Foster Wellness

Greg Lewerenz, EAMP, LMP • 4300 – 36th Ave W, Ste 130, Seattle WA 98199
(206) 856-4096 • info@fosterwellness.com

Supplemental Form for Treatment by Acupuncture and Chinese Medicine[1]

(please print and complete in full)

Name: ______________________________ Today's Date: ________________

Address: ______________________________ Zip Code: ___________________

Medical History and Current Presentation

Have you ever had an acupuncture treatment? When and for what reason?__________________

____

Are you presently being treated for a medical condition? Please describe.__________________

____

What main health issue do you want treated? Please describe as fully as possible, including when the condition first manifested:____

____

____

____

What treatment have you been using for relief of this issue?__________________________

____

Do you have other health concerns? If so, please describe______________________________

____

Please describe the type of foods you eat regularly:

Breakfast____

Lunch____

Dinner____

Snacks/Other Meals____

Do you exercise? Yes No

What type of exercise do you do and how often?____________________________________

____

[1] To be completed by those who have been previously treated at Foster Wellness for massage but not acupuncture or Chinese medicine.

How do you feel about the following areas of your life? Please circle appropriate description and indicate any problems you may be experiencing. Answers to these questions help to identify the root cause of your current symptoms and thus contribute to determining the most effective treatment approach.

						Comments
Spouse/ significant other	great	good	fair	poor	bad	____
Family	great	good	fair	poor	bad	____
Diet	great	good	fair	poor	bad	____
Sex	great	good	fair	poor	bad	____
Self	great	good	fair	poor	bad	____
Work	great	good	fair	poor	bad	____

Family History - *please complete for self and for family members (as known), checking appropriate line.*

	Self	Mother	Father	Sister	Brother	Child	Grandparent
Allergies							
Blood disorder/anemia							
Diabetes							
Cancer or tumors							
Seizures							
High Blood Pressure							
Kidney or bladder disorder							
Stomach or intestinal disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other							
Age at Death (as applicable)							

Previous Pregnancies:

Total Pregnancies_____ Living_____ Ectopic_____ Miscarriages______ Induced Abortions______

Habits - *Please indicate the use and frequency of the following and, if quit, the age stopped.*

Alcohol:

____

Tobacco:

____

Caffeine:

____

Other mind-altering substances used on a continuous basis, including prescription medications used for nonmedical reasons: ____

Other habits you might think are relevant to your current condition:_____________________________________

____

Foster Wellness

4300 – 36th Ave W, Ste 130, Seattle WA 98199 • (206) 856-4096 • info@fosterwellness.com

Patient Treatment Consent, Payment and Cancellation Agreement

Patient's Name:____

Date of Birth: ____Age:_______________

I, the undersigned, hereby consent for Foster Wellness to perform treatment utilizing acupuncture and massage therapy on me (or on the patient named above for whom I am legally responsible). I understand that methods of acupuncture may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, acupressure/tui-na (Chinese massage), gua sha (dermal friction technique), Chinese herbal medicine, and dietary advice based on Chinese medical theory. I understand that methods of massage treatment may include, but are not limited to: Swedish (petrissage and effleurage), trigger point (holding points of tight tissue to achieve myofascial release), deep tissue (slower and deeper strokes in smaller areas as compared to Swedish techniques), Chinese tui-na (including acupressure, rolling, tapotement, and other techniques to bring the body into balance), and stretching (passive or active movements to lengthen muscular tissue).

I understand that the beneficial effects associated with these treatments include decreased pain, reduced muscle spasm, and improved mobility. I understand there is no certainty that I will achieve these benefits.

I agree to follow the advice given to me by my acupuncturist and massage practitioner. I understand I might be dropped from the program for refusal to do so.

