Valley Holistic HEALING, LLC

Welcome Letter

Dear New Patient,

I'd like to take a moment to welcome you as a new patient of Valley Holistic Healing. Thank you for choosing us. We look forward to partnering with you to address your health concerns, and we will do all we can to ensure you achieve the most successful result possible for you.

The trust and confidence you have placed in us is most appreciated. We see many patients which respond favorably to acupuncture care. Our mission is to help you achieve your treatment goals, and to maintain optimal health over the long-term using safe, natural and holistic acupuncture, herbal therapy (when appropriate), and nutritional guidance and support.

Traditional Chinese Medicine, the ancient health care system of which acupuncture is a part, definitely works.

1. It can help prevent illness and disease
2. It activates the self-healing and self-regulating abilities of the body.
3. It adjusts and balances the flow of vital life energy, called Qi.
4. It can help you achieve optimal health, vitality, and well-being.

The precious gift of health is an investment that takes both time and money. In order to help you to get the most out of this worthwhile investment I would like to share a few suggestions:

1. **Be on time and keep your appointments**. Each treatment builds upon previous ones. It is important to follow through with your future care plan in order to receive maximum benefit.

2. **Do your homework**. In many ways what you do at home, at work and at play affects your progress. We offer suggestions and self-care techniques to support you on the road to your treatment goals toward a life of increased wellness and vitality.

3. **Give it time**. As with any medical treatment, healing with acupuncture is a process, not a magic pill. It takes time and is influenced by many factors. Over time, things should improve and if necessary, we will adjust your treatment plan as we proceed. Changes to your condition can happen faster than anticipated, so enjoy them!

4. **Keep a positive attitude and EXPECT positive results**. As we follow through on your treatment plan, look for signs of improvement and take encouragement from them. Build an attitude that expects positive results and knows that profound healing is possible. Your belief and expectation has an incredibly strong influence on your body, and is a key factor in healing.

It is a great pleasure to welcome you to the clinic!

Valley Holistic HEALING | Health Assessment

Thank you for choosing Valley Holistic Healing!

We are delighted to work with you to restore your body's natural rhythm.

The answers you will provide on these forms and the discussions you will share with your practitioner all add up - like individual pieces of a puzzle - to reveal a larger picture of your health and health concerns. This holistic view allows your concerns to be addressed from both a specific *branch* level and also a deeper *root* level.

Please take time to thoughtfully and honestly answer these questionnaires so that the picture of your health and health concerns are revealed as clearly as possible.

Name: _____ Today's Date: _____

Address _____

City: _____ State: _____ Zip: _____

Primary Phone # _____ Secondary Phone # _____

E-mail Address _____

Would you like to join Valley Holistic Healing's email list and be the first to know about upcoming health seminars and exclusive specials?

Date of Birth _____ Age _____ Weight _____ Height_____ Sex M / F

Marital Status: ☐ Single ☐ Married or living with significant other
☐ Separated ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Have you ever received acupuncture before? _____

Full payment is due on the day of the appointment.
Receipts for insurance reimbursement will be provided at your request.

We ask for 24 hour advance notice if you need to cancel an appointment.
You may be charged if you cancel an appointment without 24 hours notice.

Patient ID _____

Valley Holistic HEALING | Medical History

What health concern(s) bring you in today? _____

_____

_____

_____

How do these affect your daily life? _____

_____

_____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was the diagnosis? _____

Do you have other health concerns you wish we could help? _____

_____

_____

List any major surgeries you've had _____

_____

Significant trauma (accidents, falls) _____

_____

Have you ever been diagnosed with any of the following:

☐ Diabetes	☐ High blood pressure	☐ Anemia	☐ Tuberculosis
☐ Seizures	☐ Low blood pressure	☐ Arthritis	☐ Asthma
☐ Blood clots	☐ Substance addiction	☐ Fibromyalgia	☐ Cancer
☐ Stroke	☐ Peripheral neuropathy	☐ Depression	☐ HIV/AIDS
☐ Heart Attack	☐ Ulcer/GI bleeding	☐ Anxiety	☐ Hepatitis

Family medical history (parents, siblings, grandparents) _____

_____

Past medications (current medications will be listed separately on the risk assessment)

☐ Contraceptives	☐ Pain medication	☐ Anti-hypertensives
☐ Antidepressants	☐ Long-term antibiotics	☐ Cholesterol-lowering drugs
☐ Steroids	☐ Antacids	☐ Other _____

Valley Holistic HEALING | Health History

Please mark any symptoms you currently have or have had in the past year.

