CLINIQUE ASIATIQUE

Welcome to CLINIQUE ASIATIQUE!

Below is a brief introduction to the clinic and a description of what you can expect to experience during your first appointment with MALU.

BEFORE THE VISIT
Please complete the forms in this Welcome Packet in advance and bring with you, along with any Western medical test results that are relevant to your condition, to your appointment. If your health concern is Gyn or fertility-related, please also download & fill out the appropriate Questionnaire.

In order to derive the most benefit from your treatment, we recommend that you:

- do not scrape or brush your tongue 24 hours prior to your appointment
- wear loose-fitting clothing
- eat something—do not come to your appointment on an empty stomach
- avoid vigorous activity, coffee & alcohol a few hours before your appointment

THE VISIT

1. Your first appointment with MALU will last about 1 hour.
2. After going over your health history and examining your tongue & pulse, MALU will formulate a traditional Chinese medical diagnosis based on your unique history and set of symptoms and on which your acupuncture treatment will be based.
3. You will be taken to a treatment room for your acupuncture treatment. Approximately 6 to 10 acupuncture points will be cleaned with alcohol and MALU will then insert very thin, sterile, disposable needles. You should feel little or no sensation or discomfort.
4. The needles will be left in place for 20-30 minutes. Most patients find the treatment relaxing and many meditate or sleep. Should you, however, feel any discomfort, please let MALU know right away and she will make an adjustment.
5. In Traditional Chinese Medicine, herbs are an essential part of the treatment and MALU will ask if you are interested in taking an herbal formulation.
6. At the end of your rest, the needles will be removed and MALU will describe how your herbal formulation should be taken. MALU may also give you dietary recommendations and propose a treatment plan for continued treatment of your health concern.

AFTER THE VISIT

1. Plan to take it easy after your treatment.
2. Some people feel a little light-headed after treatment. If that is the case with you, please sit for a while in the waiting room. The feeling should pass after a few minutes.
3. Very rarely, symptoms may become worse following treatment. This is often a sign that previously dormant conditions are being awakened so that healing may occur.

Payment & Insurance
Payment may be made in the form of cash or check and must be paid at the time services are rendered. We do not provide insurance billing services. We can, however, provide you with a “superbill” that you can submit to your insurance company for reimbursement directly to you. Not all insurance companies provide coverage for alternative health treatments. Thus, we recommend that you call your insurance company prior to your first appointment to verify what type of coverage for acupuncture, if any, is permissible under your policy.

Cost of the initial visit is $150; follow-up visits are $100.

Cancellation or Reschedule Policy
Your appointment time is reserved specifically for you. Please provide at least 24 hours notice if you must cancel or reschedule your appointment to avoid being charged the full fee for a visit.

Please feel free to contact MALU at any time if you have any questions.

Confidential
Contact Information

CLINIQUE ASIATIQUE

NAME (LAST, FIRST, MIDDLE)	AGE	DATE

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Email Address: ______________________

Date of Birth: ______________________ Marital Status: ______________________

Occupation: ______________________ Place of Work: ______________________

Primary Care MD: ______________________ Tel #: ______________________

Emergency contact, relationship & phone #s: ______________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________

Do you require a Superbill for insurance? ______________________

ACKNOWLEDGEMENT

Please read & initial below:

_____ CLINIQUE ASIATIQUE may call me regarding my appointments or treatments at the following phone numbers: ______________________

_____ I agree to pay for services at the time they are rendered.

_____ I understand that I may be charged the full fee for a visit if I do not give at least 24 hours prior notice to cancel or reschedule an appointment.

_____ I am aware that the cost of herbs or supplements is additional to the cost of treatment.

_____ I received, read, understood & signed the form entitled "Informed Consent to Treatment."

Please indicate your understanding and acceptance of these policies by signing below.

Patient Name: ______________________
(please print)

Patient Signature: ______________________

Date: ______________________

Patient Name: ______________________
(if other than self)

Representative Signature: ______________________
(if applicable)

Relationship with Patient: ______________________
(if applicable)

Confidential
Health History

CLINIQUE ASIATIQUE

Welcome to CLINIQUE ASIATIQUE. To help us provide you with the best possible care, please fill out this form as accurately as possible. All information will be kept confidential.