I understand that acupuncture and associated treatments are generally safe methods of treatment, but risks may include pain or discomfort during the treatment, fainting/needle sickness, broken needles, bleeding, burning and/or scarring of the skin, infection, organ puncture, bruising (for example, bruising is a common side effect of cupping), pain following treatment in the insertion area, spontaneous miscarriage, pneumothorax, or allergic reactions to ingested herbal medication. I also understand that there are some very slight risks associated with massage, including but not limited to bruising and muscle soreness.

I will notify the acupuncturist at Foster Wellness *prior to treatment* if I have a severe bleeding disorder or pacemaker, or if I am or become pregnant over the course of treatment.

I understand that all needles utilized for the acupuncture treatments are prepackaged, sterile, single-use needles that have never before been used and will be disposed of after each treatment.

I understand that reasonable alternatives to the treatments described above include the following:

<u>Medications</u>: I understand that medications can be used to reduce pain. I also understand that medications may produce inadequate relief, side-effects, and physical or psychological dependence.

<u>Surgery</u>: I understand that surgery can reduce pain associated with certain conditions. I also understand that surgery may lead to unsuccessful outcome, complications, and side effects related to anesthesia.

<u>Non-treatment</u>: I understand the risks for non-treatment may include increased pain.

I understand that a $40 late fee may be incurred for a cancellation within 24 hrs of my appointment; this fee will be paid by me and cannot be billed to my insurance plan. If I have medical insurance, I hereby authorize and assign my insurance benefits to be paid directly to Foster Wellness. I understand that I am financially responsible for any services not covered by insurance. I also authorize Foster Wellness to release information in order to process any claims.

I hereby certify that I have read (or have had it read to me) and understand all of the above. I may have a copy of this form for my records upon request.

Signature:____Date:_____________
(If patient is a minor, please have parent /guardian sign)

Clinician:____Date:_____________

Greg Lewerenz, EAMP, LMP
WA State Acupuncture License #AC60114046 • WA State Massage License #MA00023193
Seattle Institute of Oriental Medicine, Masters of Oriental Medicine, Sept. 2006-Aug. 2009

Foster Wellness

4300 – 36th Ave W, Ste 130, Seattle WA 98199 • (206) 856-4096 • info@fosterwellness.com

Patient Notification of Qualifications and Scope of Practice

Washington State law requires East Asian medicine practitioners inform the public of a practitioners' scope of practice and qualifications. (Per 18.06.130 RCW) The practitioner must provide this form to each patient in writing prior to or at the time of the initial patient visit. (Per 246-803-300 WAC)

East Asian medicine means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. My qualifications include the following education and license information:
   a) Acupuncture:
      - Licensure:
        - Washington State East Asian Medicine Practitioner License #AC60114046
        - Idaho State Acupuncture License #ACU-271
      - Education: Seattle Inst. of Oriental Medicine, Masters of Oriental Medicine; 8/2009
      - Certifications: National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), Board Certified Diplomate in Oriental Medicine

   b) Massage:
      - Licensure: Washington State Massage License #MA00023193
      - Education: Inland Massage Inst., Massage Therapy Prof. Licensing Program; 8/2006
      - Certifications: National Certification Board for Therapeutic Massage and Bodywork (NCBTMB), Board Certified, Nationally Certified in Therapeutic Massage and Bodywork

2. The scope of practice for an East Asian medicine practitioner in the State of Washington includes:
   (a) Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
   (b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
   (c) Moxibustion;
   (d) Acupressure;
   (e) Cupping;
   (f) Dermal friction technique;
   (g) Infra-red;
   (h) Sonopuncture;
   (i) Laserpuncture;
   (j) Point injection therapy (aquapuncture); and
   (k) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
   (l) Breathing, relaxation, and East Asian exercise techniques;
   (m) Qi gong;
   (n) East Asian massage and tuina, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
   (o) Superficial heat and cold therapies.

3. Side effects may include, but are not limited to:
   (a) Pain following treatment;
   (b) Minor bruising;
   (c) Infection;
   (d) Needle sickness; and
   (e) Broken needle.

4. The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.

Date presented to patient:________________________________

Patient's initials:__________________________ Practitioner's initials: __________________________