Bianca Clayton, L.Ac.

Licensed Acupuncturist & Traditional Chinese Medicine Practitioner

(p) 805 996 0682 bianca@milkweedandalchemy.com

Patient Information

First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:	State:	Zip Code:
Home Phone:	Mobile Phone:	Business Phone:	
Email Address:		Male: ☐	Female: ☐
Date of Birth (mm/dd/yyyy)	Current Age:	Height:	Weight:
Occupation:	Employer:		
Relationship Status:	Children:	Ages:	
Emergency Contact:	Phone Number:	Relationship to You:	
Referring and/or Primary Physician:	Month/Year of Last Visit:		

How did You Find Us:

☐ Friend / Family / Collegue: _____ ☐ Online Search ☐ Social Media

☐ Another Healthcare Provider: _____ ☐ Other: _____

What is Your Experience with Chinese Medicine? (Check all that Apply):

☐ None ☐ Acupuncture ☐ Electro-Acupuncture ☐ Cupping ☐ Guasha ☐ Tuina ☐ Qigong ☐ Herbal Medicine

Terms of Admission

Financial Policies:

Late Cancellations & Missed Appointments: I understand that if I provide less than 24 hours notice of an appointment cancellation, or fail to show for a scheduled appointment, I may be charged $50 for a missed appointment.
Benefits Verification: I have been advised to verify my benefits directly with my insurer, and acknowledge that fees for treatment may not be covered by my insurance policy. I understand that Bianca Clayton, L.Ac. is not an insurance company representative, and is not financially responsible for benefits verification, and does not guarantee insurer payment of billed charges.
Financial Responsibility: I understand that all services rendered are charged to me, and I am personally financially responsible for all charges, regardless of insurance coverage or rejection of insurance claims. I assign any and all insurance benefits to Bianca Clayton, L.Ac. If my insurer sends payments to me, I agree to send or bring those payments directly to this office upon receipt.
Returned Checks: A $30 fee will be assessed to returned checks.

By signing below, I acknowledge the following:

- I certify that I understand the above, and that the information provided by me is true and correct.
- I have received a Notice of Privacy Practices regarding my health information.
- I authorize the release of any information necessary to coordinate medical care and to secure payment for services rendered.

Patient or Legal Guardian Signature: _____ Date: _____

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Medical History

Patient Name:	
Primary Complaint:	When did this Begin?:
Aggravating and Relieving Factors:	Any Previous Diagnosis or Treatment for this Condition?:
Secondary Complaint:	When did this Begin?:
Aggravating and Relieving Factors:	Any Previous Diagnosis or Treatment for this Condition?:

Indicate if any of the Following have been Part of your Present or Past Health History:

- ☐ Addiction
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma, Seasonal Allergies or Hayfever
- ☐ Autoimmune Disorder (specify)
- ☐ Bleeding or Clotting Disorder
- ☐ Blood Clots
- ☐ Bone Fractures
- ☐ Bronchitis
- ☐ Cancer
- ☐ Colitis / IBD
- ☐ COPD
- ☐ Diabetes (specify type 1 or 2)
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease or Heart Attack
- ☐ Hepatitis (specify type A B C D E)
- ☐ High Cholesterol
- ☐ HIV+ or AIDS
- ☐ Hypertension / High Blood Pressure
- ☐ Hypotenstion / Low Blood Pressure
- ☐ Hypoglycemia
- ☐ Immune Compromised
- ☐ Implants or Prosthetics
- ☐ Mental Illness
- ☐ Osteoporosis / Osteopenia
- ☐ Pneumonia
- ☐ Pregnancy (live birth or miscarriage)
- ☐ Pacemaker / Defibrillator
- ☐ Reynauds's Disease
- ☐ Sensory Loss (specify)
- ☐ Spinal injury
- ☐ Stones (kidney, gallbladder…)
- ☐ Stroke
- ☐ Thyroid Disorder (specify)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (please specify)

_____

_____

Please expand on any of the above conditions (previous treatment, dates, etc):

List any hospitalizations or surgeries, including dates:

List any known allergies or sensitivities (food, medications, supplements, herbs, environmental, or otherwise) and reactions:

Please list any current prescription medications, over-the-counter drugs and/or dietary supplement or herbs taken (include dosages, reason for taking, and start date):

Patient or Legal Guardian Signature: Date:

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Medical History

Patient Name:

Recent Health history & Review of Systems: Please check any symptoms or activity you CURRENTLY experience or have experienced recently (in the last 6 months):

General, Constitutional, Psychosocial:

□ Anxiety □ Depression □ Dizziness □ Emotional Symptoms Worse at Night □ Indecisiveness □ Irritability □ Nightmares
□ Panic Attack □ PTSD □ Restlessness □ Fatigue □ Fever □ Headache □ Insomnia □ Night Sweats □ Frequent Sweat
□ Memory Loss □ Weight Loss □ Weight Gain

