Rasnow Integrative Wellness, Inc.

Acupuncture Patient Demographics

Name _____ Today's Date_____

Date of Birth _____ Place of Birth _____

Gender Identity_____ Gender Assigned at Birth_____

Mailing address _____

City_____ State_____ Zip_____ Ok to send mail? Y/N _____

Email: _____ Ok to email? Y/N _____

Phone Numbers: (please circle the preferred route of contact and hours you prefer to be called)

	Preferred?	Hours?
Home _____	❑	_____
Work _____	❑	_____
Cell _____	❑	_____

Insurance Information, If using (Medicare Only- Commercial Insurance not billed for Acupuncture):

Plan: _____ID # _____ Group #_____

Subscriber:_____ DOB if not self _____

Where did you previously receive or are currently receiving (Primary) care?

PCP: _____ Last seen: _____ Phone #: _____

Specialists?_____

Have you ever recieved acupuncture before? _____ If so, What was your experience?

_____

What is the primary reason you are seeking Acupuncture today?

_____

How did you hear about this practice? _____

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Current Health History

Please list your current health concerns in order of priority to you.
Indicate severity of symptoms using a scale of 1-10 with 10 being the worst you can imagine.

Symptoms/problem/diagnosis:	Severity now	Severity at its worst /(date)	Symptom onset (date)	What interventions have you tried so far?

Allergies or sensitivities to medications/supplements/food?

Drug/substance/food	Reaction:

Patient Name:

When was the last time you felt completely healthy?

_____

_____

What did that feel like?

_____

_____

How many hours of sleep do you get each night? _____
Do you sleep regular hours (ie go to bed and wake up at approximately the same time most days of the week? _____ Do you have trouble falling or staying asleep? _____
Do you use a CPAP machine or use medications/supplements to help you sleep?
_____

Do you drink caffeine? If so, how much? _____
Do you use tobacco or nicotine products?_____
Do you use cannabis or CBD/THC products? _____
Do you drink alcohol? If so, how much and often? _____

Do you follow a particular/specific diet? y/n _____
If so, how would you describe your diet generally:_____

What are your favorite foods?

_____
Do you eat regular meals from day to day? _____ Does your appetite vary? _____

How many days/week do you exercise? _____ What types do you enjoy? _____

Patient Name:

Medications and Supplements Inventory

Medication or Supplement (include brand and dose)	Regimen for taking, including if taken only as needed or intermittently

Patient Name:

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Personal and Family Health History

Please indicate which of these conditions currently affect you or have affected you or your family members previously. Please provide details in the comments section.

Condition	Self, current	Self, past	Mother	Father	Grandparent	Aunt/Uncle	Sibling	Child	Comment
High Blood Pressure									
High Cholesterol									
Overweight/Obesity									
Diabetes									
Thyroid Problems									
Eczema/ Psoriasis/ chronic skin conditions									
Asthma/ COPD									
Seasonal allergies									
Food allergies									
Heart Attack/ Coronary Artery Disease/Stenting									
Genetic Disorder/ Chromosome Abnormality									
Breast/ ovarian/ uterine Cancer									
Lung Cancer									
Colon Cancer or Polyps									
Skin Cancer									
Migraines									
Other Chronic headache									
Multiple Sclerosis/ ALS/ Parkinson's disease									

Patient Name:

Condition	Self, current	Self, past	Mother	Father	Grandparent	Aunt/Uncle	Sibling	Child	Comment
Depression/ Anxiety									
Bipolar disorder/ Schizophrenia/ other									
Trauma/Exposure to Violence									
Constipation/Diarrhea/IBS									
Chron's/ Ulcerative Colitis									
Cataracts/Glaucoma/Vision Loss									
Vertigo/Dizziness									
Hearing Loss									
Blood disorder (sickle cell, thalassemia)									
Abnormal Uterine Bleeding/Fibroids									
Dementia/memory loss/Alzheimer's									
Stroke/ TIA									
Lupus/ Systemic Autoimmune disease									
Rheumatoid Arthritis, other inflammatory arthritis									
Addiction/ alcoholism									
Smoker (tobacco, marijuana)									
Miscarriage/ Pregnancy complications									
Infertility									
Kidney Disease/Dialysis									
Leg Ulcers or Amputations									

Patient Name:

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Fee Agreement and Consent for Treatment

Thank you for allowing me to care for you. Please read the following and initial each paragraph indicating you have read and understand each agreement.

I _____ am seeking acupuncture and related treatment modalities performed by Dr. Marina Rasnow-Hill, MD. I understand that although acupuncture is a relatively low risk procedure there are some inherent potential complications including, but not limited to:

- redness or pain at needle insertion site
- bruising where needles were placed with some residual soreness
- mild bleeding after needles are withdrawn
- mild fatigue for 6-24 hours after treatment session
- vasovagal response to needle insertion possible leading to sweating, flushing, dizziness, nausea or in rare circumstances, fainting
- incomplete response to treatment or ineffectiveness
- mild burning sensation on the skin with application of topical ointments, with rare allergic reaction (ingredients to be reviewed before use)
- mild burning of the skin with heat application or moxibustion
- significant bruising with mild soreness following cupping application that may cause discoloration of the skin for up to 7-14 days

I understand these risks and agree to discuss any specific concerns with Dr. Rasnow before proceeding with a treatment. INITIAL_____

I agree to notify Dr. Rasnow of any changes in my health that might affect my response to treatement (ie dehydration, sunburn, rash, infection, antibiotics or new medications, etc.) INITIAL _____

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I will pay for services at the time of care. I understand the payment schedule for treatments are as follows:

- **Initial Acupuncture visit**
  Includes physical exam and assessment by MD, formulation of treatment plan and performance of acupuncture, electro-acupuncture, moxibustion and/or cold laser therapy as indicated by said treatment plan.
  ★Visit length 60-90minutes: **$120**

  Follow-up Acupuncture visit, office
  ★Visit length 30-60 minutes: **$80**

  Medicare Patients- Co-Pay for acupuncture at the time of office visit - $45
  (Medicare will be billed for office visit, patient must sign ABN for acupuncture services as this is not a covered service under Medicare)

_____

Signed Date

_____

Printed Name