



**Advanced Acupuncture Inc. II**  
 Dr. Nikki N. Medghalchy, DAOM, L.Ac., M.Ac., Dip (NCCA) O.M  
 Natalie Lehmann, L.Ac, MAcOM  
 17704 Jean Way Ste. 105, Lake Oswego, Oregon 97035  
 Tel: (503) 908-0157 Fax: (503) 908-0187



<i>Office Use Only</i> <b>PROVIDER:</b>		<b>Date:</b>
<i>Office Use Only</i> <b>PATIENT #:</b> _____		<b>Age:</b> _____
<b><i>Patient Please print or type Clearly below</i></b> <b><i>PATIENT INFORMATION RECORD</i></b>		
<b>Name:</b>		<b>Occupation:</b>
<b>Address:</b>		<b>Employer:</b>
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Home Phone:</b> (    )		<b>City:</b> <b>State:</b> <b>Zip:</b>
<b>Work Phone:</b> (    )		<b>Spouse's Name:</b>
		<b>S/O Name:</b>
<b>Age:</b>		<b>Birth date:</b>
<b>Sex:</b> M    F	<b>Birth date:</b>	
<b>Referred By:</b>		<b>Employer:</b>
<b>Email Address:</b>		<b>Phone#:</b>
<b>Marital Status:</b> M   S   D   W		<b>Address:</b>
<b><i>Primary Insurance Information</i></b>		<b><i>Secondary Insurance Information</i></b>
<b>Name:</b>		<b>Name:</b>
<b>Address:</b>		<b>Address:</b>
<b>City:</b>	<b>State:</b> <b>Zip:</b>	<b>City:</b> <b>State:</b> <b>Zip:</b>
<b>Phone#:</b> (    )		<b>Phone#:</b> (    )
<b>Member#:</b>	<b>Grp#:</b>	<b>Member#:</b> <b>Grp#:</b>
<b>Insured's Name:</b>		<b>Insured's Name:</b>
<b>Relationship:</b> Self Spouse Child Other (circle)		<b>Relationship:</b> Self Spouse Child Other (circle)
<b>Account Guarantor: (Work Comp Carrier, Attorney, Etc.)</b>		
<b>Phone:</b> (    )		
<b><i>PERSONAL HISTORY</i></b>		
<b>Accident: Injury Illness Gradual Onset Date of Injury/Illness:</b>		
<b>Where were you when this first happened:</b>		
<b>What is your major complaint:</b>		
<b>Work Related? Yes No    Were you off work? Yes No    If Yes how long?</b>		
<b>Patient's Signature: (or Guardian, if Minor):</b>		<b>Date:</b>
<b><i>I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will immediately due and payable.</i></b>		
<b>Nearest relative not living with you (name &amp; phone):</b>		



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***Patient's Signature (or Guardian, if Minor):***

***Date:***

\*\*\*\*\*

Welcome to Advanced Acupuncture Inc. II clinic. We look forward to working with you to improve your health. Acupuncture is a holistic medicine that works on physical, mental, emotional and spiritual levels. The purpose of treatment is to bring balance to all of these levels. **Please bring your blood test or any study relating to your ailment.**

**PLEASE READ AND SIGN THE FOLLOWING**

I voluntarily authorize the acupuncturist to administer acupuncture and/or substances of oriental medicine, for relief of my disorders. ***I understand that appointment times are reserved especially for me and that the \$60.00 fee is charged for missed appointments and the \$40.00 for same day cancellations.***

I understand that payment is due at the end of each visit, unless otherwise arranged. *(If we are uncertain of your insurance co-pay or coverage, we ask for full payment until this is determined.)* There will be a \$35.00 charge on all returned checks.

I have read and understand the above.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

*Successful health care and preventive medicine are only possible when the health care practitioner has a complete understanding of the patient; physically, mentally, and emotionally. To assist me in better serving you, please complete the questionnaire as thoroughly as possible. Print all information and mark anything you do not understand with a question mark. All information is strictly confidential. Thank you.*

**HEALTH HISTORY QUESTIONNAIRE**

What is your primary concern, condition, injury or illness? \_\_\_\_\_

How long has it bothered you? \_\_\_\_\_

Describe what caused it/how it started: \_\_\_\_\_

How does this condition affect you? (Interference with work, sleep, appetite, etc.) \_\_\_\_\_

