

GREAT WAY WELLNESS CENTER

278 ELM ST., STE 227  
SOMERVILLE, MA 02144  
617-852-0690

My goal with each patient is to form a partnership in health, working together to create the best possible health. Please feel free to share any questions or concerns you have about your health or the treatments.

Please wear loose, comfortable clothing to your treatments. I might ask you to bring shorts or tank tops, depending on what area I will treat.

It is important that you eat regular meals on the day of your treatment. However, you should not overeat right before a treatment, nor should you consume alcohol or other intoxicants as these will affect the efficacy of the treatment.

When possible, please do not plan any strenuous or stressful activities for at least 2 hours after a treatment.

Below is a list of my policies and procedures regarding scheduling and keeping appointments, and my fee schedule. Please review and sign at the bottom, indicating that you understand my policies.

I, \_\_\_\_\_ understand that:  
Name

- Appointments must be canceled 24 hours in advance.
- Failure to show up for a scheduled appointment will result in a bill for 1/2 of the cost of the scheduled treatment.
- Arriving late will result in a shorter appointment, so it is in my best interest to arrive on time for every appointment.

I also agree to the following fees for services provided:

\$90 for the initial 1 1/2 hour visit, which includes an extensive intake and acupuncture treatment

\$70 for a 1-hour acupuncture treatment (when requested, herbal consult included\*)

\$70 for an initial 1-hour herbal consult\*

\$45 for 1/2 hour follow-up herbal consult\*

\* The cost for the herbs prescribed is separate from the consult, and varies depending on the prescribed remedy.

All fees are due at the time of service.

I have read and understood the scheduling policies, and agree to pay the fees, as listed, at the time of service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Health History Questionnaire

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

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This document is part of your confidential medical record. If anything is unclear, please ask. Thoughtful consideration of your answers will help me better address your unique health makeup.

Name (First & Last)		Home Phone		Work or Cell Phone	
Street Address			City		State/Zip
Date of Birth	Age	Height	Weight	Marital Status	
Occupation		Emergency Contact with phone number			
Family Physician			Physician Phone number		
How did you hear about us?			E-mail address (for clinic use only):		

Have you been treated by acupuncture or Chinese herbal medicine before?	Yes	No
Main problem(s) you would like help with:		
How long ago did this problem begin? Please be specific:		
Have you been given a diagnosis for this problem? If so, what?		
How much does this problem interfere with daily activities like work, sleep, recreation, etc.?		
What kinds of treatment have you tried?		

<b>Past medical history</b> <i>Circle all that are applicable and please include dates:</i>					
Cancer	Diabetes	Hepatitis	High Blood Pressure	Heart Disease	Rheumatic Fever
Thyroid Disease	Seizures	Venereal Disease	H.I.V.		
Other (Please list)					
Surgeries, hospitalizations, significant trauma (auto accidents, falls, etc.)? Please include dates.					
Allergies (drugs, chemicals, foods)					

<b>Family Medical History</b>					
Diabetes	Cancer	High Blood Pressure	Heart Disease	Stroke	Seizures
Asthma	Allergies	Other:			

Medicines, herbs and vitamins taken in past 2 months (please include dose if applicable):	
Do you have a regular exercise program? If yes, please describe:	
Have you ever been on a restricted diet? If yes, what kind? Why?	
Do you smoke? If yes, how much and how long?	
How many caffeinated beverages do you drink per week?	
How much water do you drink per day?	How much alcohol do you drink?

Please circle if you have had any of the following in the past 3 months:

<b>General:</b>		
Fevers	Poor sleeping	Fatigue
Sweat easily	Chills	Night Sweats
Bleed or bruise easily	Strong thirst (hot or cold drinks?)	Cravings
Peculiar tastes or smells	Weight loss	Change in appetite
Sudden energy drop	Weight gain	

<b>Skin and Hair:</b>		
Rashes	Ulcerations	Hives
Itching	Eczema	Pimples
Dandruff	Loss of hair	Recent moles
Change in hair or skin texture	Any other hair or skin problems?	

<b>Head, Neck, Eyes, Ears, Nose, and Throat:</b>		
Dizziness	Concussions	Migraine
Glasses/Contact lenses	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Earaches
ringing in ears	Poor hearing	Spots in front of eyes/floaters
Sinus problems	Nose bleeds	Recurrent sore throats
Grinding teeth	Facial pain	Sores on lips or tongue
Teeth problems	Jaw clicks	Headaches (where? when?)
Any other head or neck problems?		

**Cardiovascular:**

High blood pressure

Low blood pressure

Chest pain

Irregular heartbeat

Difficulty in breathing

Fainting

Cold hands or feet

Swelling of hands

Swelling of feet

Blood clots

Pacemaker (date implanted)

Any other Heart conditions?

**Respiratory:**

Coughing

Coughing blood

Asthma

Bronchitis

Pneumonia

Pain with breathing

Difficulty inhaling/exhaling

Production of phlegm  
What color?

Any other lung problems?

**Gastrointestinal:**

Nausea

Vomiting

Diarrhea

Constipation

Gas

Belching

Black stools

Blood in stools

Indigestion

Bad breath

Rectal pain

Hemorrhoids

Abdominal pain or cramps

Chronic laxative use

Bloating

Any other problems with your stomach or intestines?

**Genito-Urinary:**

Pain when urinating

Frequent urination

Blood in urine

Urgency to urinate

Unable to hold urine

Kidney stones

Decrease in urine flow

Impotence

Sores on genitals

Strong odor to urine

Cloudy urine

Do you wake up to urinate?  
How often?

