Mark Goldby, M.Ac.O.M., L.Ac. **Cita Oudijk, M.Ac.O.M., L.Ac.**

1011 E. Burnside, Portland, OR 97213 503-232-3857 www.acupunctureportland.com

ABOUT YOUR VISIT

Appointments:
Hello and welcome! It is easy to make an appointment. You can call the clinic number above. You can also call my private line: 503-720-9361, or you can email me at: acuportland@yahoo.com.

Intake:
When you come in for your appointment, I will briefly look over your paperwork and then we'll go into the treatment room to talk. We will discuss the complaint that brought you in as well as your general health and some of your habits such as sleep, diet and exercise. The reason we talk about more than just your main complaint is because that helps us get a better understanding of where things may be out of balance. That helps me give you a more comprehensive treatment that can get more to the root of the problem, rather than just the symptoms that are currently bothering you.

Once we're done talking, I will ask to feel your pulse and look at your tongue. The appearance of the tongue and the feel of the pulse supplement the information gathered from our conversation.

Then you're ready to get onto the treatment table. If you wear loose fitting clothes, those generally can be easily adjusted for treatment. Otherwise we have gowns and towels for your use.

Treatment:
Then it's time for acupuncture! Treatment often starts with palpation, so I can feel the tissue in the areas where you report experiencing pain. I may also palpate along certain acupuncture channels or points before starting acupuncture. This gives us further information about your condition, which results in a better treatment. After the needles are placed, you will rest for about 20 minutes or so. Patients often report a deep sense of calm and well being during and after treatment. Some people even fall asleep!

Herbs:
You generally won't receive herbs on your first visit. Firstly, not every condition warrants them. And for chronic conditions, it is often helpful to see how your body responds to the acupuncture first, before adding herbs. However, in the case of an acute condition, such as a cold or flu or a recent injury, herbs can be a strong adjunct therapy to your acupuncture treatment and will probably be recommended.

After Your Treatment:
After your treatment is completed, we'll chat again briefly to answer any further questions you may have and to discuss any follow up that may be needed. Then we'll check you out and you'll be on your way!

Open Gate Acupuncture and Herbal Medicine Clinic Effective Date:04/14/03
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Notice of Patient Privacy (short form)

Health Insurance Portability and Accountability Act (HIPAA)

Mark Goldby, L.Ac. and Cita Oudijk, L.Ac. do business as the Open Gate Acupuncture and Herbal Medicine Clinic, otherwise known as Open Gate. We are required by law to protect your health information and to provide you with a notice describing how your "Protected Health Information" (PHI) may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and the duties of the above practitioners with respect to your protected health information.

Mark Goldby, L.Ac. and/or Cita Oudijk, L.Ac. may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse or an employer. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amend or correct that information, obtain an accounting of our disclosures of your medical information, request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and obligations under the law. You have the right to receive a copy of our most current NOTICE in effect; please ask the front desk and we will provide you with a copy.

We may revise our NOTICE from time to time. The Effective Date at the top right hand corner of this page indicates the date of the most current NOTICE in effect. If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Cita Oudijk, L.Ac. at 503-232-3857.

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Consent to Treatment

I voluntarily consent to treatment at the Open Gate Acupuncture and Herbal Medicine Clinic. I understand that treatment is administered by licensed acupuncturists and that acupuncturists practicing in the state of Oregon are licensed as specialists, not as primary care providers.
I understand that treatment may include but is not limited to acupuncture, moxibustion, electrical stimulation, cupping, gua sha, TDP heat lamp, nutritional and lifestyle counseling and herbal therapy. I understand that acupuncture is performed by the insertion of sterile, disposable needles through the skin and that moxibustion is performed by the application of moderate heat to the skin. I understand that electrical stimulation involves the placement of small wires on a few acupuncture needles in order to conduct a very mild current to stimulate the points. I understand that cupping is a technique using glass or bamboo cups to create suction on the skin and that gua sha is a massage technique using a special spoon to increase circulation to the skin. I understand that the TDP lamp warms the skin. These practices are applied at certain points or areas on or near the surface of the skin in an attempt to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain and to normalize the body's physiological functions.
Occasionally certain side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment.
I understand that acupuncturists may recommend substances from the Oriental materia medica to treat bodily dysfunctions or diseases, to modify or to prevent the perception of pain, and to normalize the body's physiological functions. If I choose to take them, I agree that I am willing to follow the directions for administration and dosage and understand that this is carefully measured by the acupuncturist in the attempt to achieve the desired results. Occasionally, certain adverse side effects may result from taking these substances. These could include, but are not limited to, changes in bowel movements, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I will stop taking them and contact the Open Gate Acupuncture and Herbal Medicine Clinic.
I will notify my acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medical treatment can be very beneficial in the pregnancy and birthing process.
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 Patient Privacy document that has been provided to me.

