

Jennifer Lewis-Gosch, Twelve Branches Acupuncture & Herbal Medicine  
Seattle Healing Arts Center  
6300 9<sup>th</sup> Avenue NE, Ste 310 Seattle, WA 98115  
206 854 5399 ([jennifer@twelvebranches.com](mailto:jennifer@twelvebranches.com))

WA State Acupuncture License # AC00002465

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## **Welcome and Policies**

Welcome! I look forward to working with you. I want to reassure you that acupuncture is safe and, by and large, painless. Most people experience it with an overall sense of relaxation and well-being. To help serve you better, I've listed some guidelines and office policies. Please sign the Client Acknowledgement below and bring this form with you to your first treatment.

- Please eat 1 to 2 hours prior to your appointment time.
- Please fill out the enclosed forms and bring them with you to your first appointment.
- Please come in 15 minutes before your appointment to complete your Health History Questionnaire if you have not already done so.
- Please wear loose-fitting clothes if possible.

### **Appointments and Fee Information:**

Your initial visit will last approximately 1½ hours; return visits are usually about 1 hour. This time will be spent interviewing you regarding your medical history and primary complaint, conducting a physical examination based on Traditional Chinese Medicine (TCM), and performing a course of treatment.

My fee at time of service is \$85 for the first office call and \$60 for repeat visits. You are responsible for all fees. If your insurance covers part of the treatment cost, you are responsible for paying the co-payment at the time services are rendered. As it is my policy to make Chinese Medicine easily accessible to everyone, I offer a \$15 time of service credit to students, starving artists, and elders (65+).

### **Payment Method:**

I accept payment by cash or check. There is a \$30 penalty for a bounced check and only one occurrence is permitted. If a second check bounces, I will require cash-only payment from then on.

### **Cancellation and Lateness Policy:**

If you are unable to keep your appointment for any reason, I ask that you call my office at least 24 hours in advance to cancel or reschedule the appointment. Otherwise you will be charged \$65 for the appointment.

### **Client Acknowledgement:**

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I authorize Jennifer Lewis-Gosch to release to my insurance company or companies any and all information necessary to process any claim. I further authorize that payment(s) be made directly to Jennifer Lewis-Gosch. I understand the contents of this disclosure and agree to abide by these policies.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

I am pleased to have you as a client and hope you will soon share my enthusiasm for the health-enhancing benefits of acupuncture. My goal is to support your body's natural healing process and assist you in improving your overall health and vitality.

## Health History Questionnaire

Date: \_\_\_ / \_\_\_ / \_\_\_

<b>Patient's Name</b> (Last, First, M.I.)		<b>DOB</b> (mm/dd/yyyy)	<b>Sex</b> (M/F)	<b>Patient Status:</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
<b>Patient's Address</b> (No. Street)		<b>Relation to Insured</b>		<b>Employed</b> <input type="checkbox"/> <b>Student:</b> F-Time <input type="checkbox"/> P-Time <input type="checkbox"/>	
<b>Patient's Address</b> (No. Street)		<b>Relation to Insured</b>		<b>Patient's Employer</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Phone</b> (10 digit)		<b>Patient's SSN:</b>
<b>Insured's Name</b> (Last, First, M.I.)		<b>DOB</b> (mm/dd/yyyy)	<b>Sex</b> (M/F)	<b>Insured's SSN:</b>	
<b>Insured's Address</b> (No. Street)		<b>Phone</b> (10 digit)		<b>Insured's Employer</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Insured's Claim Nbr. or ID Nbr.</b>		<b>Group ID Number</b>
<b>Insurance Company</b>			<b>Plan Name or Program</b>		
<b>Billing Address</b>			<b>Referral Nbr.</b>		
<b>Onset/Injury Date</b>	<b>Similar Condition (Y/N)</b>	<b>Work related (Y/N)</b>	<b>Auto Accident (Y/N)</b>	<b>U.S. State</b>	<b>Other Acc. (Y/N)</b>

What is your main complaint today? \_\_\_\_\_

When did this problem begin? (Please be specific) \_\_\_\_\_

What do you think caused it? Is the cause still present? \_\_\_\_\_

What treatments have you tried already? What were the results? \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_

To what extent does this problem interfere with your daily activities? (work, sleep, eating, sex...) \_\_\_\_\_

How severe is your problem right now? (Please mark the scale below)

No problem	Moderate	Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem	Moderate	Worst Imaginable

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Past Medical History (please indicate by date(s):

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____
Other: _____			

Surgeries (type and date): \_\_\_\_\_

Significant Trauma (auto accidents, falls, etc.): \_\_\_\_\_

Significant Dental Work (type and date): \_\_\_\_\_

Birth History (prolonged labor, forceps delivery, caesarian section, other): \_\_\_\_\_

