dreams bother sleep
	<input type="checkbox"/> Unrested in morning	<input type="checkbox"/> Interrupted sleep	<input type="checkbox"/> Nightmares	
ENDOCRINE & IMMUNE	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis / HIV	<input type="checkbox"/> Immune disorder
	<input type="checkbox"/> Chronic Infection			
MEN'S HEALTH	<input type="checkbox"/> Enlarged prostate	<input type="checkbox"/> Poor sexual function		
MENSTRUATION	Length of Cycles? _____	<input type="checkbox"/> Menopause	Age? _____	<input type="checkbox"/> Hysterectomy
	# Days of Flow? _____	<input type="checkbox"/> Hormone Replacement		<input type="checkbox"/> Ovaries Removed
	<input type="checkbox"/> Heavy flow	<input type="checkbox"/> Light flow	<input type="checkbox"/> Clotting	<input type="checkbox"/> Very dark blood
	<input type="checkbox"/> Bloating	<input type="checkbox"/> Water retention	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Moodiness	<input type="checkbox"/> Acne	<input type="checkbox"/> Nausea	<input type="checkbox"/> Night sweats
	<input type="checkbox"/> Cramping / Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
PREGNANCY	# of Pregnancies? _____	Ages of Children? _____		
	<input type="checkbox"/> Infertility	<input type="checkbox"/> Habitual Miscarriages	<input type="checkbox"/> Birth Control	Type? _____
GYNECOLOGY	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Yeast Infections	<input type="checkbox"/> Ovarian Cysts
	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Abnormal PAP	<input type="checkbox"/> Vaginal Dryness

INFORMED CONSENT

John Frostad, EAMP is a licensed East Asian Medicine Practitioner (AC#366) in Washington. He received his Master of Science in Acupuncture (M.S.A.) from Bastyr University.

Monica Szelachowski EAMP is a licensed East Asian Medicine Practitioner (AC#60714780) in Washington.. She received her Master of Science in Acupuncture & Oriental Medicine (MSAOM) from Bastyr University.

The scope of practice for a East Asian Medicine Practitioner in Washington state includes the following:
The use of acupuncture needles or lancets and electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; moxibustion; acupressure; cupping; dermal friction; infra-red; sonopuncture; laserpuncture; point injection therapy; dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and Tuina (Chinese bodywork), superficial heat and cold therapies.

Acupuncture is safe and rarely uncomfortable. Side effects are very rare, but may include:
1. Pain following treatments. 2. Broken needles 3. Infection 4. Needle sickness 5. Minor bruising

If any of the following applies to you, please inform the acupuncturist:
1. Severe bleeding disorder; 2. Pacemakers; 3. Seizure disorders; 4. Pregnancy or suspected pregnancy

CANCELLATION POLICY

If you will be greater than 20 minutes late to your appointment, please call to reschedule. Late cancellations (made after 5pm the day prior to your visit) and missed appointments cannot and will not be billed to your insurance. We reserve the right to bill you \$25 for any missed appointment or late cancellation.

PRIVACY POLICY

I acknowledge that a copy of Edgewood Natural Health's Notice of Privacy Practices was made available.

I have read and understand the above, and consent to treatment and agree to the above policies:

Signed _____ Date _____

INSURANCE

- I authorize payment of medical benefits to Edgewood Natural Health LLC for services rendered.
- I authorize the release of any medical or other information necessary to process my claims.
- I accept responsibility for understanding my insurance coverage, copays, coinsurance, and deductibles.
- I accept responsibility for providing any necessary referrals or information required by my insurance.
- I understand that Edgewood Natural Health makes no guarantee that my insurance will cover my visits.
- I take financial responsibility for any and all charges not covered by my insurance company.
- I understand that herbal medicines and supplements will be at my expense, and that I may refuse them.
- I understand that if I do not pay in full at the time of service, any discounts will be unavailable to me.
- I understand that any visits applied to my deductible will be charged to me at the insurer's allowable rate.

Signed _____ Date _____