

Bula Wellness
Ancient Medicine for a Modern Lifestyle ®
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New Patient Intake Form

Confidential Information

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process. Download and fill out form online or print first, fill out by pen and bring to your first appointment.

Patient Information

Patient Name:		Today's Date:	
Street Address:		City/State/Zip:	
Age and Date of Birth:		Gender Identity:	
Email:		Telephone:	
Emergency Contact Name:		Emergency Contact Phone:	
Primary Care Provider:		PCP Phone:	
Date of Last Visit to PCP:		Who can I thank for the referral to Bula Wellness?	

Medical History

Major complaint/health problem:	
How did this condition develop?	
Have you received treatment for this? Where? What was the diagnosis?	
How long has this condition persisted?	
Is there anything that makes it better? Is there anything that makes it worse?:	

Significant Trauma, Hospitalizations, Surgeries, Special Studies

Trauma:		Date:	
Hospitalizations:		Date:	
Surgeries:		Date:	
Special Studies:		Date:	

Please include auto accidents, falls, illness and well as emotional along with month/year

SIGNIFICANT ILLNESSES/PERSONAL HISTORY (PLEASE CHECK ALL THAT APPLY)

- Alcohol/Drug Addiction Alzheimer's Arthritis Anemia Asthma Autoimmune Disease
 Aids/HIV Positive Blood Clotting Disorder Cancer Chronic Fatigue Chronic Pain
 Connective Tissue Disease Diabetes Eating Disorder Gallstones Heart Disease
 Hepatitis High/Low Blood Pressure Kidney Stones/Disease Prolapsed Organ
 Rheumatic Fever Ruptured Appendix Seizures Stroke Thyroid Disease Ulcer
 Venereal Disease Other: _____ Do you smoke? (Tobacco/Marijuana) For how long? _____

How much a day? _____

Allergies

Allergy:		Date of Onset:	
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Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances?

Medications and Supplements

Medication:		Dose:	
Supplement and Brand:		Dose:	

Bring all supplement bottles to your first appointment. List under dose how many per day, total dosage amount and how long you have been taking this medication or supplement.

OTC/PRESCRIPTION MEDICATIONS TAKEN IN PAST OR CURRENTLY (PLEASE CHECK ALL THAT APPLY)

- Allergy Medication Antacids Antibiotics Anti-Depressants Birth Control (Pills/IUD) Cortisone
 Heart/Blood Medication Hormones Laxatives Pain Relievers Sleeping Pills Thyroid medication

Exercise, Energy and Dietary

How much exercise per week?		Length of workout?	
Activities:		How is your energy level?:	
When is your energy highest?:		When is your energy lowest?:	

TYPICAL DAILY FOOD INTAKE:

Meals per day ____ # of Snacks per day ____ Caffeinated Drinks per week ____ Alcohol per week ____

Breakfast:		Lunch:	
Dinner:		Snacks:	
What foods are your weakness?:		Prefer warm or cold drinks?:	
Excessively thirsty?:		Special Diet/Eliminate any foods?:	

Personal Products and Household Cleaners

List all personal products brands including toothpaste and deodorant.		Do you use organic personal products?	
List all household cleaning products.		Do you use organic household cleaners?	

Family Medical History

Please check any condition that applies to your immediate family:

- Asthma [Parent_____] Cancer [Parent_____] (type) _____
 Diabetes [Parent_____] Genetic Disorder [Parent_____] Heart Disease [Parent_____]
 High Blood Pressure [Parent_____] Infertility [Parent_____] Stroke [Parent_____]
 Seizures [Parent_____] Other Serious Condition _____

Childhood Illness

Have you had any of the following Childhood Illnesses (check if yes)

- Diphtheria German Measles Measles Mumps Rheumatic Fever Scarlet Fever Negative reactions to immunization/s

General

Height _____ Weight _____ lbs. Weight one year ago _____ lbs. Maximum Weight _____ lbs. When _____
Blood Type _____

Most recent blood pressure reading? _____ / _____ Taken When? _____

Most recent blood work/stool analysis/functional medicine lab analysis/imaging? (please email or bring a copy to your first appointment) _____

What goals do you have for your acupuncture treatments? _____

Other Past Treatments Please indicate any other forms of past treatment, both conventional and alternative

Do you have any other comments, concerns, or issues that you would like to discuss?

