

# White Mountain Wellness

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**Welcome!** Thank you very much for your thoughtfulness in filling out this comprehensive and confidential health history form. The nature of your responses will help me immensely in gathering relevant information about your state of wellbeing. Having a complete understanding of your current health picture is essential in order to address your concerns, design your custom treatment plan and help you achieve your wellness goals. Please let me know if you have any questions!

<b>Name</b>	<b>Date</b>	<b>Gender</b> F M	<b>Date of Birth</b>	<b>Age</b>
<b>Address</b>	<b>Home phone</b>		<b>Work phone</b>	
<b>City / State / Zip</b>	<b>Cell Phone</b>		<b>Email Address</b>	
<b>Occupation</b>	<b>Employer Name and Address</b>			
<b>Emergency contact</b> (name & phone & relationship to you)				
<b>How did you hear about WMW? If by referral, please provide person's name.</b>				

Main reason(s) for seeking treatment- Please list your most important health concerns in order of significance:

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How long have you experienced these symptom(s)?

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Does anything make your symptom(s) better? Worse?

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**On a Scale of 1-10 (10 being the best) please rate your level of satisfaction with your:**

Physical Health	1	2	3	4	5	6	7	8	9	10
Emotional Balance	1	2	3	4	5	6	7	8	9	10
Energy Level	1	2	3	4	5	6	7	8	9	10
Activity/Fitness Level	1	2	3	4	5	6	7	8	9	10
Sexual Health	1	2	3	4	5	6	7	8	9	10
Food/Nutrition/Dietary Habits	1	2	3	4	5	6	7	8	9	10
Sleep Quality and Duration	1	2	3	4	5	6	7	8	9	10
Spiritual Practice	1	2	3	4	5	6	7	8	9	10
Overall Wellbeing	1	2	3	4	5	6	7	8	9	10

Have you ever had acupuncture before? YES NO Practitioner name (optional) \_\_\_\_\_

Please briefly describe any significant / relevant experiences you've had with Chinese Medicine/Acupuncture:

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Please describe your general goals and expectations for healing with White Mountain Wellness:

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Please describe lifestyle habits that you engage in that you believe **support** your wellbeing:

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Please describe lifestyle habits that may be **counter-productive** and **adversely affect** your health:

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What is your present level of commitment to addressing the underlying/root causes of your health concerns?

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Do you foresee any potential obstacles to healing and/or following the therapeutic protocols learned here?

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Do you have the sincere support of family/friends/community to make beneficial life changes? Describe:

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Are you currently under the care of another physician / health practitioner? Who, and for what condition(s)?

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List all current medications, prescribed or otherwise that you are taking, including vitamins & supplements

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Do you have high blood pressure and/or are you on blood pressure medications? YES NO



**For the following symptoms,**

Check the first checkbox if you presently have symptom, the second box if you have had it in the past

Presently or recently have symptom

Had symptom in past

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Symptom					
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### General Symptoms

<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Fever / chills	<input type="checkbox"/>	<input type="checkbox"/>	Bleed / bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Sweat without exertion	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Low immunity
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Do you prefer being warm or cold? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	Are your hands or feet cold, hot, clammy, sweaty? (circle)

### Digestion

<input type="checkbox"/>	<input type="checkbox"/>	Cravings	<input type="checkbox"/>	<input type="checkbox"/>	Stomachache	<input type="checkbox"/>	<input type="checkbox"/>	Tired after eating
<input type="checkbox"/>	<input type="checkbox"/>	Bloating/stomach fullness	<input type="checkbox"/>	<input type="checkbox"/>	Dieting	<input type="checkbox"/>	<input type="checkbox"/>	Irritability or low energy between meals
<input type="checkbox"/>	<input type="checkbox"/>	Gas/belching	<input type="checkbox"/>	<input type="checkbox"/>	Acid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Heart burn/ chest fullness
<input type="checkbox"/>	<input type="checkbox"/>	Irritability or low energy between meals	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting, Bulimia

