



PATIENT INSURANCE/REGISTRATION FORM

Clients Name:		
Street Address:		
City:	State:	Zip:
<i>(If your mailing address is a P O Box-Please list street address along with the P O Box)</i>		
Clients Home Phone #:	Cell #:	Work #:
Marital Status/Partner Information: Married _____ Single _____ Divorced _____ Widowed _____ Partnered _____		
Clients DOB:	ODL #:	State of Issue:

Nearest Friend or Relative not living with you in case of an emergency:

Name:	Relationship:	
Street Address:		
City:	State:	Zip:
Home Phone #:	Cell #:	Work #:

Insured Information: Primary

Name:	
Relationship To Patient: Self _____ Spouse _____ Child _____ Other _____	
Subscribers DOB:	SSN #:
ID #:	Group #:
Employer:	Occupation:
Insurance Co:	Phone:
Send Claims to:	

Insured Information: Secondary

Name:	
Relationship To Patient: Self _____ Spouse _____ Child _____ Other _____	
Subscribers DOB:	SSN #:
ID #:	Group #:
Employer:	Occupation:
Insurance Co:	Phone:
Send Claims to:	

Please remember that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance or any other balance not paid by your insurance. You will be responsible to pay full charge for missed appointments not cancelled 24 hours in advance. Patient's or authorized person's signature: I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits, Medicare, private insurance and other health plans to the party who accepts assignment below.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to a reasonable attorney's fees and cost of collections.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my records.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including; private insurance and other health plans to **Matthew Sieradski, L.Ac., D.A.O.M.**

This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ DATE: _____

RESPONSIBLE PARTY: _____ DATE: _____

HEALTH HISTORY QUESTIONNAIRE

Date: _____

Name:	
Where did you spend most of your childhood?	Place of Birth:
When did you move to the Eugene area?	
How did you find me?	

Main health issue(s) you would like me to help you with:			
How long ago did this become an issue?			
To what extent does this issue interfere with your daily activities (work, sleep, sex, etc...)?			
Have you been given a diagnosis for this issue? If so, what?			
Check the following therapies ever used in past:	Acupuncture <input type="checkbox"/>	Massage <input type="checkbox"/>	Herbs <input type="checkbox"/>
List any therapies you are employing for the current condition:			
When were you last seen by a medical doctor (date or approximate year) (This office will not contact these individuals unless you sign a release of information):			
Name of physician:	Reason for visit:		
Name of physician:	Reason for visit:		
Name of physician:	Reason for visit:		

Past Medical History (include date):	Cancer:	Diabetes:	Hepatitis:
High Blood Pressure:	Heart Disease:	Rheumatic Fever:	Thyroid Disease:
Seizures:	Venereal Disease:	Other:	
Surgeries (type of and date):			
Significant Trauma (auto accidents, falls, etc.):			
Significant Dental Work (type of and date):			
Your birth history (prolonged labor, forceps delivery, etc.):			

Allergies (drugs, chemicals, foods/result of exposure):				
Medicines taken within the last two months (vitamins, drugs, herbs, etc.):				
Family Medical History (check):				
	Diabetes <input type="checkbox"/>	Cancer <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Heart Disease <input type="checkbox"/>
Stroke <input type="checkbox"/>	Seizures <input type="checkbox"/>	Asthma <input type="checkbox"/>	Allergies <input type="checkbox"/>	Other (specify) <input type="checkbox"/>
Occupational Stress (chemical, physical, psychological, etc.):				
Do you have a regular exercise program ? Yes <input type="checkbox"/> No <input type="checkbox"/> Please describe:				
Have you ever been on a restricted diet ? Yes <input type="checkbox"/> No <input type="checkbox"/> Please describe:				
What did you have for your most recent:				
Breakfast:				
Lunch:				
Dinner:				
Snack:				
How many packs of cigarettes do you smoke per day ?				
How much alcohol do you drink per week ?				
How much coffee, tea, or cola do you drink per day?				
Please describe any use of other drugs for non-medical purposes :				
What is your work and do you enjoy it?				
If not working, what are your main activities?				
Who do you live with?				
Does that relationship have any significant problems currently?				
What do you consider your current stress level to be (low to high, etc.)?				
What is your greatest source of joy/satisfaction?				
What is your greatest source of sadness/frustration?				
Do you attend a church, synagogue, temple, or other religious institution?				
Do you consider yourself a spiritual person?			Do you practice meditation or contemplative prayer?	

F or women only: (Please check all that are or have been applicable to you – if past, indicate age or date.)

- | | |
|---|---|
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> Took birth control pills |
| <input type="checkbox"/> Scanty period | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> No period | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Heavy period | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Tender breasts before period | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Habitual miscarriage |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Sweet cravings | <input type="checkbox"/> Difficulty breastfeeding |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Uterine hemorrhage |

Age when started menses: _____

Age when started menopause: _____

Pregnancies: _____

Age: _____

Miscarriages: _____

Age: _____

Abortions: _____

Age: _____

For men only: (Please check all that are or have been applicable to you – if past, indicate age or date.)

