

WEEM



Susan Sandlin, L.Ac., MSOM, RYT500
West End Eastern Medicine
1891 Billingsgate Circle, Suite B
Richmond, VA 23238-4242
(804) 437 · 1947
www.westendeasternmedicine.com

Recommendation for Examination by a Physician

I, Susan Sandlin, L.Ac, recommend to you _____ that you be examined by a Physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

Client

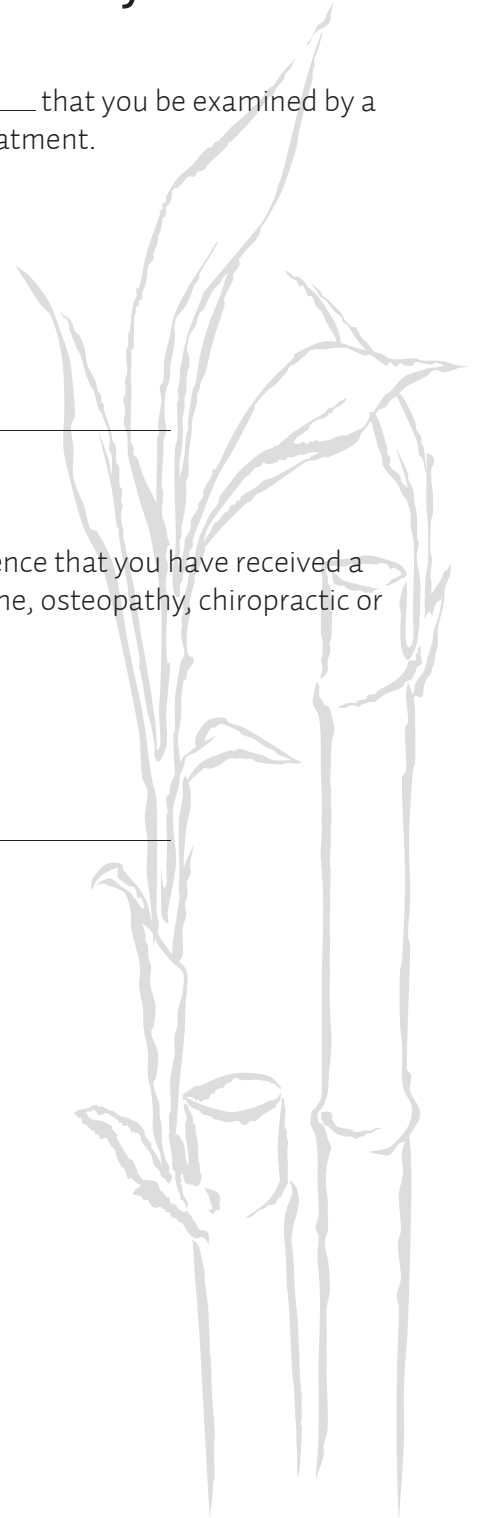
Date

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 54-2956.9 18 VAC 85-110-10)

Acupuncturist

Date



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Policies and Practices of West End Eastern Medicine

The practice is based on the commitment to mutual respect and accountability. I am strongly dedicated to working in partnership with you to enhance your life quality.

Please initial each policy

___ **Appointments** All treatments are by appointment only. In the spirit of mindfulness for all involved, please arrive at your scheduled appointment time. As I do not answer the phone when I am in with a patient, please leave a message including your phone number. If you call after hours I will return your call during business hours the next business day. Calls on Friday evening or on the weekend will be returned during business hours on the following Monday.

If you are having a Medical Emergency call 911 or go to the nearest emergency room!

___ **Cancellations** Because this is an appointment-only business, a late cancellation does not allow for an appointment time to be utilized. In the event that a scheduled appointment is cancelled with less than 24 hours notice, I, _____, understand that I will be required to pay in full for the missed appointment. (Exceptions will be made for sudden illness or other emergency situations)

___ **Payment** Payment is due at the time of treatment. Payment may be made in the form of Cash, Check, Visa or MasterCard. There is a \$25.00 charge for returned checks.

___ **Insurance** I am glad to provide you with an insurance form that you may submit to your carrier, but I do not accept insurance. I would encourage you to call your insurance carrier to check and see if acupuncture is covered. If so, check to see if you need your primary care physician's referral and diagnostic codes.

