



Lei Ann Resurreccion, MAOM, Lic.Ac.

## OFFICE POLICIES

The following policies and procedures are in place to insure that your care is as efficient and effective as possible.

**APPOINTMENTS:** We make every effort to remain on schedule. We believe that respect between patient and practitioner includes respect for each other's time. If you are late, your remaining time may not be sufficient for a full treatment, so treatment will be tailored to fit within the time available or you have the option to reschedule. Occasionally, there are situations that arise that cause us to run over. If we are late, it will not effect the time of your treatment. If you have time constraints, please let us know.

It is recommended that you wear loose fitting clothing to appointments for your comfort and to make acupuncture points accessible. You may bring a pair of shorts or loose undershirt to change into.

**The courtesy of a 24-hour notice of cancellation for any appointment is expected and appreciated. The patient is responsible for payment of a non-emergency cancellation made without a 24-hour notice.**

**CONFIDENTIALITY:** All information gathered within the context of treatment is held in strict confidence and will NOT be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

FEES:	Initial Visit (1 ½ hrs):	\$125
	Acupuncture Treatment (1 hr):	\$ 75
	Chinese Herbal Medicine Consult (½ hr):	\$ 45 (plus the cost of herbs)
	Acupuncture/Herbal Consult (1 hr):	\$ 85 (plus the cost of herbs)

**PAYMENT:** Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash, checks, MasterCard and Visa. Acupuncture is covered by worker's compensation, auto insurance and a number of private insurance policies. Should you have coverage, we can discuss the procedure for billing and payment.

I have read and agree to the policies outlined above.

Signature of Patient:  \_\_\_\_\_ Date: \_\_\_\_\_

FOUR FLOWERS ACUPUNCTURE & ORIENTAL MEDICINE  
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**INFORMED CONSENT**

I, \_\_\_\_\_, consent to the above practitioner to administer acupuncture treatment relevant to my Oriental medical diagnosis, including but not limited to:

Insertion of different sizes of acupuncture needles into various points of the body. All needles are pre-packaged, of high quality and are inserted once into the body and then properly disposed of.

Heat therapy using moxa (*Artemisia*), a dried herb, that is lit and burned on the needles or on the skin, or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of a burn ointment which will conduct the heat and prevent burns. On rare occasions, a blister may occur. The practitioner will explain the procedure as it is done and the patient is asked to let them know the status of the heat at all times.

Application of stainless steel pressballs onto various points in the ear. These are applied with adhesive tape and may be left in the ear for up to 7 days or as suggested by the practitioner.

Electrical stimulation of the needles using a battery operated machine to create a current through the needles may be used. This creates a constant vibration through the needles that would be adjusted according to patient comfort.

Bloodletting, when appropriate, is used to draw a few drops of blood from points on the body, or more commonly, on the fingertips or toes. A small needle is used to prick the skin and then cotton is applied to draw blood out until it stops.

Cupping is a technique used to resolve muscle tightness or help clear the lungs in respiratory conditions. A glass cup is applied to the skin and then a pump suctions the skin and muscle into the cup. The amount of suction is adjusted according to patient comfort. Depending on how tight the muscles are and the amount of restricted blood flow, the cups can leave a reddish or purplish mark on the skin that clears up in a few days, similar to a bruise.

Gua sha is a technique similar to cupping where a flat tool is used to scrape the skin to relieve muscle tension and congested blood flow. It leaves a similar bruise-like "rash" that lasts for a few days.

Depending on a patient's diagnosis, Chinese patent or individualized powder herbal formulas may be prescribed to treat his/her condition. Instructions on dosage and how to take the herbs will be given along with the prescription.

I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed the risks and was given the opportunity to ask questions pertaining to my treatment. I am also aware there are no guarantees made as to the results of treatment. I understand that any diagnosis given in the context of acupuncture treatment does not constitute a Western medical diagnosis and recommendations may be made to pursue further medical advice or interventions if necessary.

