Allie Machen, LAc
(503) 406-6487
allie@velawellness.com

Mama Group
Acupuncture Intake

Basic Information

Name:_____ Preferred name:_____ Preferred pronoun:_____
Date of Birth:_____ Current age:_____ Today's date:_____
Address:_____
City:_____State:_____Zip:_____
Email address:_____
Phone:_____
Relationship status? Single Partnered Married Other:_____
Emergency Contact:_____Relationship:_____
Emergency Contact Phone Number:_____
Have you had acupuncture before? **Y** **N** How many times?_____ In pregnancy?_____
How did you hear about us?_____

Pregnancy Support Health Information

How many weeks pregnant are you?_____ Approximate due date:_____
Name(s) of Midwife/Obstetrician:_____
Where do you plan to give birth?_____
Who will be supporting you in labor?_____
Are you planning to use a doula? **Y** **N** If yes, who?_____
Does your provider know you are receiving acupuncture? **Y** **N** Do they support you?_____
How long did it take you to conceive?_____ Anything you believe helped with conception?
_____
Symptoms of 1st trimester:_____
Symptoms of 2nd trimester:_____
Symptoms of 3rd trimester:_____
Any medical conditions/difficulties?_____
Do you have any particular goals or desires for this birth?_____

Do you have other children? **Y** **N** If yes, what are their ages?_____
Please describe your previous pregnancies and births (pregnancy induced hypertension, early/ postdate delivery, unexpected complications, vaginal delivery, epidural, Cesarean birth, difficulties postpartum, etc):_____
_____
_____
Previous miscarriages? **Y** **N** If yes, how many, when and at how many weeks?_____
Previous abortions? **Y** **N** If yes, how many and when?_____

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Labor Preparation

Do you have any female family members who went past due date? **Y N** Relation to you:_____
List any details you know about your own birth:_____
Have you been experiencing Braxton Hicks? **Y N** For how long:_____
Do you know baby's position? **Y N** Describe:_____
Have you experienced other changes recently (baby dropped, lost mucus plug, loose bowels, etc.)?_____
What have you been doing to encourage labor?_____
Has there been any discussion about medical induction? **Y N** When?_____
Date of last cervical check:_____
Dilation Position (posterior / anterior):_____ Station (-3 to +2):_____
Effacement %:_____Consistency (firm / medium / soft):_____
Anything else you would like to share regarding your pregnancy and upcoming birth?_____
_____

Menstrual Cycle Information

Age at menarche:_____ Length of entire cycle:_____Length of bleeding:_____
Spotting? **Y N** (before / after / mid-cycle) Cramps? **Y N** (before / during / after)
Location/quality of cramps/pain: _____
Pain medication used? **Y N** How often?_____
Flow: (Heavy / Moderate / Light)_____
Number of pads/tampons/menstrual cups per day:_____
General color/consistency: (dark red / light or bright red / brown / clots / watery / sticky)_____
Any other cyclical symptoms: (acne, night sweats, ovulation pains, yeast infections, etc.)_____
_____
PMS symptoms: (nausea/vomiting, headaches, tender breasts, irritability, sadness, change in BM consistency, etc.)_____
After how many weeks/months did your period return after any previous births?_____
Currently on birth control? **Y N** What kind and for how long?_____

Pain Conditions

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Where is your pain / when did it begin?_____
What were you doing at the time?_____
When is your pain worst/what aggravates it? (i.e. first thing in AM, end of day, sitting, walking, not moving)_____
What makes your pain better? (i.e. heat/ice, immobility, exercise to strengthen, massage, medications)_____
Describe the quality (burning, stabbing, dull, achy, etc):_____
Rate 1(least)-10(worst):_____
What previous therapies have you tried to relieve the pain and have they worked?_____
_____

General Health History

List names and specialties of other healthcare providers you have recently seen:_____
_____
List names and dosages for any medications, vitamins, supplements you currently take and reasons for taking them:_____
_____
_____
List any allergies or food sensitivities:_____
Any diagnosed health conditions?_____
List any surgeries, hospitalizations, accidents (include dates):_____
_____
Do you have a pacemaker, surgical implants, a history of seizures or fainting?_____
Have you experienced any of the following (indicate P for past issue, C for current issue)?

Cancer	Diabetes	Hepatits
Asthma	High blood pressure	Bleeding disorders
Thyroid issues	Low immunity	Anxiety/Depression
Heart condition	Venereal disease	Rheumatic fever

Do you have a history of significant antibiotic use?_____
Significant family health history (cancer, stroke, heart disease, diabetes) or any information regarding your family that may impact your health?_____
_____

Please circle any of the following symptoms you are currently experiencing or experienced in pregnancy/postpartum. Please indicate C for current, PG for pregnancy, or PP for postpartum.