Have you received treatment for this condition? \_\_\_\_\_ When? \_\_\_\_\_

From Whom? \_\_\_\_\_ Diagnosis? \_\_\_\_\_

Results of Treatment? \_\_\_\_\_

Has the condition gotten: Better: \_\_\_\_\_ Worse: \_\_\_\_\_ Same: \_\_\_\_\_

Please put a check next to conditions that you have experienced within the last three months. Indicate the length of time you have had this condition:

**GENERAL:**

- Poor Appetite \_\_\_\_\_
- Localized Weakness \_\_\_\_\_
- Weight Gain \_\_\_\_\_
- Sweating Easily \_\_\_\_\_
- Night Sweats \_\_\_\_\_
- Sudden Energy Drop (time of day?) \_\_\_\_\_
- Other unusual or abnormal conditions you have noticed in your general sense of health? \_\_\_\_\_
- Insomnia \_\_\_\_\_
- Cravings \_\_\_\_\_
- Weight Loss \_\_\_\_\_
- Tremors \_\_\_\_\_
- Fever \_\_\_\_\_
- Disturbed Sleep \_\_\_\_\_
- Strong Thirst \_\_\_\_\_
- Changes in Appetite \_\_\_\_\_
- Bleed or Bruise Easily \_\_\_\_\_
- Chills \_\_\_\_\_
- Poor Balance \_\_\_\_\_

**SKIN & HAIR:**

- Rashes \_\_\_\_\_
- Itching \_\_\_\_\_
- Dandruff \_\_\_\_\_
- Changes in hair or skin texture \_\_\_\_\_
- Ulcerations \_\_\_\_\_
- Eczema \_\_\_\_\_
- Hair Loss \_\_\_\_\_
- Hives \_\_\_\_\_
- Pimples \_\_\_\_\_
- Recent Moles \_\_\_\_\_

Any other hair or skin problems? \_\_\_\_\_

**HEAD, EYES, EARS, NOSE, THROAT:**

- Dizziness \_\_\_\_\_
- Glasses \_\_\_\_\_
- Poor Vision \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Ringing in Ears \_\_\_\_\_
- Sinus Problems \_\_\_\_\_
- Grinding Teeth \_\_\_\_\_
- Teeth Problems \_\_\_\_\_
- Concussions \_\_\_\_\_
- Spots in Front of Eyes \_\_\_\_\_
- Night Blindness \_\_\_\_\_
- Blurry Vision \_\_\_\_\_
- Poor Hearing \_\_\_\_\_
- Recurrent Sore Throat \_\_\_\_\_
- Sores on Lips/Tongue \_\_\_\_\_
- Headaches \_\_\_\_\_
- Migraines \_\_\_\_\_
- Eye Pain \_\_\_\_\_
- Color Blindness \_\_\_\_\_
- Earaches \_\_\_\_\_
- Eyestrain \_\_\_\_\_
- Nose Bleeds \_\_\_\_\_
- Facial Pain \_\_\_\_\_
- Jaw Clicks \_\_\_\_\_

Any other head or neck problems? \_\_\_\_\_

**CARDIOVASCULAR:**

- Dizziness \_\_\_\_\_
- Irregular Heartbeat \_\_\_\_\_
- Cold Hands/Feet \_\_\_\_\_
- Blood Clots \_\_\_\_\_
- Low Blood Pressure \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Swelling of Hands \_\_\_\_\_
- Difficulty Breathing \_\_\_\_\_
- Chest Pain \_\_\_\_\_
- Fainting \_\_\_\_\_
- Swelling of Feet \_\_\_\_\_
- Phlebitis \_\_\_\_\_

Any other heart or blood vessel problems? \_\_\_\_\_

**RESPIRATORY:**

- Cough \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Difficulty Breathing when Lying Down \_\_\_\_\_
- Production of Phlegm (color?) \_\_\_\_\_
- Coughing up Blood \_\_\_\_\_
- Pain w/ Deep Inhalation \_\_\_\_\_
- Asthma \_\_\_\_\_
- Pneumonia \_\_\_\_\_

Any other lung problems? \_\_\_\_\_

**GASTROINTESTINAL:**

- Nausea \_\_\_\_\_
- Constipation \_\_\_\_\_
- Black Stools \_\_\_\_\_
- Bad Breath \_\_\_\_\_
- Abdominal Pain/Cramps \_\_\_\_\_
- Vomiting \_\_\_\_\_
- Gas \_\_\_\_\_
- Blood in Stools \_\_\_\_\_
- Rectal Pain \_\_\_\_\_
- Chronic Laxative Use \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Belching \_\_\_\_\_
- Indigestion \_\_\_\_\_
- Hemorrhoids \_\_\_\_\_