### Gastrointestinal

<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Mucous in stool	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Laxative use	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal pain / cramping
<input type="checkbox"/>	<input type="checkbox"/>	Anal itching / burning	<input type="checkbox"/>	<input type="checkbox"/>	Anal fissures	<input type="checkbox"/>	<input type="checkbox"/>	Incomplete evacuation
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	How often do you have bowel movements? ___ x day; ___	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements: Soft, Hard, Wet, Dry, Float, Sink, Smell bad	<input type="checkbox"/>	<input type="checkbox"/>	What color is your stool? (circle) Black, Very dark, Brown, Green

### Ear, Eyes, Nose, Throat

<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Night blindness	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	Poor vision	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip
<input type="checkbox"/>	<input type="checkbox"/>	Spots / flowery vision	<input type="checkbox"/>	<input type="checkbox"/>	TMJ Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sores on tongue or mouth
<input type="checkbox"/>	<input type="checkbox"/>	Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	Excess saliva	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat, frequent or severe	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus / ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleed frequent or severe	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	cataracts	<input type="checkbox"/>	<input type="checkbox"/>	glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Lack of taste or smell
<input type="checkbox"/>	<input type="checkbox"/>	Any fillings, bridge work dentures, braces (please circle one)	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any phlegm or mucus in your nose, throat or lungs? No Yes	<input type="checkbox"/>	<input type="checkbox"/>	What color of phlegm do you have? Clear, White, Yellow, Green (circle one)

### Circulatory

<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve abnormality	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	Difficult inhalation	<input type="checkbox"/>	<input type="checkbox"/>	Difficult exhalation

**Skin / hair**

	Eczema		Dry skin		Rashes / hives / acne
	Fungal infections		Psoriasis		Dandruff
	Hair loss		Brittle nails		Ridged nails

**Musculoskeletal**

	Tendonitis		Spinal pain		Joint pain/ Arthritis
	Limited range of motion		Swelling		Carpal tunnel
	Numbness		Vertebral disc degeneration		Osteoporosis

**Neuropsychological**

	Insomnia		Anxiety		Irritability
	Poor memory		Depression		Easily stressed
	Tremors		Seasonal mood disorder		Tics
	Recent trauma		Currently in psychotherapy		Job stress
	Personality disorder		Death of someone close		Financial strain

**Genito-urinary**

	Dribbling when laughing or sneezing		Incomplete urination / retention		Decreased libido / sexual desire
	Burning urination		Blood in urine		Frequent urination
	Kidney stones		Bedwetting		Wake frequently to urinate
	Herpes		How many times do you urinate during the day? _____		What Time do you wake up to _____ a.m./p.m.
	Fertility Issues		Bladder Infections		Kidney Infections

**Men only**

	Impotency		Prostate problems		Erectile dysfunction
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**Women only**

	Age menses began		Age menses ended		hormone replacement therapy
	Date of last ob/gyn exam?		Hysterectomy? partial or full		Live births
	Abortion(s)		Miscarriage		Fibroids
	Birth control pills		Ovarian cysts		Vaginal odor
	Light bleeding		Medium bleeding		Heaving bleeding
	Candida / yeast		Clotting		Fibrocystic breast
	Vaginal discharge		Breast cancer		Acne associated with period
	Pain at ovulation		Emotional irritability or depression associated with period		Bleeding outside of regular menstrual cycle
	Constipation or diarrhea associated with period		Cramps / low back pain		_____ days between periods (usually)
	No period / skipped cycles		Irregular cycle		Period lasts _____ days
	Do you have recurrent bladder or vaginal infections? Yes or No				
	Hot Flashes		Bloating with period		Breast tenderness
	Headache <input type="checkbox"/> before menstrual cycle <input type="checkbox"/> during cycle <input type="checkbox"/> after cycle				