Review of Systems

Mark any symptom you currently experience with a check.

GENERAL

Poor or Change in Appetite Chills Bleed/Bruise Easily Colder than those around you Weight loss or gain

NOSE AND SINUSES

Frequent Colds Frequent Runny Nose Loss of Smell Nose Bleeds Chronic Infections Hay Fever Sinus Congestion Sinus Problems

IMMUNE

Chronic Fatigue Syndrome Glands Cravings Night Sweats or Hot Flashes Warmer than those around you Fatigue / Low Energy Slow Wound Healing Fevers High Stress Sweat Easily

HEAD / NECK

Headaches Migraines Teeth Grinding

SKIN AND HAIR

Goiter Acne, Boils Fungal Infections Dry Skin/Scalp Night Sweats Recent Moles Eczema or Psoriasis Itching Hair Loss Change in Hair texture Weak or ridged nails Rashes Redness of Skin Skin Discoloration Greasy Hair Slow healing ulcerations

MOUTH AND THROAT

Sore Throat Sore Tongue/Lips Copious Saliva Gum Problems Trouble Swallowing Hoarseness

Swollen Glands Recurrent Sore Throats/Colds

RESPIRATORY

Chest Congestion Difficulty inhale/exhale Cough Wet or Dry Asthma Pneumonia Bronchitis

Coughing Blood Phlegm

NEUROLOGIC

Seizures or Tremors Numbness or tingling Loss of Balance Paralysis

CARDIOVASCULAR

Chest Pain or Pressure Palpitations at Rest Palpitations/ Fluttering Vertigo or Dizziness Irregular Heart Beat Irregular Heart Beat Varicose Veins Deep Leg Pain Shortness of Breath Easily Stressed

EYES AND EARS

Itchy Eyes Swollen/painful eyes Spots in Front of Eyes Double Vision Ringing Dry Eyes Blurred Vision
 Color Blindness Hearing Difficulty Watery Eyes Red Eyes Cataracts Glaucoma Earaches/ Infection

DIGESTION

Abdominal Pain/Cramps Change in Appetite/Thirst Gas/Bloating Constipation Heartburn/Acid Reflux
Vomiting Diarrhea Mucous in Stools Nausea Belching or Passing Gas Hemorrhoids Strong Smelling
Stools Crohns Itchy/Burning Anus Food in Stools Excessive Hunger Black/Bloody Stool Bad Breath
 IBS Daily Bowel Movements Stools Hard Firm Soft Loose Undigested Food Small Pebbles

CIRCULATION

Faintness Easy Bleeding or Bruising Cold hands/feet Dizziness Anemia Spontaneous Sweating Heat
or Cold Intolerance Excessive Thirst Chest Tightness Swelling of Hands or Feet Blood Clots

ENDOCRINE

Hypothyroid Hyperthyroid Diabetes Hypoglycemia

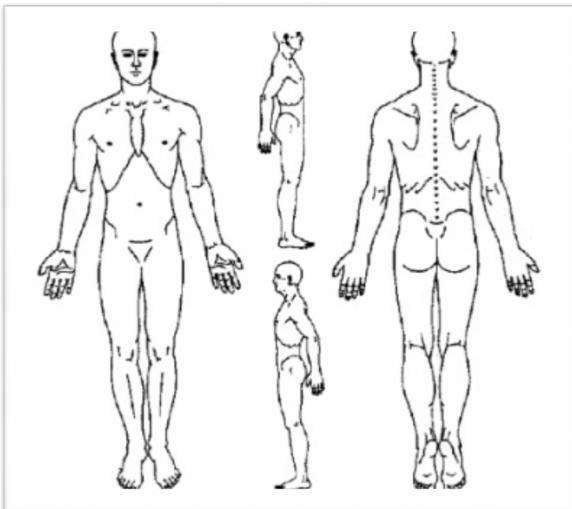
MUSCLE / JOINT / BONES

General pain or tightness Recent injuries from an auto accident or work related Neck Pain Arm/Wrist Pain
Back Pain: Low Middle Upper Jaw Pain Knee Pain Sciatica Muscle Weakness Shoulder Pain Muscle
Pain/Tension Weak/Sore Lower Body Loss of Strength Heaviness of Limbs Muscle spasms / cramps Areas
of Numbness Restless Leg Syndrome Tingling Sensations Swollen joints Arthritis/joint pain Tendonitis
 Bone pain