Signature of Patient: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION**

Your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your personal information will not be used for other purposes unless we have asked for and have been given your permission.

Your health information will be used:

1. To provide treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the practitioner and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories or other health care personnel providing your treatment.
2. To obtain payment: We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail.
3. Inspect and copy your health information: You have the right to read, review and copy your health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you to duplicate and assemble your copy.
4. Amend your health information: You have the right to ask us to update or modify your records if you believe they are incorrect or incomplete. We will accommodate you as long as our office maintains this information. Please make your request in writing and inform us of the reason for the change in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.
5. Documentation of your health information: You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or health care operations. We will be able to provide you a copy of your health information upon request, as long as it is not 7 years or older.
6. Request a paper copy of this notice: You have the right to obtain a copy of this privacy notice policy for your records.

I acknowledge that I have read and agree to the above:

Signature of Patient:  \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Do we have your permission to thank the person who referred you to our practice? Y / N

FOUR FLOWERS ACUPUNCTURE & ORIENTAL MEDICINE

1330 Beacon Street, Suite 223

Brookline, MA 02446

HEALTH HISTORY QUESTIONNAIRE

Please help us to provide you with a complete evaluation by filling out this form completely & carefully. We realize some questions seem irrelevant to your main problem, but they are significant in helping us to make an accurate diagnosis & formulate an appropriate treatment plan. All of your information will be held absolutely confidential. Thank you.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Street \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
(please circle which number you would prefer we contact you)

Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Email \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Referred by \_\_\_\_\_

Have you received acupuncture or Oriental medicine before? yes / no

What is your main complaint?

When did this problem first begin?

How often does this bother you?

Severity of the problem on a scale of 0-10 (0 = best; 10 = worst)

When problem is at its best: /10 When problem is at its worst: /10 Today: /10

If there is pain involved, what is the quality of the pain? (Circle all that apply)

Dull Achy Burning Sharp Stabbing Cold Numb Tingling Throbbing Other \_\_\_\_\_

What makes the problem feel better? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Movement Sitting Lying Massage/Pressure Stress

Other \_\_\_\_\_

What makes the problem feel worse? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Movement Sitting Lying Massage/Pressure Stress

Other \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc)?

Have you been given a diagnosis for this problem? yes / no If so, what?

What kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include dates):

Significant Illness (please circle all applicable)

Cancer          Diabetes          Hepatitis          High Blood Pressure          Heart Disease          Thyroid Disease  
Stroke          Seizures          STD's          Other:

PAST SURGICAL HISTORY (please include dates):

Significant trauma (auto accidents, falls, etc.)

ALLERGIES (drugs, chemicals, foods):

FAMILY MEDICAL HISTORY:

Cancer          Diabetes          High Blood Pressure          Heart Disease          Stroke          Seizures          Asthma  
Allergies          Other:

MEDICATIONS (please include vitamins, drugs, herbs, etc.):

<u>Name</u>	<u>Dosage</u>	<u>Reason for taking</u>

OCCUPATIONAL STRESS (physical, psychological, chemical, etc.):

EXERCISE: If you have a regular exercise program, please describe:

Are you or have you been on a restricted diet? If yes, please describe:

Average Daily Diet:

<u>Morning</u>	<u>Afternoon</u>	<u>Evening</u>	<u>Snacks</u>

DAILY FLUID INTAKE (in cups/glasses):    \_\_\_ Water    \_\_\_ Coffee    \_\_\_ Tea    \_\_\_ Alcohol    \_\_\_ Soda    \_\_\_ Other:

Do you smoke?          If yes, how much?

Please describe the use of any drugs for non-medical purposes.

Please check off if applicable to you in the past 3 months.

**HOT/COLD:**

Do you feel you tend to run \_\_\_ warm \_\_\_ cold \_\_\_ neutral?

Do your hands and feet run cold? \_\_\_ hands only \_\_\_ feet only \_\_\_ both

Do you have abnormal sweating or sweat easily? \_\_\_ night sweats \_\_\_ daytime sweating \_\_\_ mostly upper body  
\_\_\_ mostly lower body \_\_\_ whole body

Are you thirsty frequently? yes / no Do you prefer \_\_\_ cold or \_\_\_ warm beverages?

Do you tend to \_\_\_ drink large amounts or \_\_\_ just enough to moisten your throat?

**HEAD/FACE:**

\_\_\_ headaches \_\_\_ dizziness \_\_\_ eye strain \_\_\_ blurry vision \_\_\_ eye pain  
\_\_\_ floaters/spots in front of eyes \_\_\_ night blindness \_\_\_ ringing in ears \_\_\_ earache  
\_\_\_ poor hearing \_\_\_ nosebleeds \_\_\_ sinus problems \_\_\_ sore throat \_\_\_ jaw clicks  
\_\_\_ tongue/lip sores \_\_\_ toothache \_\_\_ teeth grinding \_\_\_ facial pain/twitching \_\_\_ loss of balance

Other:

**CARDIOVASCULAR:**

\_\_\_ high blood pressure \_\_\_ low blood pressure \_\_\_ chest pain \_\_\_ palpitations \_\_\_ fainting  
\_\_\_ hand swelling \_\_\_ feet swelling \_\_\_ phlebitis \_\_\_ blood clots \_\_\_ varicose veins

Other:

**RESPIRATORY:**

\_\_\_ shortness of breath \_\_\_ coughing up phlegm \_\_\_ coughing up blood \_\_\_ asthma \_\_\_ bronchitis  
\_\_\_ pneumonia \_\_\_ difficult inspiration \_\_\_ pain with deep breath

Other:

**GASTROINTESTINAL:**

\_\_\_ low appetite \_\_\_ nausea \_\_\_ vomiting \_\_\_ belching \_\_\_ gas  
\_\_\_ ulcer \_\_\_ acid reflux \_\_\_ regurgitation \_\_\_ bloating \_\_\_ indigestion  
\_\_\_ abdominal pain \_\_\_ bad breath \_\_\_ weight gain \_\_\_ weight loss  
\_\_\_ diarrhea \_\_\_ constipation \_\_\_ black/bloody stools \_\_\_ rectal pain \_\_\_ hemorrhoids

Do you have any cravings for the following? \_\_\_ sweet \_\_\_ salty \_\_\_ sour \_\_\_ bitter \_\_\_ spicy \_\_\_ fried \_\_\_ other

What is the consistency of your stool? \_\_\_ loose \_\_\_ hard \_\_\_ dry \_\_\_ formed \_\_\_ watery \_\_\_ undigested food

How often do you have a bowel movement? \_\_\_ times per day / week

**GENITOURINARY:**

\_\_\_ frequent urination    \_\_\_ scanty urination    \_\_\_ painful urination    \_\_\_ blood in urine    \_\_\_ incontinence  
\_\_\_ urgent urination    \_\_\_ kidney stones    \_\_\_ weak stream    \_\_\_ genital sores    \_\_\_ low sex drive  
\_\_\_ prostate problems    \_\_\_ erectile dysfunction

Do you wake up at night to urinate? yes / no      How many times per night?

Please describe your urine. \_\_\_ pale \_\_\_ clear yellow \_\_\_ dark yellow \_\_\_ cloudy \_\_\_ blood-tinged \_\_\_ other

**SLEEP/ENERGY:**

\_\_\_ difficulty falling asleep      \_\_\_ difficulty staying asleep      \_\_\_ nightmares      \_\_\_ vivid dreaming

How many hours of sleep do you get a night?      Are you refreshed upon awakening? yes / no

Do you have low energy levels? \_\_\_ in the morning    \_\_\_ in the afternoon    \_\_\_ at night    \_\_\_ after work  
\_\_\_ after meals    \_\_\_ after exercise    \_\_\_ in damp weather    \_\_\_ after a bowel movement

