Welcome to Essential Acupuncture!

I would like to extend my sincerest gratitude to you for choosing me to work with you as you give yourself this gift of healing. In this packet you will find information about my practice as well as the *New Patient Intake Forms* that you will need to complete and bring with you to your first appointment.

Your initial appointment with me is scheduled to last 90 minutes. During this appointment we will spend a considerable amount of time going over your completed patient forms, discussing your current condition and answering any questions you may have. Follow-up appointments are generally 60 minutes in length. Due to the holistic nature of Traditional Chinese medicine, as well as the cumulative effect of acupuncture treatments and herbal medicine, I usually recommend that patients plan for a minimum of 5 follow-up treatments. Additionally, if you are not sure if Traditional Chinese medicine is right for you and you have questions, you can make a 15 minute phone or in person consultation appointment at no cost.

It is best if you come to your appointment wearing comfortable, loose fitting clothing. It is also important that you have eaten a light meal an hour or so before your treatment. You should not be too full or too hungry.

Essential Acupuncture, PLLC is located at 5318 Patterson Avenue, upstairs in Suite E. We are just west of Willow Lawn Drive and east of Libbie Avenue. We are in the Westhampton Professional Park at the back of the parking lot in the building with the green doors and shutters.

Thank you for choosing Essential Acupuncture. I look forward to meeting you soon!

Sincerely,

Kristina Aschenbach, MAcOM, Dipl. O.M. (NCCAOM), L.Ac.
Owner, Essential Acupuncture, PLLC

essential
ACUPUNCTURE

General Information

Office Hours: Patients are seen by appointment only Monday through Friday 10:00 to 7:00.

Payment: Full payment is due at the time of service. Forms of payment accepted: Cash, Checks, Visa, Master Card, Discover and American Express.

Consultation: 15 minutes – No Charge
- I will answer any questions you have about acupuncture and its possible effectiveness for your current condition. This can be done by phone or in person.

Initial Treatment: 90 minutes $120
- Thorough review of your medical history and current condition.
- Chinese medical diagnosis
- Acupuncture and other modalities as indicated
- Nutrition and lifestyle recommendations as indicated
- Herbal prescription if indicated and desired *(extra cost for herbs)*

Follow-Up treatment: 60 minutes $85
- Follow up on previous treatment
- Adjust treatment plan and diagnosis if needed
- Acupuncture and other modalities as indicated
- Nutrition and lifestyle recommendations as indicated
- Herbal prescription follow-up and refill *(extra cost for herbs)*

Packages: Traditional Chinese medicine is a holistic medicine that works by strengthening the body's natural healing potential and treatments are cumulative in their effect. For this reason, weekly treatments for several weeks may be recommended for treatments to have the most lasting effect.
- **Follow-up appointment treatment package**: **5 appointments $375** (Initial treatment not included)

Insurance: Essential Acupuncture does not take insurance at this time. However, I can provide you with a detailed receipt that you can submit to your insurance for reimbursement.

Medical Records: All personal information and medical records are confidential and secured to protect your privacy. Essential Acupuncture, PLLC does not release personal health information without your written permission or unless required by court order. You may submit a written request to view your file and request a copy of your records. You may download our "Notice of Privacy Practices" from www.essacu.com or request a hard copy from me.

Medications: Please inform me of any prescription medication and other drugs/supplements you are taking. Please inform me of any changes in medications prior to treatment.

Cancellation Policy: Appointments cancelled without 24 hour notice are subject to be charged the full amount of the missed appointment.

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ACUPUNCTURE

Patient Information

Name:		Today's Date:
Age:	Date of Birth:	Sex: ☐ Male ☐ Female
Main Phone:	Other Phone:	
Confidential messages may be left on (circle one): Main Other None		
Mailing Address		
City	State	Zip
Email Address:		Allow email contact: Yes No
Family Physician:		OBGyn (if applicable):
Do you have Health Insurance? Yes No	Does your insurance plan cover acupuncture? Yes No Don't know	
Name of Insurance Company:		
How did you hear about us?		
Referred by:		
Emergency contact (to whom confidential information may be released):		
Contact:	Relationship	Phone
I understand that payment is due at the time of service and agree to pay at that time. I understand that I must provide at least 24 hour notice when canceling a scheduled appointment in order to avoid paying a cancellation fee.		
Signature:		Date:

Current Condition

Main Complaint/Health Problem		
When did this problem begin?		
What makes the problem worse?		
What makes the problem better?		
What diagnosis have you been given (if applicable)?		
List treatments you have received for this condition		
Treatment	Date	Effect of treatment
Is there anyone in your family with the same/similar problem?		