The pain is (check all that apply): Sharp Dull Aching Numb Superficial Pain Deep Pain Burning
Tingling Shooting Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure Pain
worse in am/pm Pain worse/better with movement Repetitive Strain Injury Fractured Bone(s) - Where? _____

Other _____

Pain Diagram (please mark all areas of pain on diagram below) A = aching B = burning N =numbness P = pins & needles
S = stabbing pain O = other type of sensation



MENTAL / EMOTIONAL/ SPIRITUAL

- Mood Swings Poor Concentration Weepy Anxiety or Nervousness Poor Memory Sadness Depression
 Angry Outbursts Seasonal Depression Treated for a psychological concern Sexual or physical abuse
Considered or attempted suicide Treated for substance abuse? Stress level- Low Medium High

Are you currently working with a counselor? If so, who? _____

Most challenging emotion you experience? _____

When do you most often feel this emotion? _____

What experiences or activities bring you the most joy and nourishment? _____

Do you have a spiritual practice? _____

SLEEP

How long do you normally sleep? _____ hours per night Trouble falling asleep Staying asleep Dream-disturbed sleep
 Waking up at about _____ am/pm. Trouble falling fall back asleep Poor Sleep

GENITO-URINARY

- Pain/Burning when urinating Cloudy Urine Copious or Scanty Urination Urinary Tract Infections Frequent Urination
 Night Urination Inability to hold Urine Dark or Pale Yellow Kidney Stones Blood in Urine

SEXUAL HISTORY

Are you sexually active? _____ Do you practice Birth Control? _____ Type? _____

Libido Low Libido Med Libido High

Sexually Transmitted Disease Chlamydia Genital Warts Herpes Other

FEMALE ONLY

Age of first menses _____ What was it like for you? _____

Date of last menses _____ Recent menstrual changes If so, what? _____

How many days do you normally bleed? _____ How many days between periods? _____

How heavy is the bleeding? _____ How many pads/tampons per day? _____

What color is the blood? _____ What texture is the blood _____

Painful periods: If so, how many days does pain last? _____ What makes the pain better? _____

Heaviness or pressure in pelvis with periods

Have you ever gone more than 2 months without getting your period? _____ When? _____

PMS What symptoms _____ When do they start? _____

Bleeding/Spotting between periods When in cycle _____

Do you ovulate regularly? _____ If so, on what day of your cycle? _____ Is ovulation painful? _____

Do you observe cervical mucus changes with ovulation? _____ Bleeding with ovulation? _____

Do any of your symptoms seem to change or worsen around your period? How? _____

Menopausal Symptoms Describe

- Irregular Cycles Pain during Intercourse Painful Menses Endometriosis Pelvic/Tubal Infection Vaginal Itching/Burning Breast Lumps Ovarian Cysts Polycystic Ovarian Syndrome Uterine Fibroids/Polyps Pelvic Inflammatory Disease Clotting PMS Vaginal Odor Vaginal Dryness Nipple Discharge Pelvic Adhesions/Scarring Bleeding between Cycles Heavy or Excessive Flow Vaginal Discharge Menopausal Symptoms Breast Pain / Tenderness Have you ever taken the Pill? Current or past use of IUD? Routine Breast Self- Exams

_____ Date of last PAP/Pelvic Abnormal PAP? When? _____

PREGNANCY, DELIVERY AND POST-PARTUM

_____ Number of Pregnancies _____ Number of Live Births _____ Number of Abortions

Miscarriage Ectopic Pregnancy Difficult or Premature Births Difficulty Conceiving

Attempting Pregnancy currently? If so, for how long? _____ Currently Pregnant If so, how far along _____

Currently breastfeeding If so, how long? _____ Difficult scanty or painful lactation _____

Post-partum difficulties _____ Premature deliveries _____

Difficult deliveries _____ Difficulties in Pregnancy _____

Your birth weight, Full term? Full size? Vaginal or C-Section? Any trauma?