Allergies (drugs, chemicals, foods, animals): \_\_\_\_\_

### Family Medical History

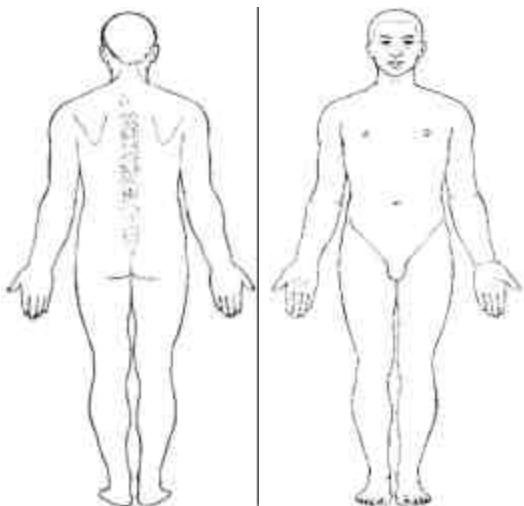
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer:	<input type="checkbox"/> Allergies:
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	_____	_____
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	_____	_____

Occupational Stress (chemical, physical, psychological, etc.): \_\_\_\_\_

Do you exercise regularly? Y or N Please describe: \_\_\_\_\_

Comments (please list any other problems you would like to discuss): \_\_\_\_\_

### Indicate Painful or Distressed Areas



### What are Your Treatment Goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past 2 weeks.

**General**

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold / hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop  
*Time of day:* \_\_\_\_\_
- Edema  
*Where:* \_\_\_\_\_
- Poor sleeping
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight change  
*Gain / Loss* \_\_\_\_\_

**Skin and Hair**

- Rashes
  - Itching
  - Change in hair or skin
  - Ulcerations
  - Eczema
  - Oozing skin lesion
  - Hives
  - Pimples
  - Recent moles
  - Loss of hair
  - Dandruff
- Other hair or skin problems*  
\_\_\_\_\_

**Head, Eyes, Ears  
Nose, and Throat**

- Dizziness
- Migraines
- Headaches  
*When:* \_\_\_\_\_  
*Where:* \_\_\_\_\_
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision

- Color blindness
  - Blind field
  - Spots in front of eyes
  - Eye pain
  - Eye strain
  - Cataracts
  - Eye Dryness
  - Excessive tearing
  - Discharge from eyes
  - Poor hearing
  - Ringing in ears
  - Earaches
  - Discharge from ear
  - Nose bleeds
  - Sinus congestion
  - Nasal drainage
  - Grinding teeth
  - Teeth problems
  - Jaw clicks
  - Concussions
  - Recurrent sore throats
  - Hoarseness
  - Sores on lips/tongue
- Other head / neck problems*  
\_\_\_\_\_

**Cardiovascular**

- High blood pressure
  - Low blood pressure
  - Chest discomfort/pain
  - Heart palpitations
  - Cold hands or feet
  - Swelling of hands
  - Swelling of feet
  - Blood clots
  - Fainting
  - Difficulty in breathing
- Other heart/blood vessel problems:* \_\_\_\_\_

**Respiratory**

- Cough
  - Asthma/wheezing
  - Difficulty in breathing when lying down
  - Phlegm *Color?* \_\_\_\_\_
  - Coughing blood
  - Pneumonia
  - Bronchitis
- Other lung problems:* \_\_\_\_\_

**Gastrointestinal**

- Bad breath
  - Nausea
  - Vomiting
  - Heartburn
  - Belching
  - Indigestion
  - Diarrhea
  - Constipation
  - Chronic laxative use
  - Blood in stools
  - Black stools
  - Abdominal pain/cramps
  - Gas
  - Rectal pain
  - Hemorrhoids
- Other stomach or intestinal problems:* \_\_\_\_\_

**Genito-Urinary**

- Pain on urination
  - Urgency to urinate
  - Frequent urination
  - Blood in urine
  - Decrease in flow
  - Dribbling
  - Kidney stones
  - Impotency
  - Change of sexual drive
  - Sores on genitals
- Do you wake to urinate?*  
 Yes  No
- How often?* \_\_\_\_\_
- What color is your urine?*  
\_\_\_\_\_
- Other genital or urinary system problems?* \_\_\_\_\_

**Pregnancy and  
Gynecology**

- # of pregnancies:* \_\_\_\_\_
- # of births:* \_\_\_\_\_
- # premature births:* \_\_\_\_\_
- # of miscarriages:* \_\_\_\_\_
- # of abortions:* \_\_\_\_\_
- Age at first menses:* \_\_\_\_\_
- Length of full cycle:* \_\_\_\_\_
- Length of menses:* \_\_\_\_\_
- Last menses start date:* \_\_\_\_\_