- | | |
|---|--|
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Exhaustion after sex |
| <input type="checkbox"/> Difficult urination | <input type="checkbox"/> Nighttime urination |
| <input type="checkbox"/> Scanty ejaculation | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Loss of force when urinating | <input type="checkbox"/> Dribbling after urination |

For All: (Please check all that are or have been applicable to you – if past, indicate age or date.)

General:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Strong thirst (for hot or cold) | <input type="checkbox"/> Thirst, but no desire to drink | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> Chills | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Cravings, for what: _____ | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Weight loss | | |

Skin and Hair:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Hives | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Other, please specify: _____ | |

Head, eyes, ears, nose and throat:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Eyes strain |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw clicks, aches |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Spots in front of the eyes | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Sores on lips or inside mouth | <input type="checkbox"/> Headaches, where on head: _____ | |
| <input type="checkbox"/> Other, please specify: _____ | | |

Cardiovascular:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Other heart or blood vessel problems: _____ | | |

Respiratory:

- | | | |
|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing lying down |
| <input type="checkbox"/> Coughing or blowing nose w/ phlegm: what color? _____ | <input type="checkbox"/> Coughing blood | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain on breathing |
| <input type="checkbox"/> Other lung or breathing problems: _____ | | |

Gastrointestinal:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> Other stomach or intestinal problems: _____ | | |

Genito-Urinary:

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Other kidney or urogenital problems: _____ | |

Musculoskeletal:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/wrist pain |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Other: _____ | | |

Neuropsychological:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of concentration |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |

Please rate the degree of severity of your problem right now (mark an X):

0 _____ 10
None Worst Imaginable

Comments: (please tell me about any other issue(s) you would like to discuss):

PRIVACY POLICY:

All information divulged on the intake questionnaire or during the course of your treatments is privileged and kept strictly confidential in accordance with the Board of Medical Examiners and HIPAA guidelines. By signing below, I indicate that I have also read the Notice of Privacy Policy as provided by the office of Matthew P. Sieradski, L.Ac.

DESCRIPTION OF THERAPEUTIC MODALITIES:

Acupuncture entails the insertion of needles that are sterile, single-use, very fine, and solid (unlike a syringe) into specific locations (acupoints) along the body to a depth that averages around 1/8 to 1/4 inch, but varies from very superficial (less than 1 mm) to deeper (1 or more inches). Acupuncture sometimes entails a momentary pricking sensation, which ceases once the skin has been breached. After insertion, a dull, achy sensation is often elicited through manipulation of the needle – this indicates the activation of the patient’s qi. Occasionally, **electro-acupuncture** will also be employed, usually in the case of stubborn pain conditions. This entails the use of small voltage current between two or more needles, most commonly producing a small buzzing or tickling sensation.

Often acupuncture is combined with **heat therapy**, most commonly the use of an infrared emitting lamp that deeply penetrates the body's tissues to promote circulation and healing. Also, **moxibustion**, the burning of small amounts of the herb mugwort, (*artemisia vulgaris*) on or near the skin may be recommended.

Cupping is the placing of glass suction cups on the skin, and is used to draw out toxins from the deeper tissues into the bloodstream where they can be properly eliminated. It effectively and efficiently increases qi and blood circulation locally and can result in reddening or bruising of the skin.

Chinese Massage, or *tuina*, is similar to Western therapeutic massage but emphasizes balancing the circulation of qi and utilizes unique techniques and tools. It is employed for specific conditions of musculoskeletal imbalance as a complement to acupuncture.

Herbal Medicine employs specially formulated decoctions (teas), powders, and pills – composed of plant, mineral, and animal substances. Herbal decoctions are usually the strongest smelling and/or tasting, and are the most effective form of administration. Powders and pills are simpler to prepare and often useful for chronic ailments that require long-term therapy. A branch of herbal medicine treats external problems such as injuries and skin ailments using pastes, plasters, and liniments. I have over 220 bulk herbs in my pharmacy.

Diet Therapy involves restrictions and additions to the patient’s daily food intake. Chinese diet therapy employs an understanding of how various types of foods are helpful or harmful for different constitutions and health conditions.

INFORMED CONSENT TO TREATMENT:

I understand that any of the above therapeutic modalities may be recommended to me by Matthew P. Sieradski, a Licensed Acupuncturist in the state of Oregon. Furthermore, by signing below, I voluntarily consent to be treated by Mr. Sieradski by one or more of the above therapies, as they fall under the scope of his licensure. I also understand that acupuncture and the above modalities of health care are generally safe, but do carry a small risk of side effects including, but not limited to, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burns are a possible side effect of moxibustion. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that other side effects may occur. I will notify Matthew P. Sieradski if I am or become pregnant or if I have any questions or concerns regarding any of these treatments at any time.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and description of therapeutic modalities, have been told about the risks and benefits of acupuncture and the other procedures, and have had an opportunity to ask questions. I have also read the Notice of Privacy Practices and understand a copy is available upon request. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient or Guardian

Date

Print Name