FERTILITY TREATMENT HISTORY

Fertility Clinic _____ Physician _____

Western Medical Diagnosis (if any) _____

Western Diagnostic Tests & Hormone Panels (include dates, menstrual cycle date & results)

Hysterosalpingogram (HSG) _____ Endometrial Biopsy _____

Clomid Challenge test _____ Follicle Stim. Horm. (FSH) _____

Leutinizing Horm. (LH) _____ Estradiol (estrogen) _____

Progesterone _____ Prolactin _____

Doppler ultrasound (blood flow) _____ Hysteroscopy/Saline Infused Sonogram _____

Any additional tests

GYN related surgeries (dates & outcome)

A.R.T. History Intrauterine Insemination (IUI) Please list each cycle with date, meds used, egg/sperm quality, any complications/side effects, outcome, etc.

In Vitro Fertilization (IVF) Please list each cycle with date, type of cycle (fresh, frozen, donor, etc.), meds used, # of eggs retrieved and # fertilized, type of fertilization (ICSI, etc), egg/sperm donor or gestational carrier use, PGD/PGS use, quality and # of embryos transferred, # of embryos frozen, any complications/side effects, outcome, etc.

MALE ONLY

Hernias Varicoceles Prostate Disease Sexual Dysfunction Testicular Masses Testicular Pain
Premature Ejaculation Discharge/Sores Infertility Semen Analysis Results?

MALE FACTOR FERTILITY

(please include dates, results and any applicable treatment)

Sperm Count (#/cc) _____ Sperm Motility (% moving) _____

Sperm Morphology _____ Sperm Rise ("swim up test") _____

Anti-sperm Antibodies _____ Varicocele (including surgery) _____

Sperm penetration assay (SPA) _____

Any Additional Male Factor Fertility Information:

HIPPA Notice Privacy Disclosure and Policies: As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include: Limited access to facilities where information is stored. Policies and procedures for handling information. Requirements for third parties to contractually comply with privacy laws. All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction: Should I see you socially, by coincidence or intent, I will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is my preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

Consultations: I consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, I may gather and maintain information that may include these examples of non-public personal information: From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners. From health care providers, insurance companies, workman's comp and your employer, and other third-party administrators (e.g. requests for medical records, claim payment information)

Records Release: Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply: Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Dr. Jodi Knauer, D.Ac. maintain my records confidentially in accordance with the law. I agree to inform Dr. Jodi Knauer, D.Ac. if I need any special arrangements pertaining to this issue.

Signature _____ Date _____

Print Name _____

Informed Consent to Receive Treatment

By signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working

at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I understand that acupuncturists practicing in the state of Virginia and the District of Columbia are not primary care providers and that regular primary care by a licensed physician is recommended by this clinic's practitioners. I understand that methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, Gua Sha, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated. **Heat Treatments with Moxa or a TDP Lamp:** These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a small glass cup. There is a possibility of local non-painful bruising from this suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is light scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pacemaker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage. I understand the clinical and administrative staff may review my

patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I

show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Dr. Jodi Knauer, D.Ac., L.Ac is not a primary care physician.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature_____ Date_____

Print Name_____

FINANCIAL POLICIES

I request payment for your treatment at the time of service. I take VISA, MasterCard Cash or Check. Payment in full is expected at each visit. It is understood that if you provide a check and it does not clear your bank you will be charged an additional \$50 fee on top of your service fee. I can provide a superbill with the proper codes for you to submit for reimbursement by your insurance carrier who may have acupuncture benefits. Initial_____

Missed Appointments. If you miss your appointment or cancel with less than 24 hours notice, you will be charged for the full appointment as I do not double book patients and often have a waitlist. Initial_____

I have read and understand the policies and agree to abide by the guidelines.

Signature of patient or responsible party_____

Date_____

Thank you for understanding my policies. Please let me know if you have any questions.