

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone # (Home): \_\_\_\_\_ Work #: \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security #: \_\_\_\_\_ Primary Health Plan: \_\_\_\_\_ Patient/Member ID #: \_\_\_\_\_

2<sup>nd</sup> Health Plan: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ PCP phone #: \_\_\_\_\_  
(Required) (Required)

Please describe your current health problem(s): \_\_\_\_\_

How and When it began: \_\_\_\_\_

If you are undergoing acupuncture treatments, describe your progress: \_\_\_\_\_

Worsened     No change     25% improved     50% improved     75% improved

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: \_\_\_\_\_  
 No Pain 0    1    2    3    4    5    6    7    8    9    10    Unbearable Pain

How often are your symptoms present?  Constantly     Frequently     Intermittently     Occasionally

Describe your current health condition:  Good     Fair     Poor     Chronically ill

Can you perform your daily activities?  Yes, all activities     Some activities     Not at all

Are you currently under the care of a physician?  No     Yes, please explain \_\_\_\_\_

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) \_\_\_\_\_

- Past Present**
- Alcohol/tobacco/drug dependence
  - Abnormal menstruation
  - Allergies
  - Angina
  - Arthritis/ rheumatoid arthritis
  - Artificial joints
  - Asthma
  - Blood disorder
  - Breast lumps
  - Cancer/tumor
  - Convulsions/seizures
  - Diabetes
  - Diarrhea/constipation
  - Excessive thirst
  - Fainting or dizziness
  - Fatigue

- Past Present**
- Frequent urination
  - Headache
  - Heart attack
  - Heartburn or indigestion
  - High blood pressure
  - Hospitalizations/surgical procedures \_\_\_\_\_
  - Kidney disease
  - Liver problems
  - Pacemaker
  - Painful menstruation
  - Palpitation/arrhythmia
  - Peptic ulcer
  - PMS
  - Pregnancy, months \_\_\_\_\_
  - Prostate problems
  - Rapid weight gain/loss

- Past Present**
- Sinusitis
  - Stroke
  - Thyroid Disease
  - Medications \_\_\_\_\_
  - Other: \_\_\_\_\_

If a family member has had any of the following, please mark the appropriate box and explain:

- Arthritis     Lupus
- Cancer     Mental disorders
- Heart disease
- Hypertension
- Other: \_\_\_\_\_

**Comments:**

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my Doctor of Acupuncture Provider \_\_\_\_\_ and \_\_\_\_\_ Clinical Services Manager may need to contact my PCP if my condition needs to be co-managed. Therefore, I give my authorization to Dr. Ericson contact my medical doctor if necessary.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

EMAIL:

## Report of Findings

**Personal Report of Findings for** \_\_\_\_\_ **Date** \_\_\_\_\_

**Your health concerns** 1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

**What we found** \_\_\_\_\_

**Patient:** check any of the boxes below that apply to you in the last 6 months

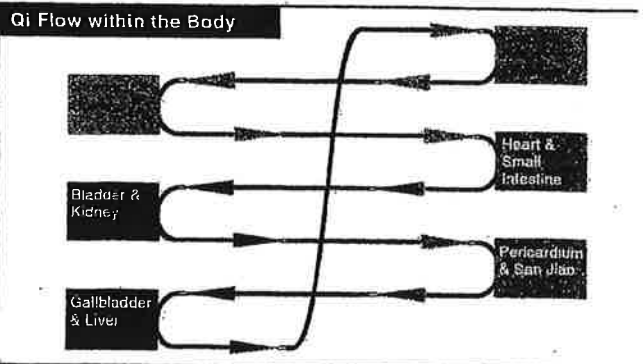
- Lung & Large Intestine Meridian/Organ Network**
- |                                                |                                           |                                            |
|------------------------------------------------|-------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Frontal/sinus HA | <input type="checkbox"/> Smell problems    |
| <input type="checkbox"/> Arm/wrist/elbow pain  | <input type="checkbox"/> Grief/sadness    | <input type="checkbox"/> Stiff joints/neck |
| <input type="checkbox"/> Asthma/bronchitis     | <input type="checkbox"/> Lethargy/fatigue | <input type="checkbox"/> Sweating prob.    |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Loose stools     | <input type="checkbox"/> Weak voice        |
| <input type="checkbox"/> Cough/sneeze/phlegm   | <input type="checkbox"/> Mucus            | <input type="checkbox"/> Wheezing/SOB      |
| <input type="checkbox"/> Eczema/psoriasis/rash | <input type="checkbox"/> Nasal problems   | Other _____                                |
| <input type="checkbox"/> Flatulence            | <input type="checkbox"/> Shoulder pain    | _____                                      |
| <input type="checkbox"/> Frequent colds        | <input type="checkbox"/> Sinusitis        | _____                                      |