**MUSCULOSKELETAL/SKIN:**

\_\_\_ neck pain      \_\_\_ shoulder pain      \_\_\_ hand/wrist pain      \_\_\_ hip pain      \_\_\_ back pain  
\_\_\_ knee pain      \_\_\_ foot/ankle pain      \_\_\_ muscle weakness      \_\_\_ muscle pain      \_\_\_ joint pain  
\_\_\_ eczema      \_\_\_ psoriasis      \_\_\_ dandruff      \_\_\_ rashes      \_\_\_ hives  
\_\_\_ acne      \_\_\_ flat lesions      \_\_\_ raised red lesions      \_\_\_ excessive moles

Other:

**EMOTIONAL:**

\_\_\_ depression      \_\_\_ anxiety      \_\_\_ fear      \_\_\_ sadness      \_\_\_ anger  
\_\_\_ worry      \_\_\_ excessive joy      \_\_\_ overthinking      \_\_\_ grief      \_\_\_ irritable  
\_\_\_ poor memory      \_\_\_ tremors      \_\_\_ lack of coordination

Other:

Have you ever been treated for emotional problems? yes / no

Have you ever considered or attempted suicide? yes / no

What is your overall stress level on a scale of 1-10 (1=low, 10=high)? \_\_\_\_\_ / 10

Job: \_\_\_\_\_ / 10      Home: \_\_\_\_\_ / 10      Relationship: \_\_\_\_\_ / 10

How would you describe yourself emotionally?

How would others describe you?

**GYNECOLOGICAL:**

At what age did you get your first period?

Date of last menstrual period:

Are your periods regular? yes / no

How many days of bleeding?

How many days in your cycle?

Any possibility you are pregnant now? yes / no

Last Pap smear & results:

Previous Pregnancies:

How many live births?

Age of children?

How many natural births?

Caesarean?

Please indicate # of the following:	How long ago?
Miscarriages	
Abortions	
Premature births	
Still births	

Do you practice birth control? yes / no

Method?

For how long?

Side effects?

Any history of sexually-transmitted diseases or infections? yes / no

How long ago?

Do you get urinary tract, bladder or kidney infections? yes / no

How often?

Would you describe your sexual energy/libido as: \_\_\_ high \_\_\_ normal \_\_\_ low \_\_\_ none

Is it affected by medication? yes / no

Do you experience PMS symptoms (physical, emotional, mental)? yes / no Please describe.

How many days before your period do you experience PMS?

Do you experience abdominal pain before, during or after your period? yes / no

Specific location of pain (right, left, middle, low abdomen, back, etc):

Does your abdomen feel hot or cold to the touch or on the inside? yes / no

Any spotting/bleeding between periods? yes / no

Color of blood?

When do you experience vaginal discharge? \_\_\_ before period \_\_\_ midcycle \_\_\_ other

Consistency? \_\_\_ thick \_\_\_ thin \_\_\_ watery \_\_\_ with mucus \_\_\_ other

Color? \_\_\_ clear \_\_\_ white \_\_\_ yellow \_\_\_ other color

Amount? \_\_\_ large amount \_\_\_ normal \_\_\_ small amount

Particular odor? \_\_\_ fishy \_\_\_ sour \_\_\_ other odor

Please use the following choices to describe your menses flow every day during your period in the table below. If no choice is appropriate, please write in your own description. If your period goes beyond 7 days, please list those days in the additional space provided. Thank you for filling this form out carefully and completely.

Color:            black            brown            purple            dark red            bright red            pink    pale

Amount:        heavy (6+ tampons/pads a day)    medium (4-6)    light (<2)            spotting

Clots:            many            few            none

Clot size:        dime-size            nickel-size            quarter-size            larger

Consistency:    with mucus/tissue            thick            thin            watery            dilute

	Color	Amount	Clots	Clot size	Consistency
Day 1					
Day 2					
Day 3					
Day 4					
Day 5					
Day 6					
Day 7					

**COMMENTS:** Please feel free to provide any other information you would like to discuss.