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Group 1 symptoms:

Heart palpitations	Mouth/tongue sores	Vivid dreams
Anxious feelings	Mental confusion	Restlessness
Chest pain		

Group 2 symptoms:

Low appetite	Fatigue after eating	Bloating/gas
Easy bruising	Overthinking/worry	Fatigue

Group 3 symptoms:

Acid regurgitation	Ulcer	Stomach pain
Strong appetite	Painful or bleeding gums	Belching
Vomiting	Heartburn	Bad breath
Burning sensation after eating		

Group 4 symptoms:

Nasal discharge	Cough	Nose bleeds
Sinus congestion	Dry mouth/throat/nose	Dry skin
Sneezing	Sore throat	Chills/fever
Sadness	Melancholy	Allergies
Easily catch colds		

Group 5 symptoms:

Diarrhea/constipation	Chest tightness	Skin rashes
Feeling of lump in throat	Headache at temples	Irritability
Bitter taste in mouth	Muscle cramping	Neck/shoulder tension
Gallstones	Floaters in eyes	Dizziness
High pitched ringing in ears	Cold extremities	

Group 6 symptoms:

Sore/weak knees	Low back pain	Early hair loss
Poor memory	Fertility issues	Early hair graying
Easily startled	Fearful	Diagnosed bone loss
Low pitched ringing in ears	Dental issues	Urinary incontinence
Low sex drive		

Group 7 symptoms:

Heavy sensation in body	Swelling at hands/feet/face	Chest congestion
Mental fogginess	Puffiness in face	Nausea

Lifestyle

Briefly describe your diet, noting any dietary restrictions/preferences:_____

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Do you eat vegetables? **Y N**
Do you eat fast food/processed foods? **Y N**
Do you feel like you are "stressed"? **Y N**
Do you exercise? **Y N** Activity/how often?_____
Do you drink water? **Y N** How much?_____
Do you consume caffeine? Frequency and amount:_____
Do/did you smoke/use tobacco? **Y N**
Do/did you drink alcohol? **Y N**
Do/did you use recreational/medicinal drugs? **Y N**

* Please rate how willing you are to make lifestyle changes to accomplish your wellness goals*
unwilling to change at all 1 2 3 4 5 6 7 8 9 10 completely willing

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Informed Consent/
Privacy and Payment

Consent to Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, acupressure, moxibustion, cupping, gua sha (scraping), electrical stimulation, massage, herbal therapy and nutritional counseling. Though we take every precaution to ensure your safety there are some risks associated with these procedures: bruising, swelling, bleeding at the needle site, sore muscles and temporary exacerbation of symptoms that may last a few days. Rare risks may include: dizziness, fainting, infection, nerve damage, and pneumothorax. I understand I can discuss risks and benefits further with my practitioner before signing if I so choose.

I understand that herbal supplements recommended to me by my acupuncturist are safe in the recommended dose. Large doses of herbs taken without my practitioner's recommendation may be toxic and some herbs are inappropriate during pregnancy/nursing. I understand that I must stop taking any herbs and notify my practitioner immediately if I experience any discomfort or adverse reactions.

This consent form is intended to cover the entire course of treatment for my present conditions, and any future conditions for which I may seek treatment at this office. I accept the risks and benefits, and hereby give my full consent to treatment.

Pregnancy Specific

Moxibustion for Breech Presentation – I understand that moxibustion and acupuncture are used to help promote relaxation and support optimal internal conditions (such as increased amniotic fluid) to allow a breech positioned baby to turn itself if it is able. Moxibustion does not directly turn the baby, and this is not a substitute for the medical procedure of an external version.

Acupuncture for Labor preparation – I understand that acupuncture can help reduce anxiety about labor/induction and stimulate proper hormone production to promote the onset of labor, however it is not a substitute for hospital-based medical interventions for ripening the cervix or inducing labor. It cannot be predicted how many treatments it may take for acupuncture to encourage the commencement of labor.

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Privacy

I understand that acupuncture in a group setting does not offer the same privacy as a one-on-one treatment behind closed doors and other participants in the group acupuncture may overhear my personal health information. I understand that my personal health information will be kept in HIPAA compliant storage. I have been given a copy of HIPAA privacy policies.

Communication via e-mail can be convenient for all parties; however, e-mails may not be encrypted and could be read by some outside party with the skills to access this information. Knowing this, I consent Swell to communicate with me via email or text regarding appointment information or non-sensitive health information.

Payment Policy

Full payment is due at the time of service.

_____ _____

Patient signature Today's date

_____

Patient name (please print)

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HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Policies

_ You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

_ You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

_ You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

_ You have a right to receive an accounting of disclosures of your protected health information made by Vela Wellness LLC.

_ You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints about your privacy rights, or how Vela Wellness LLC has handled your health information should be directed to Allie Machen by calling this office at (360)770-0191. If Allie Machen is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Ave., S.W. Room 509F HHH Building Washington, DC 20201

88FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY, PLEASE VISIT: www.hcfa.gov/medicaid/hipaa THIS NOTICE DESCRIBES HOW your MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOR-MATION. PLEASE REVIEW IT CAREFULLY.

Vela Wellness LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Communication

We may communicate the following information through one or more of these methods:

- In person
- By phone
- By Fax
- By US mail
- By Email

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. “It is our policy to provide a substitute health care provider, authorized by Vela Wellness LLC, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”