Fee Policy

I understand that treatments are payable at time of service by cash, check or verified insurance coverage only. If my insurance company denies or limits my coverage, I understand that I am responsible for the balance due.
I understand that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to cancel an appointment. Without such

advance notification, I understand that I may be charged for my appointment. I understand that most insurance companies do not reimburse for missed appointments.

Please feel free to ask any questions you may have about this form before signing it.

I have carefully read and I understand all of the above information. I am fully aware that in signing this document, I am consenting to treatment and to the fee policy stated above, and acknowledge receipt of Open Gate Clinic's Patient Privacy Policy.

_______________________________________ _______________________

Signature of Patient or Legal Guardian of Patient **Today's Date**

______________________________ _________________________________

Printed Name **Email address**

____

Home/cell phone number

Health History Questionnaire for Patients

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thank you!

Name:____

Street:______________________________City:___________________________State:________Zip:_________

Home/cell phone:____Work phone:___________________________

Email address:__________________________In Emergency Notify:______________________________________

Age:____________Height:__________________Weight:____

Date/Place of Birth:________________________________Social Security Number:___________________________

Occupation:____Marital Status:_________________

Referred by:____

Primary Care Physician (PCP) :____

Insurance Carrier:____Policy Number:____________________

Medications (if any):____

Supplements (if any vitamins, herbs, minerals, etc.):____

____

Other concurrent medical/health care (if any):____

____

Have you tried acupuncture or Chinese Herbal Medicine before?____

Main complaints(s) you would like to address in order of significance for you:

1.____

2.____

3.____

4.____

5.____

How do these conditions affect your daily activities (work, sleep, eating, etc.)?____________________________

____

Past medical history:

How was your childhood health?____

Any hospital visits/stays?____

Check any conditions you have had in the past (please include dates):

Allergies:______ Cancer:______ Diabetes:______

Hepatitis:______ High Blood Pressure:______ Heart disease:______

Seizures:______ Rheumatic Fever:______ Venereal disease:______

Thyroid disease:______ Birth trauma:______ Asthma:______

Stroke:______ HIV:______ Vein condition:______

Migraines:______ Bleeding tendency:______ Nervous disorder:______

Mononucleosis:______ Low immunity:______ History of heavy antibiotic use:______

Other significant Illness (describe):____

Accidents or significant trauma:____

Surgeries:____

Immunizations:____

Other relevant medical history:____

____

Family History:

Family Member	Alive	Deceased	Present health or cause and age of death
Father			
Mother			
Spouse			
Children			
Brother			
Brother			
Sister			
Sister			

Where are you in the birth order? First________ Middle_______ Last_______ Only________

Check the following that have occurred in your blood relatives:

Diabetes:______ Cancer:______ Heart disease:______ High blood pressure:______ Allergies:______

Tuberculosis:______ Obesity:______ Bleeding tendency:_______ Kidney disease:______ Alcoholism:______

Nervous illness:______ Mental illness:______ Alzheimer’s disease:______ Parkinson’s disease:______

Stroke:______ Other:____

Please check the following that pertain to you:

Patient Profile:

Overall Temperature:
Cold hands_____
Cold feet______
Sweaty hands______
Sweaty feet______
Body feels hot______
Body feels chilly______
Afternoon flushes______
Night sweats______
Heat in hands, feet and chest______
Hot flashes any time of day______
Thirsty______
Perspire easily______
Lack of perspiration______

Overall Energy:
Shortness of breath______
Difficulty keeping eyes open during daytime______
General weakness______
Easily catch colds______
Low energy______
Feel worse after exercise______
Dizziness______

