Provider: Jacob Godwin, DAOM, LAc | 1625 W 4th Avenue Spokane, WA 99201 | (509) 638-0808

NEW PATIENT FORM

DEMOGRAPHIC INFORMATION

Full legal name (*first, middle, last*): _____

What name do you go by? (if different from above):_____

Date of birth:_____ Race/Ethnicity: _____

Gender: ☐ M ☐ F ☐ Other

Street address:_____

City:_____State:_____Zip:_____

Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Other

Home phone#:_____Cell phone#:_____Work#:_____

Email:_____

How did you hear about us?_____

Who is your current primary care physician?_____

Where do you see your primary care physician (contact info)? _____

Name of your primary medical insurance company:_____

Insurance ID/Policy/Subscriber number: _____

Name of your secondary medical insurance company:_____

Insurance ID/Policy/Subscriber number: _____

Do you have any other insurance plans? ☐ YES ☐ NO

Is your condition related to a motor vehicle accident? ☐ YES ☐ NO

Do you have an open personal injury claim? ☐ YES ☐ NO

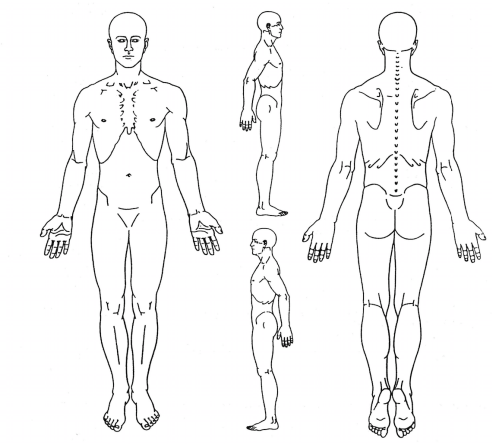
Our office uses electronic appointment reminders. Please select your preferences below (check all that apply).

1st reminder: ☐ none ☐ voice to cell ☐ voice to home ☐ text ☐ email

2nd reminder: ☐ none ☐ voice to cell ☐ voice to home ☐ text ☐ email

PAIN QUESTIONNAIRE

On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



What date did this pain begin? _____

How did the pain start? ○ Suddenly ○ Gradually

Have you had this before? ○ Yes ○ No

How frequent is this pain?

○ Constant (76-100% of the time) ○ Frequent (51-75% of the time)

○ Intermittent (26-50% of the time) ○ Occasional (0-25% of the time)

Have you seen your primary physician for this? ○ Yes ○ No

What diagnosis, if any, have you been given for this? _____

Have you had imaging (x-ray, MRI, etc.) for this? ○ Yes ○ No

Have you seen an acupuncturist before? ○ Yes ○ No

Please **rate your pain** by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

Please **rate your pain** by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

Please **rate your pain** by circling the one number that best describes your pain on the **average**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

Please **rate your pain** by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

Are you interested in ○ **Acupuncture** only, or ○ **Acupuncture** and **herbal medicine** for your condition?

Herbal supplements are not covered by most insurance plans.

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YOUR MEDICAL HISTORY

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypertension
- ☐ Fibromyalgia
- ☐ Spondylitis
- ☐ Rheum. Arthritis
- ☐ Osteoarthritis
- ☐ Scoliosis
- ☐ Epilepsy
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Vasovagal Synd.
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia

Other(s):_____

Female Reproductive Health

Number of pregnancies:_____ Number of live births:_____ Number of living children:_____

Is your menstrual cycle: ☐ short (*shorter than 28 days)* ☐ long (*longer than 28 days*) ☐ irregular

Do you have ☐ premenstrual irritability ☐ premenstrual sadness/depression ☐ painful period cramps

SURGICAL HISTORY

Please list **any** surgeries including **reason and date**:

Date:_____Procedure:_____Reason:_____

Date:_____Procedure:_____Reason:_____

Date:_____Procedure:_____Reason:_____

Date:_____Procedure:_____Reason:_____

FAMILY HISTORY

Please check any diseases in your family medical history. Indicate who has/had the disease in the space provided after each selection (eg. ☒ Spondylitis:__Mother____)

- ☐ Diabetes:_____
- ☐ Heart disease:_____
- ☐ High blood pressure:_____
- ☐ Fibromyalgia:_____
- ☐ Spondylitis:_____
- ☐ Rheum. arthritis:_____
- ☐ Osteoarthritis:_____
- ☐ Scoliosis:_____
- ☐ Epilepsy:_____
- ☐ Stroke:_____
- ☐ Heart disease:_____
- ☐ Cancer:_____

SOCIAL HISTORY

Do you currently smoke tobacco? ☐ YES ☐ NO Have you ever smoked tobacco? ☐ YES ☐ NO

If yes, when did you quit: _____ Do you have any history of substance abuse? ☐ YES ☐ NO

If yes, please describe:_____

Please list significant life changes in the past 5 years (*i.e. divorce, lost job, etc.*):

_____

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MEDICATIONS & SUPPLEMENTS

Please include ALL prescription medications and their dosage (eg. 300 mg 3x a day). You may also provide your own list.

Drug:_____Dosage:_____Reason:_____

Drug:_____Dosage:_____Reason:_____

Drug:_____Dosage:_____Reason:_____

Drug:_____Dosage:_____Reason:_____

Drug:_____Dosage:_____Reason:_____

Drug:_____Dosage:_____Reason:_____

List any supplements or over-the-counter medications you are taking

_____

List any allergies or sensitivities (*to medications, chemicals, or foods*)

_____

REVIEW OF SYSTEMS

General
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight loss
- ☐ Fever
- ☐ Chills

Head Eyes Ears Nose Throat
- ☐ Headaches
- ☐ Vertigo
- ☐ Dizziness
- ☐ Vision changes
- ☐ Ringing in ear
- ☐ Loss of hearing
- ☐ Sinus infections
- ☐ Allergies
- ☐ Grind teeth at night
- ☐ Difficulty swallowing

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Chest pain
- ☐ Irregular heart beat

Respiratory
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Asthma

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Acid reflux/GERD
- ☐ Blood in stool
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Gallbladder disorder

Genitourinary
- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Urgent urination
- ☐ Hesitancy/Dribbling

Musculoskeletal
- ☐ Pain
- ☐ Stiffness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramps
- ☐ Edema
- ☐ Arthritis

Neurological
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness/tingling
- ☐ Heaviness in limbs
- ☐ Paralysis
- ☐ Weakness

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Stress
- ☐ Irritability

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TREATMENT RESTRICTIONS

You must select one of the following:

It is important that you let us know if any of the following conditions currently apply to you**. It is also important that you let us know if any of the following conditions becomes applicable during your course of treatment with us.**

- ☐ Pacemaker
- ☐ Electrical implants
- ☐ Metal implants
- ☐ Bleeding disorders
- ☐ Taking blood thinners
- ☐ Pregnant
- ☐ Trying to get pregnant
- ☐ Breastfeeding
- ☐ Hepatitis A/B/C
- ☐ Epileptic
- ☐ Faint easily
- ☐ Food allergies
- ☐ None of these applies

Patient Signature _____ Date _____

Patient guardian signature (required if patient is under 18 years-old) _____ Date _____

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Informed Consent

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, infra-red therapy, electrical stimulation, and cupping are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my acupuncturist can modify my treatment plan accordingly.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my existing medical records and produce medical records including clinical notes, diagrams and photographs, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

I understand that, though Godwin Acupuncture and Oriental Medicine may bill my insurance company on my behalf, this is a courtesy and that **it is my responsibility to ensure that all fees are paid.** I understand that, should my insurance policy fail to pay them, I am responsible for paying any and all fees for which Godwin Acupuncture and Oriental Medicine bills me.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

_____

Patient Signature Date

_____

Patient guardian signature (required if patient is under 18 years-old) Date

Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data.

I. How we may use and share health data about you:
a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, coordination with your primary care physician, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Patient Signature Date

_____

Patient guardian signature (required if patient is under 18 years-old) Date

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Patient Notification of Qualifications and Scope of Practice

Pursuant to state law 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.

My qualifications include the following education and license information:

Doctoral Degree in Acupuncture and Oriental Medicine (OCOM)
Board Certified Diplomate in Oriental Medicine (NCCAOM)
Washington State East Asian Medicine Practitioner License (AC60129504)

The scope of practice for licensed acupuncturist (LAc) in the State of Washington includes the following:

1) Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
2) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
3) Moxibustion;
4) Acupressure;
5) Cupping;
6) Dermal friction technique;
7) Infra-red;
8) Sonopuncture;
9) Laserpuncture;
10) Point injection therapy (aquapuncture); and
11) 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;
12) Breathing, relaxation, and East Asian exercise techniques;
13) Qi gong;
14) East Asian massage and Tui na, 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
15) Superficial heat and cold therapies.

Side effects may include, but are not limited to:

1) Pain following treatment;
2) Minor bruising;
3) Infection;
4) Needle sickness; and
5) Broken needle.

The patient must inform the acupuncturist if the patient has a severe bleeding disorder or pacemaker prior to any treatment.

_____

Patient Signature Date

_____

Patient guardian signature (required if patient is under 18 years-old) Date