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:_____

Which do you prefer for confidential contact: ☐ Home# ☐ Cell# ☐ 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)? _____

Have you seen an acupuncturist before? ☐ YES ☐ NO

If yes, whom?_____when?_____for what?_____

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

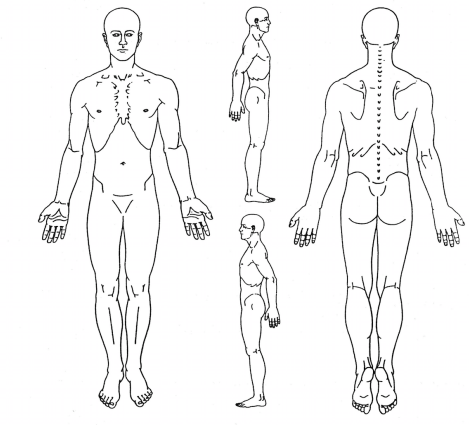
Do you have an open personal injury claim? ☐ YES ☐ NO

Do you require interpreter services? YES NO

PAIN INVENTORY

Name:_____ **Date:**_____

1. 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

3. 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

4. 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

5. 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

6. 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

7. What treatments or medications are you receiving for your pain?

_____

_____

Patient Signature Date

_____

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

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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, moxibustion, 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. Potential risks of moxibustion health therapy are burns, blistering, or scarring. 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 practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

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 medical records and lab reports, 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. I understand that I am responsible for the full appointment fee if I do not give 24 hours notification for missed appointments. I understand that insurance companies do not reimburse for missed appointments.

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.

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

Receipt of Privacy Practices

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

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:

(a) Acupuncture, including the use of acupuncture needles or lancets to directly and 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) Infrared;
(h) Sonopuncture;
(i) Laserpuncture;
(j) Point injection therapy (aquapuncture) is defined as meaning the subcutaneous, intramuscular and intradermal injection of substances consistent with the practice of East Asian medicine to stimulate acupuncture points, ashi points, trigger points and meridians.
(i) For the purposes of this section, point injection therapy includes trigger points as a subset of acupuncture points and ahshi points as recognized in the current practice of East Asian medicine.
(ii) Does not include injection of controlled substances contained in Scheduled I through V of the Uniform Controlled Substance Act, chapter 69.50 RCW or steroids as defined in RCW 69.41.300.
(iii) Substances are limited to:
(A) Saline;
(B) Sterile water;
(C) Herbs specifically manufactured for injection by means of hypodermic needles;
(D) Minerals specifically manufactured for injection by means of hypodermic needles;
(E) Vitamins in liquid form specifically manufactured for injection by means of hypodermic needles; and
(F) Homeopathic and nutritional substances specifically manufactured for injection by means of hypodermic needles.
(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 Tui na (which is a method of East Asian bodywork); and
(o) 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

YOUR INSURANCE BENEFITS

I understand that though Godwin Acupuncture may call my insurance company to verify my benefits as a courtesy to me, understanding my insurance benefits including copays, coinsurances, and deductibles is my responsibility. I understand that I will be responsible for any amounts assessed by my insurance company including copays, coinsurances, and deductibles. I will pay those amounts in a timely manner.

_____
initials

SCHEDULING

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. I understand that I am responsible for the full appointment fee if I do not give 24 hours notification for missed appointments. I understand that insurance companies do not reimburse for missed appointments.

_____
Initials

_____
Patient Signature Date

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

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PERSONAL INJURY FORM

Patient's Full Legal Name (first, middle, last):_____

TIME & LOCATION OF ACCIDENT

Time of accident:_____ ☐ a.m ☐ p.m Date of Accident: _____

Street where accident occurred: _____

City in which accident occurred: _____ State: _____

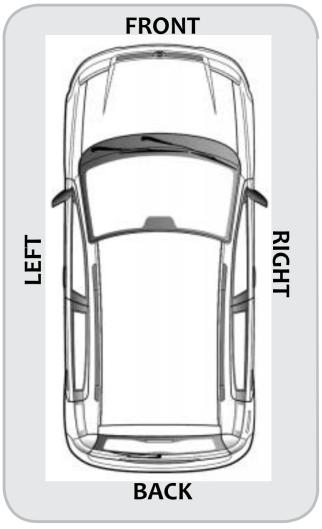
ACCIDENT DETAILS

The road was ☐ Wet ☐ Dry ☐ Icy ☐ Other _____at the time of the accident.

Did the police come to the scene of the accident? ☐ Yes ☐ No

Was an accident report filed? ☐ Yes ☐ No

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



Your position during the accident:

Were you seated in the vehicle? ☐ Yes ☐ No

Were you aware of the approaching collision, or did the impact catch you by surprise? □ Aware □ Surprised

Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No

If yes, for how long? _____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap Belt ☐ Shoulder Belt

Vehicle Information & Velocity:

Vehicle Year: _____ Make: _____Model: _____

Was your car moving, or stopped? ☐ Moving ☐ Stopped

If moving, what was your approximate speed: _____ m.p.h

Just before impact, the car was: ☐ Slowing Down ☐ Speeding Up ☐ Constant Speed

The following questions pertain to the other vehicle involved in the accident:

Other Vehicle Year: _____ Make: _____ Model: _____

Was the other car moving, or stopped? ☐ Moving ☐ Stopped

Approximate speed of other vehicle _____ m.p.h

Just before impact, the other car was: ☐ Slowing Down ☐ Speeding Up ☐ Constant Speed

---

INJURIES SUSTAINED IN THE ACCIDENT

Were there bleeding cuts caused by the accident? ☐ YES ☐ NO

Where: _____

Did the accident cause any bruises? ☐ YES ☐ NO

Where: _____

List any injuries sustained in the accident:_____

_____

Do you have any history of these injuries prior to the accident? ☐ YES ☐ NO

Where did the following body parts hit during the accident:

Head:_____Chest:_____

R/L Shouder: _____ R/L Arm:_____

R/L Hip:_____R/L Leg:_____

R/L Knee:_____Other:_____

Which (if any) of the following car parts broke during the accident:

☐ Windshield ☐ Steering Wheel ☐ Front Seat ☐ Back Seat ☐ Side Window (R/L)

Was the trunk of your body pointed straight forward at the time of impact? ☐ YES ☐ NO

If No, which direction was it pointed, and by how much? _____

Was your head pointed straight forward at the time of impact? ☐ YES ☐ NO

If No, which direction was it turned, and by how much? _____

Were you taken to a hospital? ☐ YES ☐ NO Hospital Name & City:_____

How did you get to the hospital? _____

Were diagnostic images taken? ☐ YES ☐ NO

If yes, what was imaged? ☐ Head ☐ Neck ☐ Upper Back ☐ Mid-Back ☐ Lower Back

What treatment were you given at the hospital:_____

_____

What providers have you seen since the accident:_____

_____

Do you have an attorney for this accident? ☐ YES ☐ NO

if yes, provide contact information here:_____

If you have been involved in previous auto accidents, please list the year of each incident:

_____

_____

_____

Please list any additional information not covered above that we should know about:

_____

_____

_____

_____

_____

_____

_____

Signature of Patient

_____

Patient Name (Printed)

Date ____ / ____ / _____