TEMPERATURE
- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Hot flashes
- ☐ Chills
- ☐ Fever
- ☐ Alternating chills and fever

PERSPIRATION/THIRST
- ☐ Sweat with little exertion
- ☐ Night sweats
- ☐ Can't sweat
- ☐ Thirsty and drink cold
- ☐ Thirsty and drink hot
- ☐ Thirsty but don't drink
- ☐ Not thirsty

ENERGY
- ☐ High energy/nervous
- ☐ Good energy
- ☐ Okay energy/slightly low
- ☐ Low energy/fatigue

HEAD
- ☐ Headaches
- ☐ Migraines
- ☐ Dizzy/lightheaded
- ☐ Fainting
- ☐ Foggy-headedness
- ☐ Seizures
- ☐ Tremors
- ☐ Sinus congestion
- ☐ Nasal discharge

SENSES
- ☐ Declining vision
- ☐ Eyes sensitive to light
- ☐ Red/itchy eyes
- ☐ Floating spots in vision
- ☐ Poor hearing
- ☐ Ear ringing
- ☐ Poor sense of smell
- ☐ Earaches
- ☐ Decreased night vision

MOUTH
- ☐ Frequent sore throats
- ☐ Poor teeth
- ☐ Mouth/canker sores
- ☐ Lip sores
- ☐ Dry/chapped lips
- ☐ Dry mouth and throat
- ☐ Lump in the throat
- ☐ Swollen/painful gums
- ☐ Taste in mouth, describe _____

SKIN, HAIR & NAILS
- ☐ Thin skin/nails
- ☐ Dry skin/nails
- ☐ Easily bruised
- ☐ Dark under eyes
- ☐ Lumps
- ☐ Acne
- ☐ Abscesses/infection
- ☐ Prematurely gray hair
- ☐ Hair loss
- ☐ Dry/brittle hair

LUNGS & HEART
- ☐ Wheezing
- ☐ Coughing
- ☐ Short of breath
- ☐ Tight sensation in chest
- ☐ Frequent colds, >2/year
- ☐ Seasonal allergies
- ☐ Slow heart rate
- ☐ Fast heart rate
- ☐ Irregular heart rhythm
- ☐ Palpitations/fluttering sensation
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

APPETITE & DIGESTION
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Excessive saliva
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting
- ☐ Gas
- ☐ Tired after eating
- ☐ Bad breath
- ☐ Bloating/distention
- ☐ Abdominal pain
- ☐ Stomach pain
- ☐ Belching/hiccups
- ☐ Gall stones
- ☐ Pain under ribs

CRAVINGS
- ☐ Sweet
- ☐ Salty
- ☐ Sour
- ☐ Bitter
- ☐ Hot/spicy
- ☐ Strong flavor/pungent
- ☐ Bland
- ☐ Crunchy
- ☐ Other _____

BOWEL MOVEMENTS
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Alternating constipation and diarrhea
- ☐ Cramps with BM
- ☐ Incomplete BM
- ☐ Burning with BM
- ☐ Hemorrhoids
- ☐ Bowel incontinence
- ☐ Blood or mucus in stool
- ☐ Foul odor

URINATION
- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Decreased bladder control
- ☐ Frequent urination
- ☐ Wake at night twice or more to urinate
- ☐ Frequent UTIs
- ☐ Kidney stones

SLEEP
- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Difficulty falling asleep
- ☐ Wake during the night
- ☐ Lots of vivid dreams
- ☐ Disturbing dreams
- ☐ Don't get enough sleep
- ☐ Wake unrefreshed

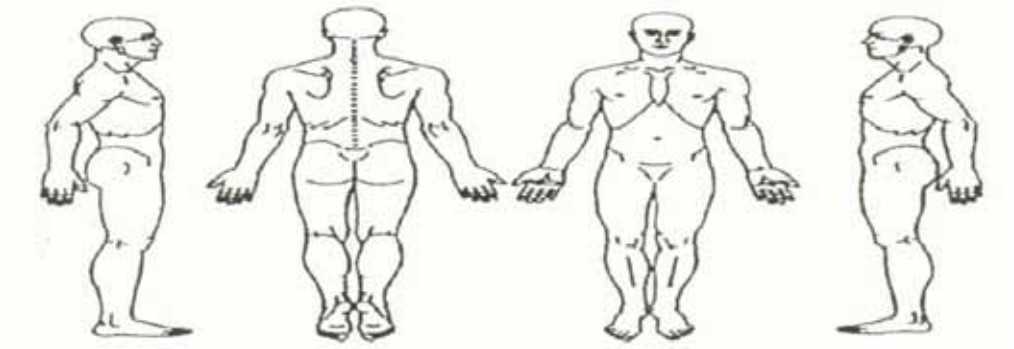
Number of hours of sleep each night _____

MENTAL & EMOTIONAL
- ☐ Forgetful/poor memory
- ☐ Poor concentration
- ☐ Irritable/angry
- ☐ Sad
- ☐ Tearful/weepy
- ☐ Restless
- ☐ Anxious/worried
- ☐ Can't stop thinking
- ☐ Fearful/easily startled
- ☐ Manic
- ☐ Depressed
- ☐ Frequent sighing or yawning