Any particular color to your urine?

Any other problems with your genital or urinary system?

**OB/GYN**

# of Pregnancies_____	# of Live births_____	# of Miscarriages_____
# of Abortions_____	# of Premature births_____	Age of first menses_____
Date of Last PAP smear_____	Duration of menses_____	Length of cycle_____
Irregular periods	Painful periods	Heavy or Light flow?
Period between menses	Vaginal discharge	Clots in menses
Breast lumps	Age of menopause onset_____	Vaginal sores
Changes in body/psyche prior to menstruation		
Are you currently pregnant?	Yes      No	Are you trying to get pregnant?      Yes      No
Do you practice birth control? What type and for how long?		

**Musculoskeletal:**

Neck pain	Muscle pain	Knee pain
Back pain: Upper?      Lower?	Muscle weakness	Foot/ankle pains
Hand/wrist pain	Shoulder pain	Hip pain
Any other joint or bone problems?		

**Neuropsychological:**

Seizures	Dizziness	Loss of balance
Areas of numbness	Lack of coordination	Poor memory
Concussion	Depression	Anxiety
Bad temper	Easily susceptible to stress	
Have you ever been treated for emotional problems? Please list:		
Have you ever considered or attempted suicide?		
Any other neurological or psychological problems?		

Please describe any other issues you would like to discuss:

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I, \_\_\_\_\_ understand that:

Acupuncture occasionally produces small bruises, which are generally not painful and will clear up in the time it normally takes for your bruises to go away.

In addition to needles, an herb called moxa, or mugwort (*Artemesia Vulgaris*) might be used. Moxa is used in several forms: a ball placed on the handle of the needle, a cone or thread placed directly on the skin or on a heat transfer medium like ginger or salt, or as a moxa pole waived over particular areas. Usually, the patient will experience a pleasant warming experience, but this procedure carries a small risk of a burn.

Gua Sha, a special massage technique involving a Chinese soup spoon or flat Gua Sha tool. Gua Sha leaves the skin with a red, bruised appearance. This discoloration is usually not painful and disappears in 1 to 5 days.

Suction cups are often used to relieve painful muscle tightness. They leave discoloration similar to Gua Sha.

Electrical stimulation is occasionally used to enhance the effects of the treatment. A small nine-volt battery powered machine produces a gentle current at certain inserted needles, producing a slight vibration or tapping sensation. The level of intensity is always adjusted to the patient's comfort level.

You have the right to decline any type of treatment, particularly if you have had an adverse reaction to it in the past.

You might feel lightheaded after a treatment. Please take the time to rest in our waiting area before venturing out to your car.

I also acknowledge that I have received Great Way Wellness Center's Notice of Information Practices.

I have read and understood this document, and consent to receive acupuncture treatments:

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

Signature \_\_\_\_\_

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

## **Notice of Information Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **Understanding your acupuncture health record information**

Each time you visit this clinic, a record is made of your visit. Typically this record contains your health history, current symptoms, examination results, Oriental medicine diagnosis, and treatment plans. This information serves as:

- a basis for planning your care and treatment
- a means of communicating among different care providers (for example, acupuncturists, chiropractors, massage therapists, family physicians, etc.)
- a legal document describing the care you received, written in a format appropriate to acupuncture and Chinese herbal medicine

### **Your rights under the Federal Privacy Standard**

Although your health record is the physical property of Cathy Thomason, Lic.Ac., you have certain rights with regard to the information contained therein. You have the following rights:

- To request restrictions on the use and disclosure of your health information for treatment, payment, and health care operations. *Health care operations* consist of activities necessary to carry out the operations of this clinic such as quality assurance and peer review. This right does not include those required by law (for example, mandatory reporting of communicable diseases like tuberculosis).
- To ask us to communicate with you by alternative means and, if the method is reasonable, we must grant the request.
- To receive and keep a copy of this notice of information practices. If you do request a copy, the law requires us to ask you to acknowledge receipt of your copy.
- To inspect and copy your health information upon request. We reserve the right to charge a reasonable, cost-based fee for making copies.
- To request a correction of your health information, unless we did not create the record or if the record is accurate and complete.
- To obtain an accounting of nonroutine uses or disclosures.
- To revoke authorization to use or disclose your health information at any time.

**With the regulatory consent granted by the Health and Human Services Department we may use or disclose your health information, payment, and operations. For example:**

- This clinic can use your personal health information to diagnose, plan, and implement the best course of treatment for you.
- This clinic may also use your health information to receive payment from a third-party payer, if applicable and appropriate (for example, Workers' Compensation).

**Examples of uses and disclosures of your personal health information other than for treatment, payment, and operation:**

- The acupuncturist may discuss or present your health information in a peer-discussion group for review and treatment suggestions. All personal information will be withheld or obscured; only particulars related to your health and case will be discussed.
- This clinic may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- If this clinic uses your personal health information for other purposes, you will be informed and asked your permission in writing. You may revoke your consent for authorization at any time.

**This clinic's responsibility under the Federal Privacy Standard**

In addition to providing you your rights, the Federal Privacy Standard requires this clinic to perform the following:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you with the notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train any personnel and students concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who break privacy and confidentiality policies.
- Lessen the harm of any breach of privacy or confidentiality.

**How to get more information or to report a problem:**

If you have any questions or problems, or would like any additional information, you may contact Cathy Thomason (who also serves as the designated security and privacy officer) directly at 617-852-0690. This clinic guarantees that your care will not be affected and no retaliatory action will be taken against you.