Any other problems with stomach or intestines? \_\_\_\_\_

**GENITO-URINARY:**

- Pain on Urination \_\_\_\_\_
- Urgency to Urinate \_\_\_\_\_
- Decrease in Flow \_\_\_\_\_
- Frequent Urination \_\_\_\_\_
- Unable to Hold Urine \_\_\_\_\_
- Impotence \_\_\_\_\_
- Blood in Urine \_\_\_\_\_
- Kidney Stones \_\_\_\_\_
- Sores on genitals \_\_\_\_\_

Do you wake up at night to urinate? \_\_\_\_\_ If so, how often? \_\_\_\_\_

Any particular color to your urine? \_\_\_\_\_

Any other problems with your genital/urinary functions? \_\_\_\_\_

**REPRODUCTIVE & GYNECOLOGIC:**

- Menstrual Clots \_\_\_\_\_
- Changes in body/psyche prior to menstruation \_\_\_\_\_
- Irregular Menses \_\_\_\_\_
- Age at 1<sup>st</sup> Menses \_\_\_\_\_
- First day of last Menses \_\_\_\_\_
- Miscarriages \_\_\_\_\_
- Painful Menses \_\_\_\_\_
- Menopause (Age) \_\_\_\_\_
- Menopause (Age) \_\_\_\_\_
- Time between Menses \_\_\_\_\_
- # of Pregnancies \_\_\_\_\_
- Abortions \_\_\_\_\_
- Unusual Menses \_\_\_\_\_
- Duration \_\_\_\_\_
- Other Problems \_\_\_\_\_
- Duration \_\_\_\_\_
- # of Births \_\_\_\_\_
- Premature Births \_\_\_\_\_

Birth Control? \_\_\_\_\_ If so, type? \_\_\_\_\_ How Long? \_\_\_\_\_

**MUSCULOSKELETAL:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck Pain _____       | <input type="checkbox"/> Muscle Spasms _____   | <input type="checkbox"/> Knee Pain _____       |
| <input type="checkbox"/> Back Pain _____       | <input type="checkbox"/> Muscle Weakness _____ | <input type="checkbox"/> Foot/Ankle Pain _____ |
| <input type="checkbox"/> Hand/Wrist Pain _____ | <input type="checkbox"/> Shoulder Pain _____   | <input type="checkbox"/> Hip Pain _____        |

Any other joint/bone problems? \_\_\_\_\_

**NEUROPSYCHOLOGICAL:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Seizures _____         | <input type="checkbox"/> Dizziness _____                    | <input type="checkbox"/> Loss of Balance _____      |
| <input type="checkbox"/> Area of Numbness _____ | <input type="checkbox"/> Poor Memory _____                  | <input type="checkbox"/> Lack of Coordination _____ |
| <input type="checkbox"/> Concussion _____       | <input type="checkbox"/> Depression _____                   | <input type="checkbox"/> Anxiety _____              |
| <input type="checkbox"/> Bad Temper _____       | <input type="checkbox"/> Easily Susceptible to Stress _____ |   |

Have you ever been treated for emotional problems? \_\_\_\_\_

Have you ever considered or attempted suicide? \_\_\_\_\_

Any other neurological/psychological problems? \_\_\_\_\_

**LIFESTYLE:**

Do you follow a regular exercise program? \_\_\_\_\_

Please describe your average daily diet: \_\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cigarette Smoking _____ | <input type="checkbox"/> Coffee, Tea & Cola _____ | <input type="checkbox"/> Alcoholic Beverages _____ |
|--|---|--|

Medications taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_

Please describe any use of drugs for non-medicinal purposes: \_\_\_\_\_

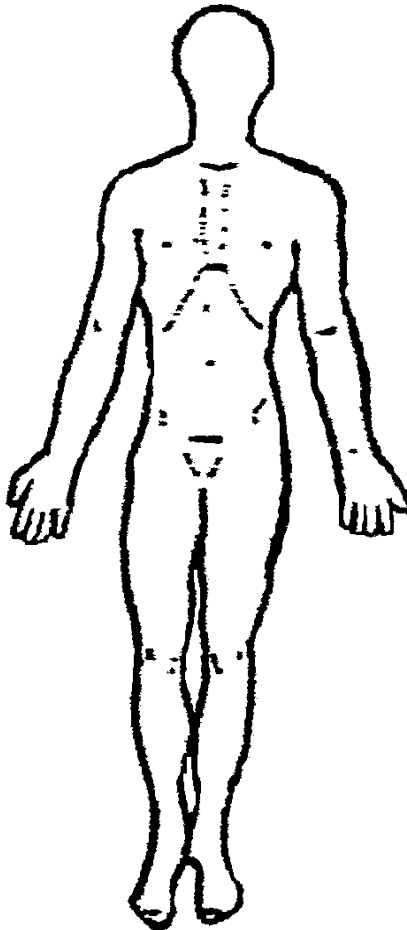
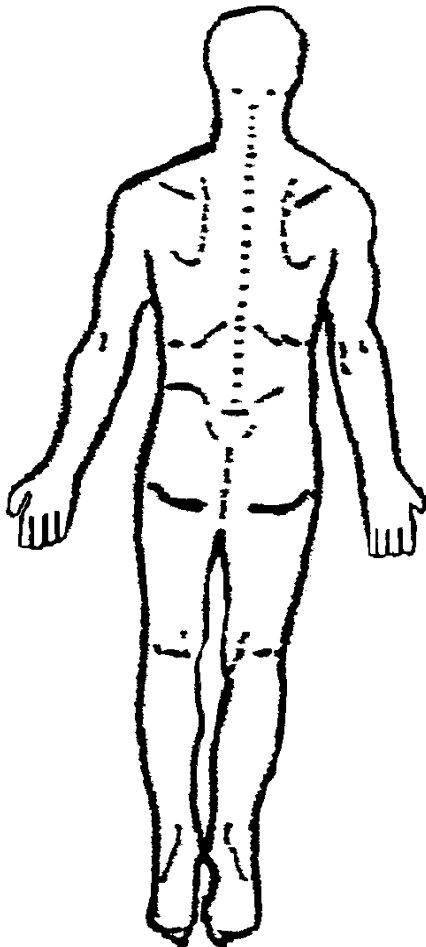
**INDICATE PAINFUL OR DISTRESSES AREAS:**

**BACK**

**FRONT**

**LEFT**

**RIGHT**



# PATIENT CONSENT FORM

Dr. Nikki Nooshin Medghalchy is a licensed acupuncturist in the: State of Washington: License number 029501, dated 11/5/99; State of Oregon: License number AC00502, dated 10/20/00. She received her Doctoral degree and Master of Science degree in Acupuncture and Oriental Medicine from Oregon School of Oriental Medicine in Portland, OR, in June of 1999 and Sep. 2007. Her didactic and clinical training was completed between 1993 and 2007.

Amber Robidoux is a licensed acupuncturist in Oregon, number AC156926, dated 2/13/12. She received her Master of Acupuncture and Oriental Medicine from the Oregon College of Oriental Medicine in Sept. 2011. She began her training in the healing arts at the Heartwood Institute where she received her Holistic Health Practitioner certification in May 2002. She is a licensed massage therapist in the state of Oregon, number 10026, dated 1/4/03 with specialized training in Cranial Sacral Therapy.

Washington and Oregon law require that each patient be informed regarding the scope of practice in which a licensed acupuncturist is allowed to engage, which included but is not limited to the following techniques:

- 1) Use of acupuncture needles to stimulate acupuncture points and meridians;
- 2) Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians;
- 3) Moxabustion;
- 4) Acupressure/massage
- 5) Cupping;
- 6) Dermal Friction (gua sha);
- 7) Infra-red;
- 8) Sonopuncture;
- 9) Laserpuncture;
- 10) Dietary advice based on Traditional Chinese medical theory; and

Side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the insertion area, minor bruising, infection, needle sickness (fainting), and broken needle.

**IF YOU HAVE A SEVERE BLEEDING DISORDER OR HAVE A PACEMAKER, YOU SHOULD MAKE THAT INFORMATION KNOWN TO YOUR PRACTITIONER PRIOR TO TREATMENT.**

I have read and understood the above information.

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

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

## ***ACKNOWLEDGEMENT OF PRIVACY PRACTICES***

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third-party payers for my health services; and
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my acupuncture provider's **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such **NOTICE OF PRIVACY PRACTICES**. I understand that my acupuncture provider has the right to change the **NOTICE OF PRIVACY PRACTICES** and that I may contact this office at the address above 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

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For office use only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason(s):

- Patient refused to sign
- Communications barriers
- Emergency situation
- other