Rate your overall health:

1 2 3 4 5 6 7 8 9 10

Poor Excellent

Rate your energy level:

1 2 3 4 5 6 7 8 9 10

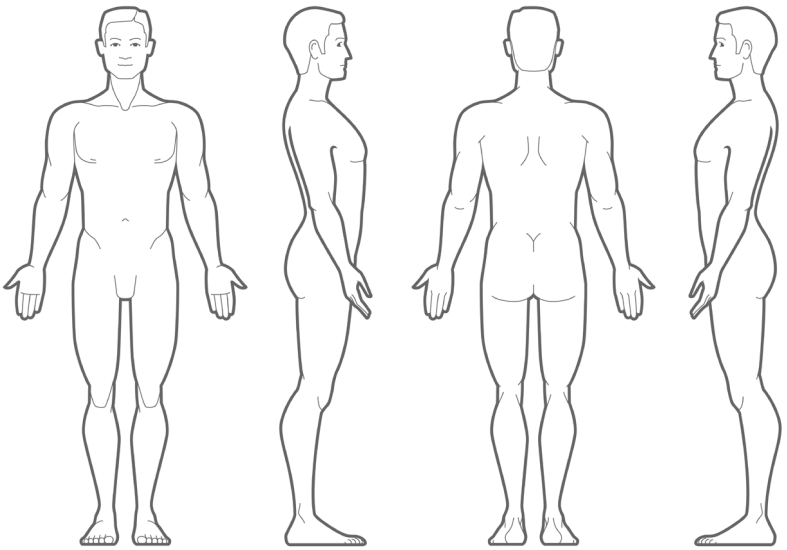
Low High

Rate your pain level:

1 2 3 4 5 6 7 8 9 10

Low High

Please mark current painful or distressed areas:



Medical History

Significant Illness (check all that apply)

☐ Tuberculosis	☐ Asthma	☐ Emotional Imbalance
☐ Hepatitis A B C	☐ Mononucleosis	☐ Thyroid Problems
☐ HIV/AIDS	☐ Anemia	☐ _____
☐ Venereal Disease	☐ Heart Disease	☐ _____
☐ Seizures	☐ Kidney Disease	☐ _____
☐ Diabetes	☐ Liver Disease	☐ _____
☐ Cancer (type _____)	☐ Bleeding Disorder	☐ _____
☐ Hypertension	☐ Alcoholism/Addiction	☐ _____

Current Conditions (check all that apply)

☐ Pacemaker	☐ Menstruation	☐ Trying to conceive
☐ Blood Thinner	☐ Pregnancy/Lactation	

Surgeries, Hospitalizations, and Significant Traumas (auto accidents, falls, loss of loved one, etc.)

Date	Event
Date	Event
Date	Event

Current medications including vitamins, supplements, over-the-counter medicines, herbal medicines.

Medication	Dosage
Purpose	Date Started
Medication	Dosage
Purpose	Date Started
Medication	Dosage
Purpose	Date Started
Medication	Dosage
Purpose	Date Started

Allergies/Adverse Reactions:

Significant Family Health History (physical and/or emotional):

Personal Information

Occupation:		
Occupational Stress (chemical, physical, psychological, etc):		
Height:	Weight:	
Weight one year ago:	Maximum weight:	When:
Habits		
Substance	Amount/Type	Frequency
☐ Coffee		
☐ Soda		
☐ Alcohol		
☐ Smoking		
☐ Drugs		
☐ Other		
Exercise		
Type		
Frequency		
Type		
Frequency		
Diet: Please describe your average daily diet.		
Morning		
Afternoon		
Evening		
Snacks		
How much water do you drink daily?		
Check all that apply to your current diet:		
☐ Vegetarian ☐ Vegan ☐ Gluten free	☐ Dairy free ☐ Sugar free ☐ Fat free	☐ Paleo ☐ Weight Watchers ☐ Other _____

Health History

Please select any ongoing symptoms you currently have or have had in the past 3 months.

Temperature

- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Cold hands/feet
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Sweat with little exertion
- ☐ Abnormal sweating
- ☐ explain _____

Head & Senses

- ☐ Naturally poor vision
- ☐ Floaters/spots in vision
- ☐ Red/itchy eyes
- ☐ Poor hearing
- ☐ Ear ringing
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Sinus/nasal problems
- ☐ Frequent nosebleeds
- ☐ Frequent sore throats
- ☐ Teeth problems
- ☐ Jaw clenching/ grinding teeth
- ☐ Mouth/tongue sores
- ☐ Lip sores
- ☐ Dry/chapped lips
- ☐ Dry mouth & throat
- ☐ Dizzy/lightheaded
- ☐ Fainting
- ☐ Heavy-headedness

Sleep

- ☐ Insomnia
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Not rested in morning
- ☐ Vivid dreams
- ☐ Sleepwalk/sleeptalk
- ☐ Do not get enough sleep
- ☐ Excessive sleep

Lungs & Heart

- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Frequent colds
- ☐ Seasonal allergies
- ☐ Slow heart rate
- ☐ Fast heart rate
- ☐ Irregular heart rhythm
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Low blood pressure

Musculoskeletal

- ☐ Muscular pain
- ☐ Joint pain
- ☐ Numbness/tingling
- ☐ Muscle weakness
- ☐ Poor balance
- ☐ Tremors
- ☐ Muscle twitching/spasm
- ☐ Joint swelling
- ☐ Varicose veins
- ☐ All over body pain
- ☐ Restricted movement
- ☐ Broken bones
- ☐ Paralysis

Mental & Emotional

- ☐ Forgetful/poor memory
- ☐ Poor concentration
- ☐ Irritable/angry
- ☐ Grief
- ☐ Anxiety/worry
- ☐ Fearful
- ☐ Obsessive/compulsive
- ☐ Depression
- ☐ Stress
- ☐ Bad Temper

Appetite & Digestion

- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Food cravings _____
- ☐ Thirst
- ☐ Dry mouth
- ☐ Feel a “lump in throat”
- ☐ Bad breath
- ☐ Belching
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Bloating/distention
- ☐ Gas
- ☐ Constipation
- ☐ Loose stools/diarrhea
- ☐ Alternating loose & constipation
- ☐ Fecal incontinence
- ☐ Cramps with BM
- ☐ Incomplete BM
- ☐ Hemorrhoids

Urinary

- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Frequent UTIs
- ☐ Wake at night to urinate
- ☐ Dribbling
- ☐ Urinary Incontinence

Skin Hair & Nails

- ☐ Acne
- ☐ Itching
- ☐ Dry skin
- ☐ Bruise easily
- ☐ Dark under eyes
- ☐ Dandruff
- ☐ Premature grey hair
- ☐ Hair loss
- ☐ Dry/brittle hair
- ☐ Brittle nails

Male Health

- ☐ Erectile dysfunction
- ☐ Lack of sex drive
- ☐ Genital pain
- ☐ Male infertility

Female Health

- ☐ Endometriosis
- ☐ Fibroids/polyps
- ☐ PCOS
- ☐ Irregular periods
- ☐ Heavy bleeding
- ☐ Scanty bleeding
- ☐ Frequent yeast infections
- ☐ Fertility problems
- ☐ Pain/cramps at period
- ☐ Cystic breasts
- ☐ Breast tenderness
- ☐ PMS
- ☐ Lack of sex drive
- ☐ Painful intercourse
- ☐ Birth control
- ☐ Hot flashes
- ☐ Vaginal dryness
- ☐ Menopause
- ☐ Age at first cycle _____
- ☐ Start date of last cycle _____
- ☐ Duration of period _____ days
- ☐ Duration of cycle _____ days
- ☐ Number of: Pregnancies _____
- ☐ Live births _____
- ☐ Miscarriages _____
- ☐ Early terminations _____

Recommendation for Examination by a Physician

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10).

I, Kristina Aschenbach, L.Ac., recommend to you,_____
(patient)
that you be examined by a physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Patient Date

_____ _____
Kristina Aschenbach, L.Ac. Date

INFORMED CONSENT TO TREATMENT

By signing below, I hereby voluntarily consent to be treated with acupuncture and Chinese medicine by Kristina Aschenbach, a Licensed Acupuncturist, at Essential Acupuncture, PLLC. I understand that methods of treatment may include, but are not limited to: acupuncture, cupping/gua-sha, moxibustion, acupressure, electrical stimulation, heat/cold therapy, Chinese herbal medicine, nutritional recommendations, and healthy lifestyle recommendations. Essential Acupuncture my also use, but not be limited to, diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion and orthopedic muscle testing.

Although I am aware that acupuncture and the other procedures used in Chinese medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied and that I am free to stop treatment at any time. I understand that acupuncturists practicing in the state of Virginia are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommend.

I understand and am informed that in the practice of Chinese medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: fainting, minor bleeding, local bruising at needle insertion site, pain or strong sensation at the needle insertion site, or where cupping or herbal application is made, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other extremely uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs or stroke.

I understand that if I choose to take any recommended herbal medicine, I must follow the directions for administration and dosage. I am aware, that although uncommon, adverse side effects may result from taking Chinese herbal medicine. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any discomfort that I associate with these substances, I understand that I am to cease taking the herbal medicine and call the clinic as soon as possible.

I understand that if I choose to have cupping administered that, as a course of the treatment, skin sensitivity and discoloration of the skin will likely result for several days following treatment. I understand that I may refuse or stop this treatment at any time.

I understand that if I choose to have electrical stimulation administered that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment or stop treatment at any time.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise her best judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask the practitioner for a more detailed explanation. I agree to the above named procedures and conditions of treatment and give my permission and consent to treatment. 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 at Essential Acupuncture, PLLC.

_____	_____	_____
Patient's name (please print)	**Patient's signature**	**Date Signed**

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION
I received, in substantial detail, further explanation of the treatment, other alternative methods of treatment, and/or information about the material risks of the treatment. I give my consent to treatment.

_____	_____
Patient's Signature	**Date**
_____	_____
Kristina Aschenbach, L.Ac.	**Date**

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to Essential Acupuncture's "Notice of Privacy Practices" (found on the website or paper copy). I understand that I have the right to review Essential Acupuncture's "Notice of Privacy Practices" prior to signing this document.

I understand that Kristina Aschenbach, owner of Essential Acupuncture, PLLC, may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Essential Acupuncture the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

_____ _____

Patient's Signature Date