Samantha Mason
Acupuncture and Wellness

3417 Evanston Ave N Suite 418 Seattle, WA 98103
(206) 866-4680 SamanthaMasonLAc@gmail.com

New Patient Questionnaire and Health History

Patient Information

Legal Name_____ Today's date ____ /____ /_____

Preferred Name _____ Date of Birth ____ /____ /_____ Age _____

Address_____ City _____ State _____ Zip _____

Email _____ Best contact Phone # (____)____-_____

Preferred method of contact: ◻ email ◻phone call ◻text message

Emergency Contact _____ Relationship _____ Phone (____)____-_____

Primary Care Provider (MD/ND) _____ Phone (____)____-_____

How did you hear about Samantha Mason Acupuncture and Wellness? _____

Is this your first time receiving acupuncture? ◻ Yes ◻ No
Would you like to be added to the mailing list for wellness updates and specials? ◻Yes ◻No

Insurance & Payment for Care

☐ Self-pay ☐ Commercial health insurance ☐MVA/Car insurance ☐ Workers Compensation

Insured Name (On Card): _____ Insured Date of Birth: _____
Relationship to insured: ☐ Self ☐ Spouse ☐Other _____
Marital Status: ☐ Single ☐ Married ☐ Other _____
Working Status: ☐ Employed ☐ Student ☐ Retired ☐ Other _____
If Employed, Employers Name: _____
Insurance Company: _____ Phone: _____
Send Claims to Address: _____
ID/Policy #: _____ Group #: _____
Secondary Insurance?: ☐ Yes ☐ No (If yes, we will get this information at first visit)

Health Information

What is the primary reason for your visit today? _____
How long has this been a problem? _____
What other treatments have you tried to address this concern? _____
_____

Please list any other health concerns you would like addresssed (physical, mental, emotional):
_____
_____
_____

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Please list any major illnesses, injuries or hospitalizations (with approx. dates):

_____

_____

Please list any medications/supplements you are currently taking:

_____

_____

Do you have any allergies? _____

Review of Symptoms

Please check if you have experienced any of the following in the last three months:

◻Headaches	◻Dizziness	◻Eye pain	◻Dry/itchy eyes
◻Ringing in ears	◻Visual floaters	◻Poor balance	◻Tremors
◻Fatigue	◻ Sweat easily	◻Tend to feel hot	◻Tend to feel cold
◻Insomnia	◻Cravings	◻Weight loss	◻Weight gain
◻Fevers	◻Change in appetite	◻Easy bruising	◻Peculiar taste in mouth
◻Peculiar smells	◻Chills	◻Weak limbs	◻Night sweats
◻Cold hands	◻Cold feet	◻Constipation	◻Diarrhea
◻Gas/bloating	◻Painful urination	◻Poor Appetite	◻Abdominal cramping
◻Hemorrhoids	◻Difficult urination	◻Heartburn/reflux	◻Fatigue after eating
◻Anxiety	◻Depression	◻Panic attacks	◻Suicidal thoughts

Family Medical History (please specify family member)

◻ Cancer _____ ◻ Kidney Disease _____

◻ Heart Disease _____ ◻ Stroke _____

◻ High BP _____ ◻ Diabetes_____

◻ Alzheimer's _____ ◻ Arthritis _____

◻ Osteoporosis _____ ◻ Anxiety _____

◻ Depression _____ ◻ Mental Illness _____

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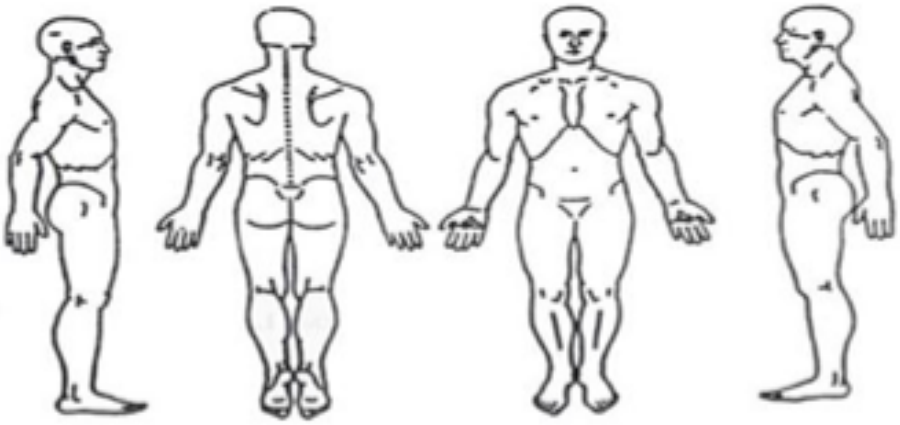
SHOW ALL AREA(S) OF PAIN OR DISCOMFORT Mark the areas on the figures below, using the appropriate symbols, where you feel the described sensations. Mark areas of radiating pain. Include all affected areas.

Numbness	Pins & Needles	Stiffness	Burning	Aching	Stabbing
•••	000	sss	xxx	>>>	////



On a scale of zero to ten, I rate my discomfort as follows:
(0=no discomfort 10=severe-unable to preform daily tasks) 0 5 10

Diet and Lifestyle

Do you have a regular exercise program? If so, please describe_____
_____
_____

Do you have any dietary restrictions?_____

How do you deal with stress in your daily life? _____
_____

What do you do for fun? _____
_____

How many hours of sleep a night on average? _____ Do you wake feeling rested? □Y □N

Is there a time of day when your energy tends to be lowest? _____ highest? _____

Do you smoke cigarettes? □ Y □ N If yes, how often? _____
Do you drink alcohol? □ Y □ N If yes, how many drinks per week? _____
Do you drink caffeine? □ Y □ N If yes, in what form and how often? _____
Have you ever been treated for chemical dependency? □ Yes □ No

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Reproductive Health

Men Only
Do you get regular screening tests done by your doctor (blood work, prostate exam)? □Y □N
Date of last prostate examination? (month/yr) _____ /_____
Have you experienced any of the following:
□ Testicular pain □ Hernia □ Discharge □ Sores □ Numbness/tingling in genitals

Other concerns not addressed:_____
_____

Women Only
Are you currently pregnant? ? □ Y □ N If yes, how many weeks_____
Total number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____

What was the date of your last period? _____ Average length of monthly cycle ____ days
Blood flow: ☐ heavy ☐ light ☐ normal # days of bleeding _____
If you experience cramping, during which part of your cycle? ☐ before ☐ during ☐ after
Date of last Pap? (month/yr) _____/_____ Have you ever had an abnormal Pap? ☐ Yes ☐ No

Have you experienced any of the following in the past or present:
☐ Irregular cycle ☐ Painful cycle ☐ Missed period ☐ Menstrual cramps
☐ Ovarian cysts ☐ Breast tenderness ☐ Clotting ☐ Lumps in breasts
☐ Nipple Discharge ☐ Endometriosis
If you experience cramping, during which part of your cycle? ☐ before ☐ during ☐ after

Do you experience other changes in your body/psyche prior to menstruation (PMS symptoms)?
Please describe:_____
_____

If you are currently using birth control, what type and for how long? _____
Do you experience bladder infections? ☐ Never ☐ Rarely ☐ Frequently
Do you experience vaginal infections? ☐ Never ☐ Rarely ☐ Frequently

Other concerns not addressed:_____
_____

Thank you for taking the time to complete this form

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Consent to Treatment

I voluntarily consent to acupuncture and other procedures associated with the practice of Classical Chinese Medicine provided by Samantha Mason, a licensed acupuncturist in the state of Washington. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that it is recommended that all patients have a primary care provider as part of a complementary care program.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, guasha, cupping, electro stimulation, and bodywork therapies.

Adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of preexisting symptoms. Burns and/or scarring are a potential risk of moxibustion and heat lamp therapy.

I understand that Chinese Herbal Medicine may be recommended and that I am not required to take these substances. If I do decide to take them I agree to follow the directions for administration and dosage. Adverse side effects may result from taking these substances. These include, but are not limited to, changes in bowel movements, temporary abdominal pain or discomfort, and possible temporary aggravation of preexisting symptoms. If I experience any issues that I believe may be associated with the taking of these substances, I agree to contact Samantha Mason LAc as soon as possible with my concerns.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment. I have been informed about the risks and benefits of acupuncture and other associated procedures, and have had an opportunity to ask questions. I understand that this consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be sign by patient's representative if the patient is a minor or physically or legally unable to sign on their own behalf.

Patient Signature: _____ Date: _____

Patient Representative (if applicable): _____

Representative Signature: _____ Date: _____

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Policies and Financial Agreement

To help serve you better, I've listed some guidelines and office policies to review prior to your visit.

ACUPUNCTURE APPOINTMENT GUIDELINES
Initial visits are 90 minutes, follow ups visits are 60 minutes
Please eat at least 2-3 hours prior to your appointment time
Fill out the enclosed forms and bring them to your first appointment
Wear loose fitting clothing if possible

Following your treatment:
Avoid strenuous activity, a few hours of relaxation is best
Avoid alcohol for 24 hours -consuming alcohol may produce adverse effects
Enjoy a light meal including proteins and vegetables. Avoid heavy foods including fried foods, dairy, and desserts. Drink plenty of water

TIME OF SERVICE RATES
Initial Visit 90 min - $105
Follow up Visit 60 min - $85
5 visit package - $400 ($5 off each visit)
10 visit package - $750 ($10 off each visit)
I accept cash, check, and credit card payments. Due at time of service.

INSURANCE POLICY
I am in-network with Premera, Lifewise, United Health Care, Aetna and Cigna. Billing services are also available for some out-of-network plans including Group Health PPO. Superbills can be provided for those interested in submitting for reimbursement on their own. Copay is due at time of service. Coinsurance and deductible will be billed after claims have been submitted.

CANCELLATION POLICY
There is a 24-hour cancellation policy. Please call 206 866-4680 to cancel or reschedule your appointment. All visits cancelled with less than 24 hour notice will be charged the time of service rate

CLIENT ACKNOWLEDGEMENT
I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I understand the contents of this disclosure and agree to abide by these policies.

Patient Signature:_____ Date: _____

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Medical Notice of Privacy Practices

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

We respect our legal obligation to keep health information that identifies you private. We do not use your health information inside our office our outside without your written permission.
In some limited situations, the law requires us to use and disclose your health information without your permission. These examples include:
-For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
-Disclosure to government authorities about victims or suspected abuse, neglect, or violence.
-Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
-Disclosures in response to subpoenas of orders of the court.
-Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.
-Disclosure related to worker's compensation programs.

We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization.

You have the right to:
- request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you.
-The right to amend your protected health information.
-The right to obtain a paper copy of this notice at your request.
-You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services in the event you feel your privacy rights have been violated.

I, _____, (patient name) have read and acknowledge the Notice of Privacy Practices form offered by Samantha Mason Acupuncture and Wellness, have had the opportunity to ask any questions I have regarding this information, and have received a copy of the Notice of Privacy Practices for my own records.

Patient Signature: _____ Date: _____