STONEBURNER ACUPUNCTURE, LLC
Erin K. Stoneburner, MAOM, LAc
1135 SE Salmon St., Suite 211 | 503.784.1660 | stoneburneracupuncture@gmail.com

INTAKE FORM

Date: _____

Name: _____
(First) (Middle) (Last)

DOB: _____ Age: _____ Gender Preference: _____

Address: _____ City/State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

May messages be left on one or both of these numbers? Y / N

E-Mail: _____ Social Security #_____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Insurance Provider: _____

Policy Number: _____ ID Number: _____

Emergency Contact: (name, telephone, relation): _____

_____

How did you hear about us? _____

Please identify the health concerns (past or present) that have brought you into the clinic:

Condition	Treatments Received
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

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Please list any **foods, medications, or drugs** you are hypersensitive or allergic to

(including reactions): _____

_____

Please list any **medications, vitamins or supplements** you are currently taking (including dosages):

_____

Do you have any reason to believe you may be **pregnant**? Y / N

If yes, how far along are you? _____

Do you have any **infectious diseases**? Y / N

If yes, please identify: _____

Blood Pressure: What was your most recent reading? _____ /_____

When was this taken? _____

Height: _____ **Weight** (Current): _____

Past Maximum: _____ When? _____

Hospitalizations and Surgeries:

Reason _____ When _____

Reason _____ When _____

Reason _____ When _____

Reason _____ When _____

FAMILY HISTORY	Father	Mother	Brothers	Sisters	Grandparents
Cancer (Please note type)					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Mental Illness					
Asthma					

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LIFESTYLE

a. Do you typically eat three meals per day? Y / N If no, how many? _____

b. Do you feel you have a healthy diet? Y / N

c. Do you have particular food cravings? _____

d. Exercise routine: _____

e. On average, how many hours per night do you sleep? _____

Do you wake rested? Y / N

g. Do you smoke? Y / N How much? _____

h. What is your caffeine intake? _____

i. How much alcohol do you consume? _____

FEMALE ONLY

a. Age of First Menses: _____

b. Number of Days of Flow: _____

c. Length of Cycle: _____

d. Date of last menstruation: _____

f. Menstrual cramping? Y / N

g. PMS? Y / N

k. Number of Pregnancies: _____

l. Number of Live Births: _____

m. Number of Miscarriages: _____

n. Number of Abortions: _____

o. Birth Control Type: _____

s. Onset of Menopause: _____

Any other gynecological information your practitioner should be aware of? _____

MALE ONLY

a. Prostate concerns? Y / N

PSA level, if applicable: _____

b. Painful urination? Y / N

c. Decreased stream? Y / N

d. Discolored urine? Y / N

e. Impotence? Y / N

f. Testicular Pain/Swelling? Y / N

Any other male concerns your practitioner should be aware of? _____

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For the conditions listed below, please **CIRCLE** any that you have now and **UNDERLINE** any you have experienced in the past:

EMOTIONAL

Mood Swings
Anxiety
Depression
Stress

ENERGY & IMMUNITY

Fatigue/Low Energy
Chronic Fatigue Syn.
Insomnia
Frequent colds and flu
Slow Wound Healing

MUSCULOSKELETAL

Neck/Shoulder Pain
Muscle Tension
Muscle Spasms
Back Pain
Headaches
Fibromyalgia
Joint Pain
Stiffness
Restless Legs
Leg Cramps
Sprains/Strains
Tendonitis
Arthritis

EYE, EAR, NOSE AND THROAT

Impaired Vision
Poor Night Vision
Floaters
Eye Pain/Strain
Glaucom
Glasses/Contacts
Excessive Tearing
Redness/Dryness
Ringing In The Ears
Ear Aches
Sinus Problems
Allergies
Frequent Sore Throats
Teeth Grinding
TMJ

CARDIOVASCULAR

Heart Disease
Chest Pain
Palpitations/Fluttering
High Blood Pressure
Stroke
High Cholesterol
Varicose Veins
DVT
Cold Hands and Feet
Anemia

GASTROINTESTINAL

Ulcers
Low Appetite
Excessive Hunger
Nausea/Vomiting
Abdominal Pain
Flatulence
Bloating
Acid Reflux
Belching
Chronic Constipation
Chronic Diarrhea
IBS
Hemorrhoids
Food Sensitivities

GENITAL/URINARY TRACT

Painful Urination
Frequent/Urgent Urination
Frequent UTI
Burning/Pain with Urination
Blood in Urine
Kidney Disease
Kidney Stones
Wake At Night to Urinate
Irregular Menses
Heavy Bleeding
Complications with Pregnancy
Infertility

NEUROLOGICAL

Vertigo
Dizziness
Numbness/Tingling
Loss of Balance
Seizures
Trigeminal Neuralgia
Stroke
Shingles
MS

ENDOCRINE

Hypothyroid
Hyperthyroid
Diabetes
Night Sweats
Low Libido

RESPIRATORY

Asthma
Shortness of Breath
Wheezing
Emphysema
Bronchitis

ADDICTIONS

Alcohol
Cigarettes
Narcotics

OTHER

_____

_____

_____

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INFORMED CONSENT FOR ACUPUNCTURE & ORIENTAL MEDICINE

I, _____ , voluntarily and knowingly, give my consent and authorization to Erin K. Stoneburner, MAOM, LAc to treat me with acupuncture and other Oriental medicine therapies. I will be open to discussing my current and past medical conditions and treatments with my acupuncturist to help her create a complete picture of my state of health. I have the right to discontinue or refuse treatments at any time. I understand that all information I disclose will be kept confidential, in accordance with current HIPPA regulations.

Acupuncturists are not primary care providers in the state of Oregon. Erin recommends that patients have and maintain a regular primary care physician (PCP) during their course of treatment. I understand that Erin may request medical records from my PCP or other Western physician.