DIET & LIFESTYLE
- ☐ Poor diet
- ☐ Consume caffeine daily
- ☐ Smoke cigarettes
- ☐ Chew tobacco
- ☐ Drink alcohol
- ☐ Use drugs
- ☐ Too little activity/ exercise
- ☐ Exercise excessively
- ☐ Eating disorder
- ☐ Job stress/concerns
- ☐ Family stress/concerns
- ☐ Other stress/concerns

MUSCULOSKELETAL & EXTREMITIES

Mark any areas where you experience pain or numbness



- ☐ TMJ
- ☐ Scoliosis
- ☐ Joint swelling
- ☐ All over body pain
- ☐ Muscle tightness
- ☐ Cold back or knees
- ☐ Weak back or knees
- ☐ Body heaviness

Valley Holistic HEALING | Women's Health History

GENERAL GYNECOLOGY
- ☐ High sexual energy
- ☐ Low sexual energy
- ☐ Chronic vaginal discharge
- ☐ Regular yeast infections
- ☐ Vaginal dryness
- ☐ Breast lumps/nodules
- ☐ Mastitis
- ☐ Cysts
- ☐ Endometriosis
- ☐ Pelvic abnormalities/adhesions
- ☐ Fibroids
- ☐ PID
- ☐ STDs
- ☐ Abnormal pap smear
- ☐ Uterine or bladder prolapse
- ☐ Others _____

REPRODUCTIVE HISTORY
Are you currently using birth control? Y / N

Are you trying to conceive? Y / N

Are you currently lactating? Y / N

How many pregnancies have you had? ____

How many children do you have? ____

How many abortions have you had? ____

How many miscarriages have you had? ____

Have you had any:
- ☐ High-risk pregnancies
- ☐ Difficult labor/deliveries
- ☐ Postpartum concerns
- ☐ Lactation concerns

MENOPAUSE
- ☐ Peri-menopausal
- ☐ Post-menopause since _____

(Please answer menstruation questions to the best of your recollection)

MENSTRUATION
Age when menses began _____

Menstruation lasts _____ days
- ☐ Regular cycle: _____ days total
- ☐ Irregular: _____ to _____ days

Can you tell when you ovulate? Y / N

During your period, the flow is:
- ☐ Light/spotting on days _____
- ☐ Medium on days _____
- ☐ Heavy on days _____
- ☐ With clots on days _____
- ☐ Spotting between periods

What color is the blood?
- ☐ Light Red on days _____
- ☐ Bright Red on days _____
- ☐ Dark Red on days _____
- ☐ Purple on days _____
- ☐ Brown on days _____
- ☐ Black on days _____

PMS
- ☐ Acne
- ☐ Cramps/Backache
- ☐ Bowel changes
- ☐ Breast changes
- ☐ Food cravings
- ☐ Irritability/anger
- ☐ Nausea
- ☐ Sad/Weeping
- ☐ Others _____

POST-MENSTRUATION
- ☐ Dizziness
- ☐ Fatigue
- ☐ Insomnia
- ☐ Night sweats
- ☐ Others _____

Thank you for choosing Valley Holistic Healing!

Patient ID _____

Valley Holistic Healing

Policy on Cancellation of Appointments

In order for Valley Holistic Healing to serve you to the best of our ability, we need to manage our time and scheduling carefully.

- If you are unable to keep your scheduled appointment(s), we respectfully request that you cancel your scheduled appointment a minimum of 24 hours in advance. Please try to reschedule at the time of cancellation.
- Receiving your cancellation information in advance allows us to schedule and serve other clients. If this is not possible due to illness or an emergency please contact us as soon as possible.
- If you cancel with less than 24 hour notice or do not show for the appointment, you will be charged a $30.00 fee billed directly to you. This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay before your next visit.
- If you accumulate 3 no shows or cancellations with less than 24 hour notice, or have repetitive cancellations, we reserve the right to cancel our services with you.

Payment Policy including Co-Pays/Deductibles

You will be responsible to make payment in full for your services at the time of your session. If you have Insurance coverage and have a Co-Pay this amount is due at the time of your session.

If you have a Deductible to pay for your insurance coverage, you will be responsible to pay for the services provided to you until the amount of your deductible is paid in full. A statement from us will be mailed to you after receipt of your member liability has been determined with your insurance company. Payment will be expected within 30 days of the mailed notification (and prior to receipt of further service).

Checks or cash are accepted. If you are paying by check, please make the check payable to: Valley Holistic Healing.

I have read and understand the Valley Holistic Healing cancellation policy and the Payment, co-pay/deductible policy and agree to follow it as stated.

_____ _____

Client/Parent/Guardian Date

Valley Holistic HEALING, LLC

116 E Chestnut Street, Stillwater, MN 55082
651-253-5712

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist. I understand that acupuncturists practicing in the state of WI and MN are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Valley Holistic Healing LLC, as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*_____ *X*_____
Patient's Signature Date Explained by me and signed in my presence Date