- Kidney & Bladder Meridian/Organ Network**
- |                                                 |                                                |                                             |
|-------------------------------------------------|------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Adrenal weakness       | <input type="checkbox"/> Hot flashes           | <input type="checkbox"/> Sciatica/back pain |
| <input type="checkbox"/> Back/hip/knee pain     | <input type="checkbox"/> Impotence/libido      | <input type="checkbox"/> Sore throat in AM  |
| <input type="checkbox"/> Bladder infec./control | <input type="checkbox"/> Infertility/sterility | <input type="checkbox"/> Tight hamstrings   |
| <input type="checkbox"/> Brittle bones          | <input type="checkbox"/> Lethargy/fatigue      | <input type="checkbox"/> Tinnitus           |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Loss/thinning hair    | <input type="checkbox"/> Urine problems     |
| <input type="checkbox"/> Dark/Puffy around eyes | <input type="checkbox"/> Night sweats          | Other _____                                 |
| <input type="checkbox"/> Depression/fear        | <input type="checkbox"/> Poor memory           | _____                                       |
| <input type="checkbox"/> Edema/water retention  | <input type="checkbox"/> Premature gray        | _____                                       |

- Liver & Gallbladder Meridian/Organ Network**
- |                                                    |                                              |                                              |
|----------------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Anger/irritability        | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Nausea/vomiting     |
| <input type="checkbox"/> Breast tenderness         | <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> PMS                 |
| <input type="checkbox"/> Brittle/coarse nails/hair | <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Stick neck/shoulder |
| <input type="checkbox"/> Bruising                  | <input type="checkbox"/> Irritable bowel     | <input type="checkbox"/> Tension/cramps      |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> IT Band tightness   | <input type="checkbox"/> Tinnitus            |
| <input type="checkbox"/> Distention/bloating       | <input type="checkbox"/> Lack of flexibility | Others _____                                 |
| <input type="checkbox"/> Eye/vision problems       | <input type="checkbox"/> Menstrual irreg.    | _____                                        |
| <input type="checkbox"/> Flatulence                | <input type="checkbox"/> Migraines           | _____                                        |

- Heart & Small Intestine Meridian/Organ Network**
- |                                              |                                             |                                            |
|----------------------------------------------|---------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Abdominal pain      | <input type="checkbox"/> Hot flashes        | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Hot/painful joints | <input type="checkbox"/> Tongue/speech     |
| <input type="checkbox"/> Anxiety/dread       | <input type="checkbox"/> Lack of joy/humor  | <input type="checkbox"/> Upper back pain   |
| <input type="checkbox"/> Digestive troubles  | <input type="checkbox"/> Mouth/tongue sores | <input type="checkbox"/> Urine problems    |
| <input type="checkbox"/> Dream dist sleep    | <input type="checkbox"/> Neck pain          | <input type="checkbox"/> Wrist pain        |
| <input type="checkbox"/> Elbow/shoulder pain | <input type="checkbox"/> Palpitations       | Other _____                                |
| <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Poor circulation   | _____                                      |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Restlessness       | _____                                      |

- Spleen & Stomach Meridian/Organ Network**
- |                                                  |                                              |                                          |
|--------------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Abdominal pain          | <input type="checkbox"/> Distention/bloating | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Aching/heavy limbs      | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Heaviness at heart  | <input type="checkbox"/> Poor memory     |
| <input type="checkbox"/> Appetite/digestive prob | <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Prolapse        |
| <input type="checkbox"/> Belching                | <input type="checkbox"/> Hiccups             | <input type="checkbox"/> Worry/overthing |
| <input type="checkbox"/> Bruise indigestion      | <input type="checkbox"/> Irritable bowel     | Other _____                              |
| <input type="checkbox"/> Colic/indigestion       | <input type="checkbox"/> Lethargy/fatigue    | _____                                    |
| <input type="checkbox"/> Difficulty focused      | <input type="checkbox"/> Loose stools        | _____                                    |



# TCM DIAGNOSIS: Traditional Chinese Medicine

## FERTILITY LAB WORK TO CHECK:

**WOMEN:** FSH, E2, LH, Progesterone, HCG, Prolactin, GnRH, Basal body temperature chart, Thyroid: TSH, free T3, free T4, antithyroblobulin, antiTPO, and autoimmune tests.

**MEN:** Sperm: count, motility, morphology, sperm DNA fragmentation, and viscosity.

**OTHER:** In depth autoimmune tests (see Reproductive Endocrinologist), i.e. antinuclear antibody (ANA), anticardiolipin antibody (ACA), antiphospholipid antibody (APA), or lupus anticoagulant.

## WESTERN DIAGNOSIS (circle what applies to you)

1. **LUTEAL PHASE DEFECT** - need to strengthen the kidneys and spleen in TCM
2. **OVARIAN AGE** - if over 35. Deficient Kidney Jing – TCM
3. **"UNEXPECTED INFERTILITY"** – usually due to liver qi stagnation (70%) and deficient kidney qi (30%) in TCM. Kidney Yin & Yang Def., Liver Qi Stagnation, or Blood Deficiency according to TCM.
4. **IMMUNOLOGIC REACTION AND RECURRENT MISCARRIAGE** – spleen, liver, and kidney deficiencies in TCM and/or damp: in blood flow (stagnation or overabundance); in the levels of Yin or Yang; or in the level of Qi energy.
5. **ENDOMETRIOSIS AND FIBROIDS** – general kidney deficiency in conjunction with Blood stagnation in TCM.
6. **POLYCYSTIC OVARIAN SYNDROME** – dampness and phlegm due to excess or deficiencies in body; yang def. with excess phlegm – in TCM.
7. **MECHANICAL INFERTILITY**
  - A) Pelvic Inflammatory Disease (PID) usually from chlamydia can cause fallopian tube obstruction (damp cold or damp heat in TCM)
  - B) Fallopian Tube Obstruction can result in ectopic pregnancies. Need a laparoscopy or some type of surgery (stagnant blood in TCM)
  - C) Pelvic Adhesions – adhesions and/or scar tissue inside or outside the organs of the reproductive tract. Can be due to trauma or endometriosis, yeast or bladder infection, PID or surgeries (D&C, abortion, cesarean section or appendectomy). Due to blood stagnation in TCM.
8. **GENETIC ABNORMALITIES** – two uteruses, etc.
9. **HYPOTHYROIDISM** – deficient kidney, spleen, and heart yang in TCM
10. **MALE FACTOR** – deficient sperm count (less than 20 million per milliliter), insufficient sperm motility (over 50% should be motile), poor sperm morphology (less than 30% normal form), anti-sperm antibodies, mechanical obstruction. TCM causes: 1) Deficiency of the kidney ying or yang, or spleen Qi deficiency, or 2) excess of stagnation or damp heat in the pelvic organs.
11. **OTHER HORMONAL ABNORMALITIES**

Reference: The Infertility Cure by Randine Lewis, Ph.D.