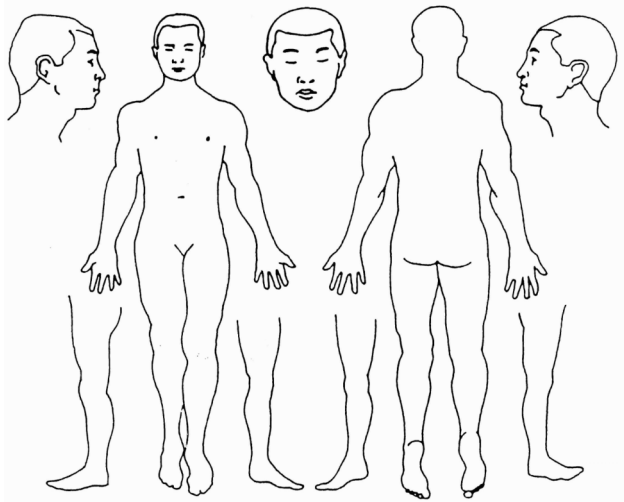
Anything else you would like me to know about you?

**AREAS OF PAIN**

Are you experiencing pain/discomfort in any area of your body?   Y   N

If yes, using the models to the right, please indicate the location of the discomfort by using the symbol that best describes the feeling:

+++      Sharp/stabbing  
 / / /      Pins & needles  
 v v v      Dull/aching  
 o o o      Numbness



**Patient Consent Form**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by White Mountain Wellness of the *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that White Mountain Wellness has taken action relying on this consent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

This Consent was signed by: \_\_\_\_\_

(Print name of Patient or Guardian authorizing this treatment)

For more information about HIPPA or to file a complaint:  
**The U.S. Department of Health & Human Services/Office of Civil Rights**  
 200 Independence Avenue, S.W.  
 Washington, D.C. 20201  
 (202) 619.0257  
 Toll Free: 1.877.696.6775

## INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese medicine (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below 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 acupuncturist named below.

I understand that the scope of practice for an acupuncturist in the state of Washington includes methods of treatment which may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, shiatsu (oriental massage), gua sha (dermal friction technique), infrared therapy (heat lamp), Chinese herbal medicine, and nutritional counseling.

I have been informed that Sarah Reese, LAc. has been extensively trained by an accredited 4-year graduate program in Oriental Medicine (MSOM) at the National College of Natural Medicine in Portland, Oregon. After graduating in 2006, Sarah was board certified in Acupuncture and Chinese herbalism by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and holds an acupuncture license from both Oregon and Washington states. (Washington State License # AC00002993 Date: 2/7/07. Oregon State License #AC01061 Date: 2/16/07).

Acupuncture is considered a generally safe method of treatment, but I understand that it may have some side effects, including; pain in the area of insertion, minor bruising, and/or numbness or tingling near the needling sites that may last a few days. Bruising is a common and expected side effect of cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include a broken needle, infection, and dizziness or fainting. Acupuncture uses sterile, single use, disposable needles and the practitioner has been properly trained and certified in "Clean Needle Technique" and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment; other side effect and risks may occur. I understand that results are not guaranteed. **I will notify my practitioner prior to any treatment if I have a severe bleeding disorder and/or a pacemaker.**

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended 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 the Chinese herbs prescribed may need to be prepared and consumed according to the instructions provided out loud and/or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify White Mountain Wellness of any unanticipated or unpleasant effects associated with the consumption of the herbs. **I also understand that some herbs and certain acupuncture points may be inappropriate during pregnancy and I will notify White Mountain Wellness if I am or become pregnant.**

I understand White Mountain Wellness 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 consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend for 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.

\*Please note: "White Mountain Wellness" is interchangeable with "Sarah Reese, LAc" throughout this document.

**PATIENT SIGNATURE** \_\_\_\_\_

(Or Patient Representative, please indicate relationship if signing for patient)

**DATE** \_\_\_\_\_

**Sarah Reese, MSOM, Dipl. Ac, CH, LAc.  
145 E. Jewett Blvd. Suite 301 White Salmon, WA 98672  
ph 509-637-3307 fax 509-637-2776**

## Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully, if you'd like, **you may keep this form for your records**.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by White Mountain Wellness in any form whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment** means providing, coordinating, or managing health care and related services by one or more health care operations.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill from your first visit to your insurance company for payment.

**Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to us:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to agree to a requested restriction, if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy practices currently in effect. We reserve the right to change the terms of our Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.