___ **Safety** Only pre-packaged sterilized, disposable needles are used and are inserted according to clean procedures based on nationally prescribed standards. To prevent the transmission of infectious disease by physical contact, such as conjunctivitis, the practitioner practices strict hand washing before seeing each patient. If the practitioner is ill, she may postpone treatment until a later day, or use a mask during treatment.

___ **Possible Side Effects/Healing Reactions** As with any treatment, some side effects are possible. These may include temporary pain or discomfort, local bruising, slight bleeding, or swelling. It is also important to be aware of the fact that sometimes a healing reaction follows acupuncture treatment. This may involve the temporary aggravation of pre-existing symptoms. If such a healing reaction occurs, the symptoms typically abate within 24-48 hours after they appear (72 hours for skin problems)

___ **Confidentiality** Information regarding treatment will be kept strictly confidential. Charts and documents are stored safely. No one will have access to treatment records without your written permission.

Print Name of Patient

Today's Date

Signed by Patient (or Guardian)

Signed by Practitioner / Witness

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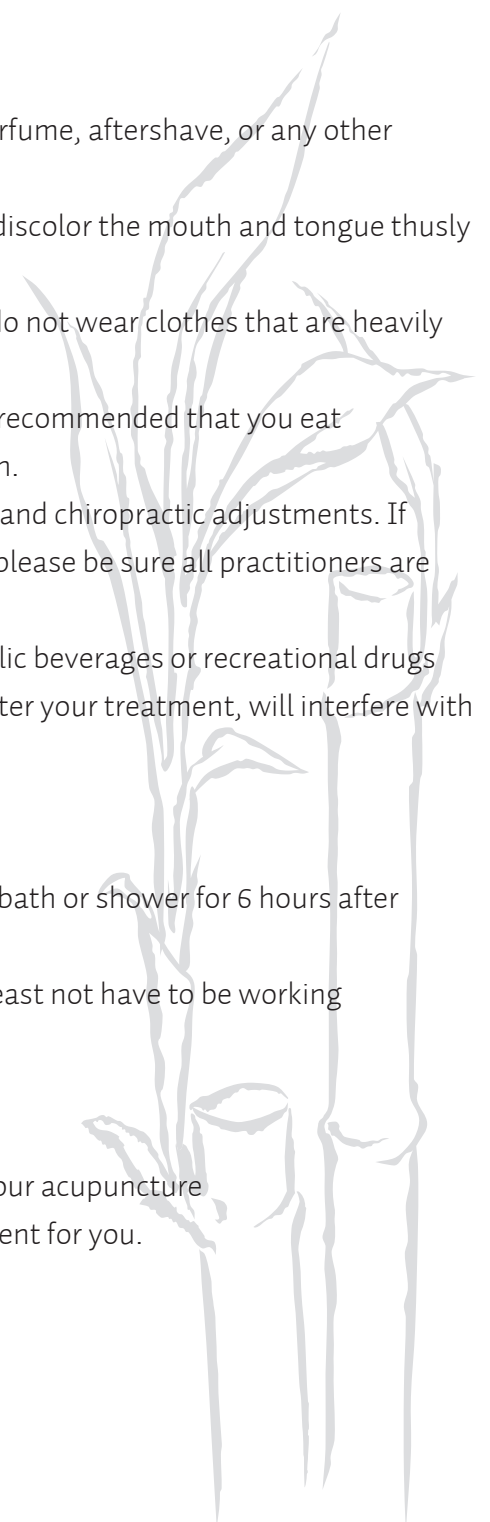
Patient Guidelines

Pre-Treatment

- Due to patients with sensitivities to scents, please refrain from wearing perfume, aftershave, or any other products that are heavily scented to your appointment.
- Please avoid tongue brushing, and chewing gum or eating candy that can discolor the mouth and tongue thusly making the tongue diagnosis less accurate.
- Smoking is not advisable within 1 hour prior to your appointment. Please do not wear clothes that are heavily scented with smoke.
- Please do not eat a large meal immediately before your appointment. It is recommended that you eat something light. It is best not to receive acupuncture on an empty stomach.
- Acupuncture is an excellent adjunct therapy to massage, physical therapy and chiropractic adjustments. If these treatments are on the same day as your acupuncture appointment, please be sure all practitioners are aware of this so that treatments can be adjusted to enhance your therapy.
- Please do not engage in heavy exercise, sexual activity, or consume alcoholic beverages or recreational drugs within 6 hours before or after your treatment. These activities, before or after your treatment, will interfere with the effectiveness of that treatment.

Post-Therapy

- Please refrain from entering a jacuzzi or sauna, or taking an extremely hot bath or shower for 6 hours after your treatment.
- Plan your activities so that after a treatment you can get some rest, or at least not have to be working strenuously. This especially important for the first few visits.
- Continue to take any prescription medications as directed by your doctor.
- Be sure to drink plenty of water after your treatment.
- Remember to keep good mental or written notes on how you respond to your acupuncture treatment. This will help the practitioner design the best follow-up treatment for you.



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Patient Intake Form 1

Date _____

First name _____

Last name _____

Gender: Female Male Age _____ Birth date _____

Height _____ Weight _____

Relationship status: Married Widowed Single Minor Separated
 Divorced Partnered for: _____ (# of years)

Occupation _____

Address _____

City, State and Zip _____

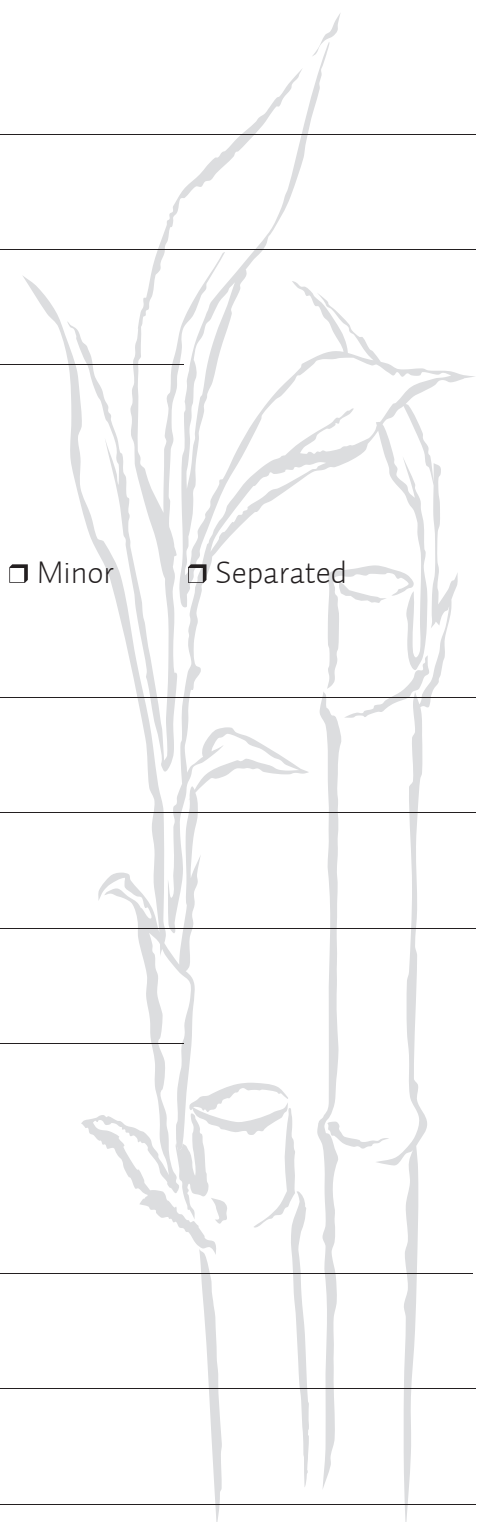
Home phone _____ Work phone _____

Cell phone _____

E-mail address _____

Emergency contact person & phone number _____

Referred to WEEM by _____



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Patient Intake Form 2

Reason for visit today _____

Have you had acupuncture before? YES NO

Have you taken Chinese herbs before? YES NO

How long have you had this condition? _____

Is it getting worse? _____

Does it bother your: Sleep Work Other: _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What makes it worse? _____

Are you under the care of a physician now? YES NO

If yes, for what? Physician's number _____

Who is your physician? _____

Other concurrent therapies _____





Family Medical History

Allergies:	Cancer type:	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
		<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
		<input type="checkbox"/> Alcoholism	<input type="checkbox"/> High Blood Pressure	

Your Past Medical History

Check any of the following conditions you currently have or have had in the past. Also check if you feel any of the following are a significant part of your medical history.