The following Oriental medical modalities may be used in your treatment exclusively or in combination with one another: Acupuncture is performed by inserting needles into the skin and flesh at various points on the surface of the body. All acupuncture needles are sterile, single-use needles. The needles are inserted into a specific set of acupuncture points that your practitioner has selected for your personalized treatment. If at any time you feel discomfort or pain, please tell your practitioner so that she may adjust the treatment or needles. There may be occasional adverse effects such as: local bruising, minor bleeding, fainting, pain or discomfort, or the possible aggravation of symptoms existing prior to acupuncture treatment and, very rarely, a lung puncture (pneumothorax).

Moxibustion (direct or indirect) is a form of heat therapy. The mugwort plant is processed into different forms, and these products are smoldered on or over the body. This therapy does create small amounts of smoke; if you are very sensitive to smoke please let your practitioner know. It may be used along with acupuncture or by itself in a treatment. There is a slight risk of burning or scarring. Cupping is an old Chinese technique of using glass or plastic cups that are suctioned to the body. The suction is created when a flame is placed into the upside-down cup and then quickly removed as the cup is placed onto the body. Cupping can be used for many symptoms that range from coughing to tight muscles. You may experience a deep red to purple skin discoloration that may turn into bruising and can last up to 1 week. Please inform anyone that might see these marks that they are the result of a medical treatment.

Gua Sha has similar effects as cupping but is administered by a scraping technique with a ceramic soupspoon or carved piece of jade or buffalo horn. You may get skin discoloration with this technique as well.

Bleeding is a procedure that releases heat and toxins from the body. Using a lancet, a small area on the body is pricked to remove a few drops of blood.

Electro-Acupuncture may be used along with standard acupuncture. Cords from a battery powered estim machine are connected to acupuncture needles, and a small electric pulsation

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is administered to the needles. Certain adverse reactions include: slight electrical shock, pain or discomfort, and/or the possible aggravation of pre-existing conditions.

Body work may include Zen Shiatsu, Tuina, So Tai, or Acupressure. Certain adverse reactions include: muscle soreness and the possible aggravation of pre-existing conditions.

Aromatherapy incorporates herbal essential oils to compliment and enhance your treatment. There may be adverse effects such as: sensitivity to smells, redness, skin irritation, or a stinging sensation.

Chinese Herbs may be administered internally as nutritional nourishment in bulk, granule, powdered, tincture, or tea-pill forms, and/or topically as liniments or salves. Herbs are recommended to help increase your treatment potential. Possible adverse effects include: changes in bowel movements, abdominal pain or discomfort, and the aggravation of pre-existing symptoms.

Contraindications & side effects in acupuncture and oriental medicine are rare and usually mild. If you do experience any adverse side effects please let your practitioner know immediately. There may be a chance you will feel an aggravation of symptoms directly after treatment but this usually dissipates within a couple of days. **Please let your practitioner know if you currently have any of the following conditions: are pregnant or are trying to get pregnant; are prone to seizures; have a heart condition; have a pace maker or valve replacement; or have problems with blood clotting and are on a blood thinning medication.**

Financial Policy: I understand that payment is due at the time of service and I will comply with this policy. Upon request, my acupuncturist will give me an insurance super-bill after each treatment.

Insurance claims: Stoneburner Acupuncture bills insurance policies as a courtesy. Please understand that for one reason or another, insurance companies will not always reimburse the full cost of treatments. In these situations, the patient will be responsible for the balance of unpaid claims.

Cancellation: In the event of an emergency, I will give as much notice as possible if I need to

Patient Signature: _____

Printed Name: _____

Date: _____

Parent/ Guardian: _____

Printed Name: _____

Date: _____

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APPOINTMENT POLICY

Stoneburner Acupuncture will work with you to schedule appointment times that are convenient for you. **Please respect our cancellation policy and provide 24 hours of notice for any changes to your scheduled appointment time. An appointment cancelled or changed with less than 24 hours of the scheduled time will be considered a broken appointments or a no-show, and will be recorded as such.** We do not overbook patients in anticipation of no shows or last minute cancellations therefore it is important that you keep scheduled appointments. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes if possible. However, when appointments are scheduled our acupuncturist time is reserved for you and is unavailable to other patients who need to schedule an appointment. Broken appointments add to the cost of providing care for all our patients. We strive to see patients on time for scheduled appointments; however there are times when our schedule is delayed in order to accommodate unforeseen circumstances.

We attempt to remind patients via text of upcoming appointments, but please do not depend on this courtesy. If we are unable to reach you, your email reminder will serve as confirmation of your appointment and implies your obligation to be present. Your acceptance of a scheduled appointment serves as a contract for services with S toneburner Acupuncture.

BROKEN APPOINTMENTS

Notation will be placed in the patient's record to indicate that an appointment has been broken. The clinic will attempt to contact patient to reschedule; however, it is not Stoneburner Acupuncture's responsibility if patient demographics (phone number or address) are not updated.

Patients with three (3) or more broken appointments will be notified by mail that all future acupuncture visits with Stoneburner Acupuncture will remain accessible. However future appointments will be scheduled on a space available basis with the exceptions of emergency needs. Further broken appointments may result in termination of care from the practice.

LATE APPOINTMENTS

Our office policy is that fifteen minutes late without phone the office is considered a "Broken Appointment." However, considering that acupuncture appointments are scheduled for a full hour, we may be able to give you a modified treatment if time is still available and your appointment has not been filled.

Thank you in advance for your cooperation.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE CLINIC'S APPOINTMENT POLICY.

Patient Signature: _____

Date: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator together with other expenses of the arbitration incurred or approved by the neutral arbitrator not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE