MARYA DEDA DAOM, LAC

2808 NE MLK Jr. Blvd Suite C

Portland, OR 97212 #503-282-2268

Name:_____ Date: _____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____Email_____

Date of Birth: _____ Age: _____ Preferred gender:_____

Marital Status: _____Reside with:_____

Occupation: _____ Referred by: _____

Physician/PCP: _____PCP Phone: _____

PCP Address: _____ City: _____State: _____ Zip: _____

In Emergency Notify: _____Relationship: _____

Phone: _____ Address: _____

Main Complaint (symptoms, diagnosis, duration, current treatment, how does current complaint affect your life etc.)

_____

_____

_____

HEALTH HISTORY

Surgeries (including date):_____

Height_____ Weight_____

Allergies (chemical, environmental, food, drugs, etc.) _____

Current medications (names & dosages). Please attach an additional page if necessary.

_____

_____

Vitamins/Supplements/Herbs: _____

Name_____ Date of Birth_____

Exercise

Type, times per week, and duration: _____

Diet

Meals per day: _____Snacks: _____

Caffeinated drinks, daily quantity and type:_____

Alcohol drinks per week: _____

Family Medical History

Please check any condition that applies to your family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

Diabetes _____ Seizures _____ Heart Disease _____ High Cholesterol_____Stroke _____

High Blood Pressure _____ Allergies _____ Alcoholism _____ Back Problems_____

Cancer _____ Asthma _____ Other_____

Personal Health History

Ever used services of Naturopathy, Acupuncture, Shiatsu, Body Work, Chiropractic or Osteopathic care in the past? (Circle the ones you have had.)

Major illnesses or injuries (include dates):

_____

_____

Do you smoke?_____ If yes, how many cigarettes a day? _____

General Personal Health History

Please underline if you had this in the past but do not any longer.

Please circle if you have had any of these items listed below in the last year.

General

Poor Appetite | Poor Sleeping | Fatigue | Fevers | Chills | Night Sweats | Sweats Easily | Tremors | Cravings | Localized Weakness | Poor Balance | Change in appetite | Bleed/Bruise easily | Weight loss/gain | Peculiar tastes/smells | Dental/gum problems | Muscle weakness/fatigue | Sudden energy drop | Strong thirst (hot or cold drinks)

Name_____ Date of Birth_____

Particular diseases

Appendicitis | Tuberculosis | Cancer | High Cholesterol | Pneumonia | Rheumatic Fever | Mononucleosis | Malaria | Diabetes | Epilepsy | Mental Disorder | Measles | Mumps | Chicken Pox | Arthritis | Pleurisy | Goiter | Influenza | Alcoholism | Whooping Cough | Heart Disease | STD's | Other: _____

Skin and Hair

Rashes | Ulcerations | Hives/Allergic Dermatitis | Itching | Eczema | Psoriasis | Dandruff | Loss of hair | Recent moles | Skin discoloration | Acne | Change in skin/hair texture | Face flushing | Dermatitis | Warts | Fungal Infection | Weak or ridged nails

Eyes, Ears, Nose and Throat

Dizziness | Difficulty swallowing | Migraines | Glasses | Eye Strain | Eye pain | Poor vision | Night Blindness | Color Blindness | Cataracts | Blurred vision | Earaches | Ringing in ears | Poor hearing | Spots in front of eyes | Sinus problems | Nose bleeds | Recurrent sore throats/colds | Runny nose | Allergies | Grinding teeth | Facial pain | Sores on lips/tongue | Dental problems | Jaw clicks/locks | Headaches

Cardiovascular

Chest pain or pressure | Irregular heart beat | Palpitations at rest | Fainting | Cold hands/feet | Swelling of hands/feet | Blood clots | Phlebitis | Shortness of breath | Varicose/spider veins | High blood pressure | Low blood pressure | Spontaneous sweating | Dizziness

Respiratory

Cough | Wheezing | Coughing blood | Tight sensation in chest | Bronchitis | Pneumonia | Pain with deep inhalation | Asthma | Difficult inhale/exhale | Difficulty breathing when lying down | Production of phlegm: What color?_____

Gastrointestinal

Nausea | Abdominal pain/cramps | Vomiting | Gas | Constipation | Diarrhea | Indigestion | Black stools | Loose stools (>2 per day) | Bloating/Edema | Blood in stool | Rectal pain | Bad breath | Changes in appetite | Hemorrhoids | Acid reflux/GERD | Excessive appetite | Chronic laxative use | Belching | Poor appetite | Significant thirst | Hernia | IBS | Crohn's Disease

Name_____ Date of Birth_____

Genitourinary

Pain on urination | Frequent urination | Blood in urine | Urgent urination | Unable to hold urine | Kidney stones |Scanty flow | Copious flow | Impotence | Sores on genitals | Urinary tract infection | Burning urination | Premature ejaculation | Decreased libido | Prostatitis | Dribbling after urination | Nocturnal emission | Pain in testicles | Herpes Infections | Excessive libido | Impotence | Night urination: What time?_____ How often?_____

Gynecological/Reproductive

Difficult/Painful intercourse | Ovarian cysts | Age of first menses_____ | Vaginal dryness | Endometriosis | Date of last menses_____ | Vaginal sores | Uterine Fibroids | Date of last PAP/Pelvic_____ | Vaginal discharge | Fibrocystic breast tissue | Number of pregnancies____ | Infertility | Polycystic Ovarian Disease | Number ectopic pregnancies ___ | Irregular menstruation | PMS | Number of live births_____ | Painful menstruation Number of miscarriages_____ | Number of abortions_____ | Do you practice birth control?_____ What type?_____ How long _____?

Musculoskeletal

Neck pain | Shoulder pain | Muscle pain | Knee pain | Hand/wrist pain | Muscle weakness | Hip pain | Carpal Tunnel | Sciatica | Foot/ankle pain | Tendonitis | Bursitis | Rotator Cuff Sprains/Strains | Back pain Low___ Middle___ Upper___ | Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

Seizures | Concussion | Nervousness | Areas of numbness | ADD/ADHD | Anxiety/Panic attacks | Loss of balance | Bad temper/irritable | Depression | Vertigo/Dizziness | Poor memory | Manic Depression |Lack of coordination | Easily susceptible to stress | Seasonal Affective Disorder

Consent

I hereby consent to the performance of Oriental medicine procedures on (Patient's name) _____ (or on the patient named below, for which I am legally responsible) by Marya Deda DAOM, LAc. Details of such treatments are listed below. **Please initial all the lines as you read them. We will also discuss treatment procedures as needed.**

Name_____ Date of Birth_____

Shiatsu

Shiatsu is a Japanese form of body work intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. There may be certain side effects such as muscle soreness and then aggravation of symptoms existing prior to treatment. _____ (initial)

Acupuncture

Acupuncture is the insertion of needles through the skin at certain points on the body to treat bodily dysfunction or disease, to modify or prevent pain, and to normalize the body's physiological functions. Certain adverse side effects may include local bruising, minor bleeding, fainting, pain or discomfort, and/or possible aggravation of symptoms existing prior to the acupuncture treatment. With unintentional mistreatment, more serious side effects can include pneumothorax (collapse of the lung) and migrating needles(embedded needle forgotten after treatment). If you feel dizzy during a treatment or a needle feels painful, please notify the practitioner right away. _____(initial)

Moxibustion

Moxibustion is the application of heat to the skin at certain points on the body to treat bodily dysfunction or disease. There is a risk of burning or scarring. _____(initial)

Chinese Herbs/ Supplements

Chinese herbs are plants, insects, and minerals from the Oriental materia medica to treat bodily dysfunction or disease. The herbs and nutritional supplements recommended are traditionally considered safe in the practice of Chinese Medicine. Our clinic offers a full medicinary of Chinese herbs and nutritional supplements for your convince and patients are welcome to purchase recommended herbs and supplements from our clinic. I understand the some herbs and supplements may be inappropriate during pregnancy and I will inform my practitioner immediately of pregnancy status. With Chinese herbs and supplements there may be a risk of increased bowl movements, abdominal pain or discomfort and possible aggravation of symptoms existing prior to herbal treatment. Please notify your acupuncturist if any adverse side effects occur. _____(initial)

Electro-Acupuncture

Electro-Acupuncture is the addition of an electric current used with acupuncture needles or with non-needle probes. Possible adverse reactions include mild shock, pain or discomfort or possible aggravation of symptoms existing prior to treatment. _____(initial)

Essential Oils

Essential oils are plant based oils that are applied to the acupuncture points. There is a chance of an oil causing and uncommon skin reaction including redness, swelling or other irritation. If this occurs please tell your provider and diluted carrier oil will be applied to the area to relieve the reaction. _____ (initial)

Marya Deda DAOM, LAc, 2808 NE MLK Jr. Blvd. Suite C, Portland, OR 97212 #503-282-2268

Name_____ Date of Birth_____

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____Date:_____

Facial Acupuncture/Rejuvenation

Facial acupuncture is the insertion of small needles into the face along with a series of natural and Chinese herbal facial products. Please inform your practitioner if you have any skin allergies or sensitivities prior to treatment. Possible bruising or skin irritation may occur with Facial Rejuvenation procedures. _____ (initial)

Fees and Policies

I, _____ (client) understand that my insurance is an agreement between the insurance company and myself. Insurance billing is a courtesy that this office extends to our patients. I understands that Marya Deda DAOM, LAc will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance company. I agree to accept full responsibility for all amounts not paid for by my insurance company and agree to pay Mary Deda DAOM, LAc for all services provided to me which the insurance company denies due to their usual and customary policy or for other reasons. I understand that the balances are due net 30 days. Herbs and supplements are not included in acupuncture fees. If supplements are prescribed, there will be an extra charge in addition to the acupuncture treatment.
_____(initials)

Cancellation Policy

I, _____ (client) agree that if I am unable to keep an appointment, I will give 24 hours notice. I also understand that there is a **$50 fee for any missed, cancelled, or forgotten appointments without 24-hour notice** of cancellation. I understand that the fee is my responsibility. Cancellation due to illness, accident or injury will not be charged. _____ (initials)

HIPPA Privacy Practices

I, _____ (client) consent to the use or disclosure of my protected health information by Marya Deda DAOM, LAc, for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Marya Deda DAOM, LAc. I understand that diagnosis or treatment of me by Marya Deda DAOM, LAc, may be conditioned upon my consent as evidenced by my signature on this document. Marya Deda DAOM,

Name_____ Date of Birth_____

LAc reserves the right to leave a message on the patients phone or answering machine regarding appointments or requesting a return call. As the patient I consent to this right.
I understand that if I, the patient refuse to sign this consent for, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.
Private health insurance information is stored safely in locked cabinets and locked computers. We do everything with in our means to keep this information secure and safe. Internet, email, texting maybe used to transfer information to allow for insurance billing or scheduling purposes.
Patient's Name _____ Date: _____

Patient's Signature _____

Signature of Personal Representative _____

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