NAME (LAST, FIRST, MIDDLE)	DATE

Reasons you are coming to see us:______________________________

When developed & how? ______________________________

Have you had this condition in the past? ☐ no ☐ yes When: ______________
What treatment did you receive? ______________________________
What other healthcare are you currently receiving? ______________________________

Primary Care MD ______________________ Tel #: ______________
When was your last physical exam? ______________________________
Your most recent blood pressure reading was: ☐ normal ☐ high When was this reading taken? ______________
Height _________ Current Weight: __________ Past Maximum Weight ____________ When? ______________

Please answer the following questions:

Have you had acupuncture before? ☐ no ☐ yes
Do you catch colds easily? ☐ no ☐ yes
Do you often feel thirsty? ☐ no ☐ yes
Do you bruise or discolor easily? ☐ no ☐ yes
Do you have a tendency to feel hot? ☐ no ☐ yes
How would you describe your stress level? ☐ low ☐ moderate ☐ high
How would you describe your energy level? ☐ low ☐ normal ☐ high

Are you pregnant at this time? ☐ no ☐ yes
Do you sweat easily? ☐ no ☐ yes
Do you get hungry easily? ☐ no ☐ yes
Do you have any problems sleeping? ☐ no ☐ yes
Do you have a tendency to feel cold? ☐ no ☐ yes

OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1				
2				
3				

MEDICATIONS *(List all prescriptions and over-the-counter drugs used during the past year)*

Date	Dose and Frequency	From when to when	Reason
1			
2			
3			

NUTRITIONAL AND HERBAL SUPPLEMENTS

Date	Dose and Frequency	From when to when	Reason
1			
2			
3			

ALLERGIES

Drug or Substance	When	Reaction
1		
2		

LIFESTYLE

Do you typically eat at least three meals per day? ☐ yes ☐ no If no, how many? ______________________

Please briefly describe your diet: ______________________

Dietary restrictions: ______________________

Exercise (type, frequency): ______________________

Spiritual practice, if any: ______________________

How many hours per night do you sleep: __________ Do you wake up rested? ☐ yes ☐ no

Level of education completed: ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate Other ______________

Occupation: ______________ Employer: ______________ Hrs/Week: ________

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? ______________

Caffeine (cups/day): ______________________

Nicotine (packs): ______________________

Alcohol (type, amount per week): ______________________

Interests and hobbies: ______________________

FAMILY HEALTH HISTORY

	Living	Age or age at death	Health Problems
Mother			
Father			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			

Which of your blood relatives have?

Cancer (type): ______________________
Venous thrombosis (blood clotting) ______________________
Diabetes ______________________
Hypertension ______________________
High cholesterol ______________________
Heart disease ______________________
Stroke ______________________
Thyroid problems ______________________
Premature menopause ______________________
Endometriosis ______________________
Uterine fibroids (myomas) ______________________

REVIEW OF SYSTEMS

Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood swings	Nervousness	Mental tension	Anxiety/worry
Irritability	Frequent crying	Anger	Fear
Restlessness	Confusion	Depression	Suicidal

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue	Slow Wound Healing	Chronic Infections	Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts
Tearing/Dryness	Impaired Hearing	Ear Ringing	Earaches
Sinus Problems	Nose Bleeds	Hay Fever	Frequent Sore Throats
Teeth Grinding	TMJ/Jaw Problems		

Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Difficulty Breathing	Emphysema	Frequent Common Colds
Persistent Cough	Pleurisy	Asthma	Shortness of Breath

Other Respiratory Problems: ____

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling Ankles	High Blood Pressure
Palpitations/Fluttering	Heart Murmurs	Stroke	Rheumatic Fever

Varicose Veins Other Cardiovascular Problems: ____

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Abdominal Pain	Gall Bladder Disease	Liver Disease	Hemorrhoids	Hepatitis B or C	Belching

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent Bladder Infections	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

Menstrual/Birth History:

1. Age of First Menses: ______
2. # of Days of Menses: _____
3. Length of Cycle: _________
4. Birth Control Type: _______
5. # of Pregnancies: _________
6. # of Miscarriages: ________
7. # of Abortions: _____
8. # of Live Births: _________

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties   Prostrate Problems   Testicular Pain/Swelling   Penile Discharge

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain Upper Back Pain   Mid Back Pain

Lower Back Pain   Leg Pain   Joint Pain (if so, where?): ____________________________

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet

Any other information about your health that you would like to add:

CLINIQUE ASIATIQUE

I hereby request and consent to the performance of acupuncture & other Oriental medical procedures, including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist &/or other licensed acupuncturist who now or in the future may treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office or clinic, or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electric stimulation, Chinese or Western herbs, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying perception of pain, and treating certain diseases or dysfunctions of the human body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be bruising or tingling near the needling sites that may last for a few days.

The herbs & nutritional supplements (which are from plant, animal or mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all the risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based on the facts then known, is in my best interest.

I understand that the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent, and by signing below I agree to the above named procedures. 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 may seek treatment.

Name of Treating Acupuncturist: Malu Rydfors, M.S., L.Ac., Dipl. O. M.

Patient Name: ______________________________
(please print)

Patient Name: ______________________________
(if other than self)

Patient Signature: ______________________________

Patient Representative's Signature: ______________________________
(if applicable)

Date signed: ______________________________

Relationship with Patient: ______________________________
(if applicable)

Are you pregnant? ☐ Yes ☐ No

Address: ____

Phone: ____________________ Email: ____