Heart Energy:
Palpitations______
"Anxiety"______
Sores on tongue______
Restlessness______
Mental confusion______
Chest pain______
Frequent dreams______
Wake unrefreshed______

Lung Energy:
Nasal discharge______
Cough______
Nose bleeds______
Sinus congestion______
Dry mouth______
Dry throat______
Dry nose______
Dry skin______
Allergies (To what?____________________)
Alternating chills and fever______
Sneezing______
Sore throat______
Smoke cigarettes (# of cigs per day______)
Sadness______
Melancholy______

Spleen Energy:
Low appetite______
Abrupt weight gain/loss (Which?_____________)
Abdominal bloating______
Gas______
Gurgling noise in stomach______
Fatigue after eating______
Crave sweets/carbohydrates______
Prolapsed organs (Previously diagnosed; which organ?__________________)
Easily bruised______
Hemorrhoids______
Pensive______
Over-thinking______
Worry______

Elimination:
Loose stools______
Constipation______
Incomplete______
Diarrhea______
Blood in stools______
Mucous in stools______
Undigested food in stools______

Dampness:
Heavy sensation in body______
Mental sluggishness______
Mental fogginess______
Swollen hands______
Swollen feet______
Puffiness in face______
Other edema______
Chest congestion______
Nausea______
Snoring______

Stomach Energy:
Burning sensation after eating______
Large appetite______
Bad breath______
Mouth sores______
Bleeding, swollen or painful gums______
Heartburn______
Acid regurgitation______
Ulcer (diagnosed)______
Belching______
Hiccoughs______
Stomach pain______
Vomiting______

Liver/Gallbladder Energy:
Alternating diarrhea and constipation______
Tight sensation in chest______
Bitter taste in mouth______
Anger easily______
Frustration/Irritability______
Depression______
Trouble adapting to stress (What causes the stress? ____)
Skin rashes______
Temple/eye headache______
Tingling sensation______
Numbness______
Muscle spasms______
Muscle twitching or cramps (which?______)
Seizures______
Convulsions______
Lump in throat______

Neck/shoulder tension______
Drink alcohol (how much?_______________________)
Recreational drugs______
High-pitched ringing in ears______
Gallstones(history or current)______
Sexually transmitted disease (Which?_______________)

Eyes:
Itchy______
Bloodshot______
Hot______
Dry______
Watery______
Gritty______
Blurry vision______
Decreased night vision______
Near-sighted______
Far-sighted______
Floaters (dark or clear?________)
Other______

Kidney/Bladder Energy:
Tooth problems(what kind?________________________)
Easily broken bones______
Osteoporosis/osteopenia (diagnosed)______
Sore knees______
Weak knees______
Low back pain______
Memory problems______
Excessive hair loss______
Low-pitched ringing in ears______
Kidney stones______
Fear______
Easily startled______

General Urination:
Normal color______
Dark Yellow______
Clear______
Reddish______
Cloudy______
Scanty______
Profuse______
Strong odor______
Burning______
Painful______
Discharge______
Difficult______
Urgent______
Lack of bladder control______
Frequent______
Nighttime urination (how often?________)
Bladder infections______

Libido:
Normal______
High______
Low______

Other symptoms:

Women only:
Regular menstrual cycle? Y______ N______
Number of children:______
Age of first menstruation:______
Average number of days of flow:______
Average number of days in cycle:______
Pregnant? Y______ N______
Number of pregnancies:______
Age of menopause:______
Vaginal discharge?______
Bleeding between periods?______

Do you experience any of the following before/during period? (please specify before or during):
Nausea______
Vomiting______
Light-headedness______
Headaches______
Migraines______
“Anxiety”______
“Depression”______
Irritability______
Weepiness______
Food cravings (for what?_________________________)
Breast swelling/tenderness______
Water retention______
Pain (Sharp? Dull? Where?________________________)

Men only:
Swollen testes______
Testicular pain______
Impotence______
Premature ejaculation______
Feeling of coldness or numbness in external genitalia______
Other______

All please fill out:

Occupational stress factors (physical, psychological, chemical):____________________________________
____
____

Do you exercise regularly? ______ If so, what do you do?____
____
____

Please describe your average daily diet, including beverages:______________________________________
____
____
____

Other Comments:____
____
____
____
____
____

____
Patient Signature and Date

____
Acupuncturist Signature and Date