Cardiovascular & Pulmonary:

□ Angina □ Asthma □ Bronchitis □ Bruise Easily □ Chest Pain □ Cough □ High Cholesterol □ Irregular Heartbeat
□ Leg Cramps □ Palpitations □ Pneumonia □ Shortness of Breath □ Frequent Sighing or Yawning □ Snoring or Sleep Apnea
□ Swelling (legs, ankles, feet, hands) □ Varicose Veins □ Wheezing

Head, Eyes, Ears, Nose & Throat (HEENT):

□ Changes in Vision □ Corrective Lenses □ Diminished Hearing □ Double Vision □ Dry Mouth □ Dry Eyes □ Ear Ache
□ Eye Twitch □ Frequent Colds □ Hairloss □ Itchy Eyes □ Loss of Smell □ Light Sensitivity □ Noise Sensitivity □ Nosebleed
□ Red or Burning Eyes □ Ringing / Tinnitus □ Runny Nose □ Sinus Infection □ Sore Throat □ Vertigo □ Watery Eyes

Gastrointestinal:

□ Abdominal Pain □ Acid Reflux □ Black/Tarry Stool □ Bloating □ Bitter Taste □ Constipation □ Diarrhea
□ Excess Hunger or Thirst □ Gas □ Hemorrhoids □ Indigestion □ Jaundice □ Loss of Taste □ Low Appetite □ Nausea
□ Trouble Swallowing □ Ulcer □ Undigested Food in Stool □ Urgent Stool □ Vomiting

Musculoskeletal & Neurologic:

□ Arthritis □ Bone Pain □ Bone Spur □ Bunion □ Joint Pain □ Concussion □ Fainting or Lightheaded □ Fibromyalgia □ Gout
□ Limited Range of Motion □ Muscle Pain □ Muscle Weakness □ Nerve Pain □ Numbness or Tingling □ Paralysis
□ Poor Balance □ Seizures □ Stiffness □ Tics □ Tremors

Skin & Lymphatic:

□ Acne □ Cysts □ Change in Moles or Growths □ Dry Skin / Hair □ Eczema □ Hives □ Itching □ Lumps
□ New Moles or Growths □ Psoriasis □ Rashes □ Sensitive Skin □ Swelling □ Swollen Lymph Nodes □ Tender Lymph Nodes

Urinary & Reproductive:

□ Blood in Urine □ Burning or Painful Urination □ Change in Urinary Frequency □ Difficult or Hesitant Urination □ Hernia
□ Nocturnal Urination □ Urinary Urgency □ Amenorrhea □ Breast Pain □ Discharge □ Dysmenorrhea / Painful Menses
□ Erectile Dysfunction □ Heavy Menstruation □ High Libido □ Low Libido

Habits & Cravings:

□ Cigarette Smoking □ Alcohol _____ drinks per week □ Recreational Drugs □ Caffeine □ Sugar □ Soft Drinks □ Salt
□ Fried or Fast Food □ Other:_____ □ Preference for cold food / drink □ Preference for warm food / drink
□ Thirsty with no desire to drink □ Hungry with no desire to eat □ Excess hungry □ Excess thirst

Is there anything else you would like me to know about your health history?:

The above information regarding my medical history is, to the best of my knowledge, complete and accurate. I agree to promptly notify Bianca Clayton, L.Ac., of any changes in my health status and/or additional medical history.

Patient or Legal Guardian Signature: Date:

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Informed Consent

• I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture by the acupuncturist named below.

• I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, tui-na (Chinese massage), cupping, gua sha, electrical stimulation, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. I will immediately notify my acupuncturist of any adverse effects associated with the consumption of herbs prescribed.

• I have been informed that these treatments are generally safe methods of care, but that they may have some side effects including bruising, numbness or tingling near the needling sites, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains procedures in accordance with California clean needle technique.

• I understand that while this document describes the major risks of treatment, albeit rare. There are other side effects that may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, and rashes. I will notify my acupuncturist if I am or become pregnant.

• I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments, and I wish to rely on my acupuncturist to exercise good judgment during the course of treatment. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 Name (print): _____

Patient or Legal Guardian Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name: Date of Birth:

I understand that as a part of my healthcare, Bianca Clayton, L.Ac. originates and maintains health records describing my health history, signs & symptoms, examination findings, test results, diagnoses, treatment and/or care plans for future treatment.

I understand that this information serves as:
- A basis for planning, managing & documenting my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and procedure information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restriction to the use of disclosure of my health information:

Patient or Legal Guardian Signature: Date:

Office Use Only: _____ Accepted _____ Denied

Signature: Title: Date: