Optimal Health  Acupuncture 针灸

Welcome to Optimal Health and Bodywork!

We are happy that you have chosen us to assist you in your journey towards optimal health. We understand that it is a process that requires a relationship of trust, confidentiality and compassion. We look forward to serving you! We strive to provide a clinic that is a warm, friendly, and conscious space. Together we can bring balance to your life.

Our goal is to assist you in understanding how the choices you make in all areas of your life affect your health physically, emotionally, mentally, and spiritually. Diet, exercise, mediation, and other lifestyle choices will be addressed. Awareness of these choices is the first step towards regaining control of your health. Once aware, you can then make the necessary changes and begin the journey towards balance.

Many people come in for treatment with the expectation of relieving a particular symptom or set of symptoms. Traditional Chinese Medicine treats not only symptoms, but the underlying causes or roots of these imbalances. Once the root causes are addressed you may experience other positive changes in your being, such as increased energy and more restful sleep.

During the course of treatment you may receive instructions for your care. It is important for you to follow the treatment plan and other recommendations to achieve optimal care. Working together we can more effectively treat your original concerns and any other underlying issues.

As questions arise, feel free to email me or call the office. Outside of office hours, all calls are forwarded to my cell.

In Good Health,

Glenn Sadowsky, L. Ac.

We look forward to your first consultation and session on _____.

Please note the following for your first appointment:

- Expect to be here for 1½ to 2 hours as the initial consultation may take up to 1 hour.
- Bring all supplements, herbs, and medications you are currently taking.
- Fill out the enclosed Patient Intake Form and bring it in with you.
- Eat a small meal or snack before your treatment.
- Please refrain from stimulants such as coffee, tea, soda, sugar, tobacco, alcohol, and chocolate several hours prior to treatment.

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After Your First Treatment

How will I feel after a treatment?

It really depends. Sorry for the vague answer, but sometimes people feel very rested and have more energy than they know what to do with. Others are tired and feel the need to relax. Use your energy wisely after a treatment. I do recommend that you avoid excessive physical exercise for a few hours after treatment.

Drink plenty of water.

This will help flush the toxins and to help with releasing blocked energy. You normally should be drinking ½ ounce for every pound of body weight. In circumstances of disharmony more water may be needed to aid in the healing process.

What you may receive today or during the course of treatment:

Herbal Prescriptions

These are for your use only. Take as directed finish any recommended doses, even if you are feeling better. If you have any questions, call. If you experience any changes in your mood, sleep pattern, digestion, emotions, or energy that are unpleasant, call.

Herbal Cream or Patches

These have Chinese Herbs in them that will increase circulation and release muscle spasms (hyper tonicity). Do not leave patches on longer than overnight and watch for itching or skin irritation. If either occurs, remove patches and discontinue use. You are most likely having an adverse reaction to the adhesive.

Ear Seeds

These are designed to activate acupuncture points in the ear corresponding to a disharmony in the body. Stimulate the points three times per day by putting pressure on each seed until you feel the ache or pressure of the acupuncture point. Keep the ear seeds on for three days and remove. If they interrupt your sleep, remove them. Sleep is more important. You may leave them on when showering or bathing – just towel dry.

Enjoy a Healthy Lifestyle and Diet.

There may be dietary or lifestyle recommendations made at any of your appointments. This is an opportunity for you to be involved in your journey towards optimal health. Your participation is an important part of the process and often requires changes in your beliefs about health as well. If you have any questions – call. I'll be there to answer when I can.

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Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address if different from above: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

S.S.N. _____ Sex: M F D.O.B. _____ Age: _____

Marital Status: Married Single Separated Divorced Widowed

Occupation: _____ Phone: _____

Children and Ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you had Acupuncture or Oriental Medicine before? Yes or No

Family Physician: _____ Contact: _____

May we contact them Y / N Are you presently under a doctor's care? Y / N

Who and for what? _____

Are there any other therapies which you are involved? Yes or No

Who and for what? _____

Primary Ins. Co _____ Phone # _____
Policy # _____
Group # _____
Address _____
_____

Name of Insured: _____ Date of Birth: _____
S.S.N. _____ Employer _____
Patient's Relationship to insured:

Self Spouse Child Other

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Auto Insurance (If Applicable)

Insurance Company Name: _____ Phone #: _____

Policy # _____ Name of Insured _____ Relationship _____

Ins. Co. Address: _____ City: _____

State: _____ Zip: _____

Claim # _____ Adjustor's name & # _____

Workers Compensation Information (If Applicable)

Employer's Name at time of injury _____ Date of injury _____

W/C Ins. Co. Name: _____ Phone # _____

Ins. Co. Address: _____ City: _____

State: _____ Zip: _____

Claim # _____ Adjustor's name & # _____

Assignment of Benefits

I hereby assign, transfer, and set over to Optimal Health Acupuncture and Bodywork, Glenn Sadowsky, L. Ac. all of my right, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. Understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date: _____

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What is your primary reason for seeking care at our office? _____

_____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

_____Work _____ Sleep _____Walking _____ Sitting _____ Standing _____ Emotional

_____ Relationships _____ Social Life _____ Sexually _____ Recreation _____ Bending

What have you done about this? _____

Are you interested in:

_____Pain Relief _____ Preventative Care _____Oriental Nutrition _____ Performance Care _____ Herbal Therapy

_____ Holistic Health _____ Meridian Yoga _____ Maintenance Care _____ Stress Relief _____ Other

What are your goals? _____

_____

Doctor's Notes: _____

_____

_____

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What are your health goals? _____

List any past or future surgeries _____

_____

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc...) _____

_____

List excercise and sports activities you have been or are currently involved in: _____

_____

IV Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth/gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss/gain
- ❍ Wheezing

V Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N Is your cycle painful? Y/N Have you ever been pregnant? Y/N

Birth control? Y/N How long? _____ ❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

VI Medical History

Do you have any allergies? Y/N _____ If so, to what? _____

Do you take medication? Y/N _____ If so what types and how often _____

Do you take supplements? Y/N _____ If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

VII Web of Wellness

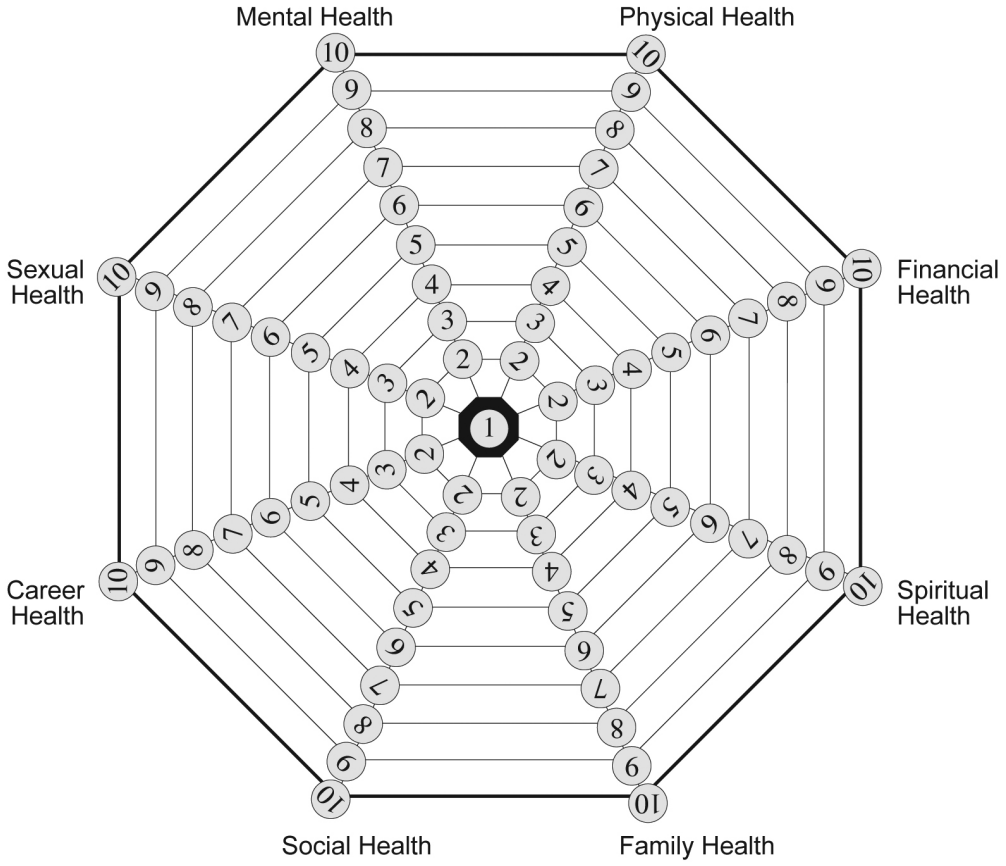
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



VIII Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit

Please mark areas where you are experiencing pain

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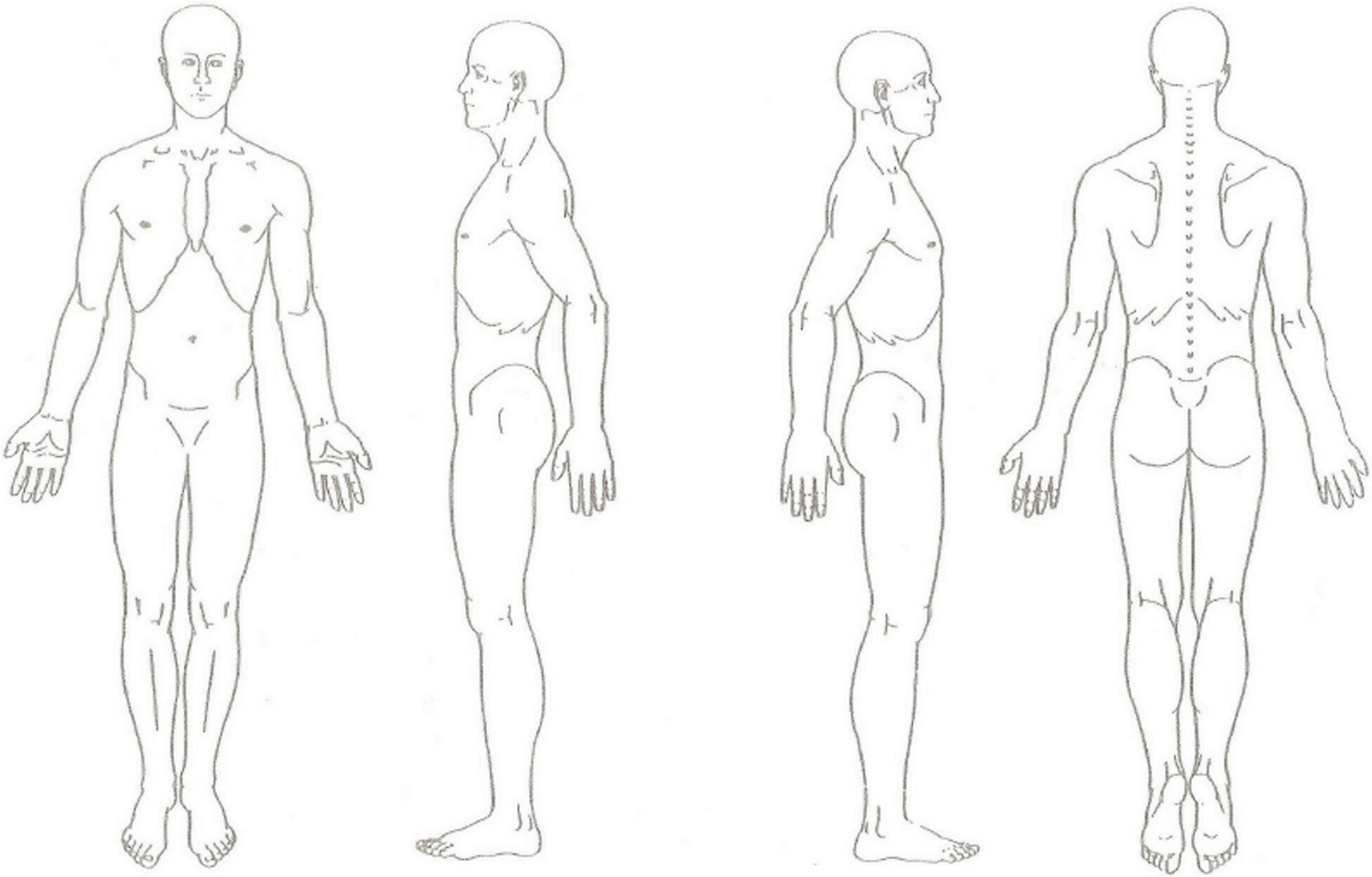

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Types of Care

Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

When a client seeks acupuncture health care and I accept a patient for such care, it is essential for both to be working toward the same objectives.

Acupuncture is focused upon a few goals: to detect and correct the quality, quantity and balance of Qi, Blood, and other body fluids. When this is done correctly, the body will have the capacity to obtain and maintain health and well-being.

It is important that each client understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Acupoint stimulation: The insertion of sterile acupuncture needles cause a specific stimulation of an acupoint. This will facilitate the normal and balanced flow of Qi through the Meridian pathways.

Health: A state of optimal physical, mental and spiritual well-being, not merely the absence of infirmity.

Qi imbalance: When the quality, quantity and balance of Qi is disrupted, it causes illness and disease. An imbalance in any of the 14 main meridian channels causes an alteration in the flow of Qi through the entire body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential

I do not offer to diagnose or treat any disease or condition other than the quality, quantity and balance of Qi. However, if during the course of an acupuncture examination I encounter non-acupuncture or unusual findings, I will advise you. If you desire advice, diagnosis or treatments of those findings, I will recommend that you seek the services of a health care provider qualified to treat those problems.

Regardless of what a disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. The ONLY practice objective is to detect and correct imbalances within Meridian pathways using Acupuncture and Chinese medical techniques. This can help to facilitate healing and a potentially lead to a full expression of your body's innate wisdom.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept acupuncture care on this basis.

(Signature) _____ (date) _____

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Cancellation Policy
For all Cash and Insurance Patients

All fees for services are due at the time of each appointment. In order for us to provide efficient and consistent care for all of our patients, we discourage canceling appointments if at all possible. If you cannot keep an appointment, please notify us 24 hours in advance so we may give up your time to another patient. Failing to attend your scheduled appointment or call to cancel with sufficient notice will result in a $40 charge to be paid prior to the next appointment. If you call to cancel on the same day, and reschedule for the same work week, we will not charge you for a late cancelation. Your signature below indicates your understanding of this policy.

Thank you for choosing Optimal Health Acupuncture and Bodywork, and for your cooperation and commitment to your well being.

Name_____ Date_____