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Major Trauma
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mumps	<input type="checkbox"/> Stroke	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Birth Trauma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pleurisy	Surgeries:	Other:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia		

Your Diet / Appetite

<input type="checkbox"/> Low appetite	<input type="checkbox"/> Coffee	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Sugar	<input type="checkbox"/> Thirst for water.
<input type="checkbox"/> High appetite	<input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Cravings _____	<input type="checkbox"/> Salty Food	# of glasses per day: _____

Average Daily Food Intake

Morning:	Snack:	Noon:	Snack:	Evening:

Pharmaceuticals taken in the last 2 months:

Vitamins / supplements taken in the last 2 months:

Your Lifestyle

<input type="checkbox"/> Alcohol, qty: _____	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Stress	Regular Exercise: Type / Frequency
<input type="checkbox"/> Tobacco, qty: _____	<input type="checkbox"/> Recreational Drugs	<input type="checkbox"/> Occupational Hazards	

General Symptoms

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Recent weight gain	<input type="checkbox"/> Lack of strength	<input type="checkbox"/> Fever	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Heavy appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Bodily heaviness	<input type="checkbox"/> Chills	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Strongly like cold drinks	<input type="checkbox"/> Heavy sleep	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Bleed or bruise easily
<input type="checkbox"/> Strongly like hot drinks	<input type="checkbox"/> Dream-disturbed sleep	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Sweat easily	Peculiar taste:
<input type="checkbox"/> Recent weight loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Muscle cramps	

Head, Eyes, Ears, Nose, Throat, Mouth

<input type="checkbox"/> Glasses	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Color of phlegm	<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Gum problems	<input type="checkbox"/> Recurrent sore throat	<input type="checkbox"/> Earaches
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sore on lips or tongue	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Headaches
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Lumps in throat	<input type="checkbox"/> Migraine
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Excessive saliva	<input type="checkbox"/> Enlarged thyroid	<input type="checkbox"/> Concussions
<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	Head or neck trauma:
<input type="checkbox"/> Poor vision	<input type="checkbox"/> TMJ	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Ringing in ears	



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Patient Intake Form 4

Respiratory

- | | | | | |
|---|--|--|------------------|---|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | Color of phlegm: | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma / wheezing | <input type="checkbox"/> Wet or <input type="checkbox"/> Dry? | | <input type="checkbox"/> Pneumonia |
| | | <input type="checkbox"/> Thick or <input type="checkbox"/> Thin? | | <input type="checkbox"/> Frequent colds |

Cardiovascular

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

Gastrointestinal

- | | | | | | | |
|---|--|--|-------------------------------|-----------------|--------|-------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain or cramping | Bowel movements
Frequency: | Texture / form: | | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Itchy anus | | | Color: | Odor: |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Burning anus | | | | |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Black stools | <input type="checkbox"/> Rectal pain | | | | |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Hemorrhoid | | | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucous stools | <input type="checkbox"/> Anal fissures | | | | |
| <input type="checkbox"/> Bad breath | | | | | | |

Musculoskeletal

- | | | | | |
|---|--|-------------------------------------|--|--------|
| <input type="checkbox"/> Neck / shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | Other: |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use | |

Skin and Hair

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|--|------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair/skin texture | Hair or skin problems: |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections | |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | | |

Neuropsychological

- | | | | | |
|-----------------------------------|--------------------------------------|--|--|--------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered or attempted suicide | Other: |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist | |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | | |

Genito-urinary

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission |

Gynecology

- | | | | | |
|---|--|--|---------------------------------------|-------------------------------|
| Age menses began: _____ | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast lumps | Date of last PAP: _____ |
| Length of cycle (day 1 to day 1): _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal sores | # Pregnancies _____ | |
| Duration of flow: _____ | <input type="checkbox"/> PMS | <input type="checkbox"/> Vaginal odor | # Live births _____ | |
| | | <input type="checkbox"/> Clots | Premature births _____ | |
| | | | Age at Menopause _____ | Date last period began: _____ |

Other: _____