- Heavy periods
  - Light periods
  - Painful periods
  - Irregular periods
  - Changes in body/psyche prior to menstruation
  - Clots
  - Vaginal discharge:
  - Menopause:  
*Age:* \_\_\_\_\_  
*Year:* \_\_\_\_\_
  - Postcoital bleeding
  - Vaginal sores
  - Breast lumps
  - Nipple discharge
- Do you practice birth control?*  
 Yes  No
- What type and for how long?*  
\_\_\_\_\_

**Musculoskeletal**

- Neck pain
  - Shoulder pain
  - Back pain
  - Elbow pain
  - Hand/wrist pain
  - Hip pain
  - Knee pain
  - Foot/ankle pain
  - Muscle pain
  - Muscle weakness
- Other pain?* \_\_\_\_\_

**Neuropsychological**

- Seizures
  - Areas of numbness
  - Weakness
  - Sleep disorder
  - Concussion
  - Violence potential
  - Vertigo
  - Lack of coordination
  - Bad temper
  - Depression
  - Easily stressed
  - Loss of balance
  - Poor memory
  - Anxiety
  - Substance abuse
- Have you ever been treated for emotional problems?*  
 Yes  No

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Last Physical Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Results: \_\_\_\_\_

**Habits** Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salt Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stress Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Diet** Please give a general description of the food you eat during a "typical" day.

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Before bed: \_\_\_\_\_

Between meals: \_\_\_\_\_

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

\_\_\_\_\_  
\_\_\_\_\_

What medicines have you taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

\_\_\_\_\_  
\_\_\_\_\_

What allergies do you have? What reactions do you have to these chemicals, foods, etc?

\_\_\_\_\_  
\_\_\_\_\_

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INSURANCE INTAKE FORM

PATIENT

Date of Birth \_\_\_\_\_  
Name \_\_\_\_\_ Phone (Home) \_\_\_\_\_  
Address \_\_\_\_\_ Phone (Work) \_\_\_\_\_  
\_\_\_\_\_  
Single \_\_\_\_\_ Married \_\_\_\_\_  
Employer \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

PRIMARY PLAN INFORMATION

ID# \_\_\_\_\_  
Plan Name \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_

Relationship To Insured

Self \_\_\_\_\_ Child \_\_\_\_\_  
Spouse \_\_\_\_\_ Other \_\_\_\_\_

INSURED INFORMATION, IF OTHER THAN YOURSELF

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Date of Birth \_\_\_\_\_  
Plan Name \_\_\_\_\_ ID# or Claim # \_\_\_\_\_  
Address \_\_\_\_\_ Adjuster's name \_\_\_\_\_  
\_\_\_\_\_ Date of Injury \_\_\_\_\_  
Phone # \_\_\_\_\_ Name of Insured \_\_\_\_\_

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider in the event that my insurance coverage expires or denies payment.

I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Consent Form for Traditional Methods**

I, the undersigned hereby authorize Jennifer Lewis-Gosch, who received her Master of Traditional Chinese Medicine from the Northwest Institute of Acupuncture and Oriental Medicine and who is currently licensed in the State of Washington (Lic # AC00002465) to perform the following acupuncture procedures:

**Acupuncture:** the insertion of special sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body

**Cupping:** a technique used to relieve symptoms by applying cups made of glass, bamboo, or other materials to the skin with a vacuum created by heat or other devices.

**Plum Blossom or Seven Star Hammer:** multi-needle devices applied to areas of the body with a light-to-moderate tapping technique.

**Gua Sha:** the rubbing of an area of the body with a blunt-edged instrument

**Moxabustion (Moxa):** the burning of herbs on or near the body to warm it, strengthen it, and relieve symptoms. Moxa comes in several forms such as a stick, string, ball, cone, or rice grain.

**Tuina:** an ancient technique of Chinese medical massage, used for a variety of common illnesses.

**Dietary Advice:** food and herbal advice based on traditional Chinese medical theory.

**Electro-Acupuncture:** the running of very low electrical current through one or more needles to help heal the body

**Sonopuncture:** the use of tuning forks to help heal the body with sound waves and vibration. The forks are placed near and on the body, often on acupuncture points and energy meridians.

*I recognize the potential risk and benefit of these procedures as described below*

**Potential risks:** Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, minor bruising, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentially... an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pace-makers should inform their practitioners prior to treatment.

**Potential benefits:** drugless or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the client's main complaint(s).

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Jennifer Lewis-Gosch, regarding the cure or improvement of my conditions.

I hereby release Jennifer Lewis-Gosch, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

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Signature of Client

Date

---

Signature of Person Authorized to Consent

Date

---

Signature of Witness

Date

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## **HIPAA NOTICE OF PRIVACY PRACTICES**

I keep medical records of the health care services I provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give me written permission to release them or I am required to do so by law. I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. You may see your records or get more information about them by contacting my office.

For more information about our privacy practices please inquire with me.  
By signing below, I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date