**Way of Wellness  
Natural Healthcare, Inc.  
940 Saratoga Ave. Ste 104  
San Jose, CA 95129**

## Informed Consent to Receive Treatment and Care

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*You are always welcome to ask for more details if you wish. Contraindications (symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a history of bleeding disorder or current anticoagulation therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.*

\_\_\_\_\_ I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

\_\_\_\_\_ I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM). I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

\_\_\_\_\_ I understand that I may stop treatment at any time.

\_\_\_\_\_ I understand that while this document describes major risks of treatment, other side effects and risks may occur.

\_\_\_\_\_ **Acupuncture:** I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapsed lung) and infection.

\_\_\_\_\_ **Moxibustion:** I understand that this is the application of indirect heat supplied by burning the herb *Folium Artemisiae Vulgaris* over a single acupuncture point or group of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion.

\_\_\_\_\_ **Cupping:** I understand that this is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury.

\_\_\_\_\_ **Acupressure/Tui Na Massage:** I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am

aware that side effects may result from this treatment include, 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.

\_\_\_\_\_ **Herbs and Nutritional Supplements:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them.

\_\_\_\_\_ I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my practitioner if any unanticipated or unpleasant effects associated with herb or supplement treatment.

\_\_\_\_\_ I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

\_\_\_\_\_ I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment at any time.

\_\_\_\_\_  
*Patient Name:*

\_\_\_\_\_  
*Signature of Patient or person authorized to consent on behalf of the patient:*

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

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. **IMPORTANT NOTE:** This does not include all of the details about our privacy policy. For more details, please read the **NOTICE OF PRIVACY PRACTICES** that your practitioner has provided you.

**I. How we may use and share health data about you:**

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

**II. Disclosures where we do not have to give you a chance to agree or object:**

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

**III. Disclosures where we have to give you a chance to agree or object:**

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

**IV. Other uses of health data:** Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

**V. You have the following rights relating to the health data we keep about you:**

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES** of this practice.

\_\_\_\_\_  
Signature of or representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print patient name

\_\_\_\_\_  
Patient Birth Date -11/12/08sc

---

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940 Saratoga Ave. Ste 104  
San Jose, CA 95129

408-615-1995  
**NUTRITIONAL INFORMED CONSENT**

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

*"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advise is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above:

Signature

Date:

Financial Policy

Welcome to our family of acupuncture providers, we are committed to your treatment being successful. Please understand that payment of your bills is a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept cash, check, or credit cards.

**Regarding insurance:** We verify your insurance as a courtesy to you. HOWEVER, **you are ultimately responsible for your payment of any co pays/coinsurance.** Insurance carriers can and do make mistakes when verifying coverage as such you may want to confirm your benefits and read your explanation of benefits as you receive them in the mail. In order to provide this service to you, we must have completed insurance information and confirmation of your coverage. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance within 45 days of billing, the balance if a problem occurs. We expect all balances to be cleared in less than 45 days

**Usual and customary rates:** Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

**Billing:** For all accounts over 45 days with patient amounts due, there will be a \$10.00 billing fee or a finance charge of 1.5% per month. We assign all accounts over 120 days to a collection service for processing. You agree to pay any reasonable additional fees, including all collection agency, legal fees and/or court cost, necessary.

**Cancellation policy:** There will be a charge of \$25.00 for any cancelling an appointment without a 24 hour notice or for failing an appointment. Online deals have their own cancellation policies. Groupon requires a "24 hour cancellation notice." Amazon's policy says "24 hour notice or subject to forfeiture." Our policy for these online deals is 24 hour notice or that session is forfeited. The amount paid for the voucher never expires and can be applied to future visits at the regular fee for services (see these terms on the online terms and conditions).

I agree to this financial policy, and I have read and received a copy of this statement.

Patient or parent/guardian signature \_\_\_\_\_ DATE: \_\_\_\_\_