Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

ACUPUNCTURE APPOINTMENTS

New Patient Visits:

Please note that appointments are often scheduled outside of office hours. If you arrive to the office and find the door locked, please wait patiently while the previous patient visit is concluded. Please come prepared with a listing of all current medications and if possible bring the original containers.

- If you have any recent blood-work, x-ray or any other medical documents please bring these to your appointment. If you do not have any of these, we may request your permission to obtain these records from your doctor if it is necessary.
- Your initial appointment will be approximately 1 hr in length and will include the initial intake discussion and acupuncture treatment.
- Our office does not bill directly to insurance companies. Receipts are issued upon request. Our office strongly encourages you to contact your insurance company prior to your scheduled visit to determine your coverage for Acupuncture services.
- The cost of your first visit is **£90**
- Payment for services is rendered at the conclusion of each visit. Payment by cash, debit or credit is accepted.

Follow-up Appointments:

- Best results with acupuncture are typically achieved with a series of acupuncture visits. For this reason, it is often recommended to schedule one acupuncture treatment weekly for the first 4 weeks. From there, a treatment schedule will be determined based on each individual.
- Each follow-up visit is approximately 60 minutes in length.
- The cost of each follow-up visit is £70

Missed Appointment Fee

- A fee of £30 will be charged for any missed appointment or cancellation without 24hrs notice. Extenuating circumstances will always be taken into consideration.

Scent Free Policy

- Please refrain from wearing any fragranced products (perfume, cologne, lotion, deodorants, hair products, etc.) on the day of your appointment.

Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

ACUPUNTURE INTAKE FORM[1]

Name: _____ Date:_____

Date of birth: _____ Sex: M F

Address: _____
_____
_
_____
_

Email address: _____

Phone number: Home: _____ Work/Cell: _____

Can we leave messages relating to your visits (eg: reminder calls)? Y N

Emergency contact: Name: _____

Relation: _____ Phone number: _____

How did you hear about the clinic?
_____
_____

Other health care providers you are seeing (ie. medical doctor, chiropractor, etc):

1. _____ 2. _____ 3. _____
_____ _____ _____
_____ _____ _____
(____)_____ (____)_____ (____)_____

Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

Your reasons for seeking acupuncture/treatment goals:

1. _____
2. _____
3. _____

Have you had acupuncture before: Y N

If yes, please explain (what it was for, how was the experience)

_____

_ Do needles bother you: Y N

If yes, please explain

_____ Have you had Moxibustion before: Y N

Medical History:

Do you see a medical doctor regularly: Y N

Do you get regular blood work: Y N

Do you currently have or have you ever had any of the following: (please circle)

AIDS
Allergies
Anemia
Anxiety
Arthritis
Asthma
Bipolar disorder
Cancer
Chronic fatigue syndrome
Deep vein thrombosis
Depression
Diabetes
Digestive disorders
Drug addiction
Epilepsy
Fibromyalgia
Gall stones
HIV
Heart condition
Hemophilia
High/Low blood pressure
Jaw pain
Kidney disease/stones
Liver condition
Migraines
Multiple sclerosis
Osteoporosis
Pacemaker

Respiratory	Spinal injury	problem
condition Rheumatic	Sprains or	Tuberculosis
fever Sinus problems	fractures Stroke	Ulcers
Skin condition	Thyroid	Ulcerative Colitis

Other (Please specify): _____

_____

Please list all Medications, Herbs, Vitamins and Supplements:

_____

_____

_____

_____

List past injuries, hospitalizations or surgeries with approximate dates (unless already noted previously:

_____

_____

_____

_____

_____

_____

Do you have any allergies (medications, environmental, etc)?

_____

_____

_____

Do you frequently use any of the following (please check yes or no):

	Yes	No	If yes, how often				
Painkillers	____	____	_____	Antacids	____	____	_____
Laxatives	____	____	_____	Birth control pills	____	____	_____

	Yes	No	If yes, form and how often				
Tobacco	____	____	_____	Alcohol	____	____	_____
Caffeine	____	____	_____				

Recreational drugs _____ _____ _____

Lifestyle:

Describe your diet:

_____

_____

Do you crave any particular foods: _____

Exercise: Y N If yes, describe _____

Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

_____

Stress level: Low - 1 2 3 4 5 6 7 8 9 10 – High

Physical symptoms when stressed: _____

_____

Sleep: Hours per night: _____ Rested in AM: _____ Trouble falling asleep: _____ Trouble staying asleep: _____ Frequent Urination at night: Y N If Yes, how many times _____ Occupation: _____ Enjoy work: Y N Hobbies: _____ Do you have children (if so what age): _____

Symptom Survey (please check all that apply):

0= Never 1= Rarely 2= Occasionally 3= Frequently4= Always

0 1 2 3 4 low appetite

0 1 2 3 4 loose stools

0 1 2 3 4 gas/ abdominal bloating 0 1 2 3 4 fatigue after eating

0 1 2 3 4 hemorrhoids

0 1 2 3 4 bruise easily

0 1 2 3 4 anemia

0 1 2 3 4 abnormal swelling

0 1 2 3 4 allergies

0 1 2 3 4 asthma

0 1 2 3 4 shortness of breath 0 1 2 3 4 cough

0 1 2 3 4 dry nose/mouth/skin/throat

0 1 2 3 4 ravenous appetite 0 1 2 3 4 heartburn/ acid reflux 0 1 2 3 4 mouth sores

0 1 2 3 4 belching or vomiting 0 1 2 3 4 gums bleeding/swollen 0 1 2 3 4 thirst Hot? Cold? 0 1 2 3 4 bad breath

0 1 2 3 4 fatigue

0 1 2 3 4 catch colds easily 0 1 2 3 4 tired after little exertion 0 1 2 3 4 general weakness 0 1 2 3 4 nasal discharge 0 1 2 3 4 sinus congestion

0 1 2 3 4 sore, cold or weak knees 0 1 2 3 4 low back pain

Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

neck/shoulder tension

0 1 2 3 4 frequent urination 0 1 2 3 4 urinary incontinence 0 1 2 3 4 ear/hearing problems

0 1 2 3 4 early morning diarrhea 0 1 2 3 4 feel cold often

0 1 2 3 4 swollen ankles

0 1 2 3 4 poor memory

0 1 2 3 4 hair loss

0 1 2 3 4 infertility

Low Normal High libido

0 1 2 3 4 irritable

0 1 2 3 4 ligament/tendon issues 0 1 2 3 4 tight feeling in chest

0 1 2 3 4 alternate diarrhea/constipation

0 1 2 3 4 sigh frequently 0 1 2 3 4

0 1 2 3 4 muscle spasms/twitches 0 1 2 3 4 numb extremities 0 1 2 3 4 dry, irritated eyes 0 1 2 3 4 ear ringing

0 1 2 3 4 anger easily

0 1 2 3 4 red eyes

0= Never 1= Rarely 2= Occasionally 3= Frequently4= Always

0 1 2 3 4 feel heart beating 0 1 2 3 4 insomnia

0 1 2 3 4 sores on tip of tongue 0 1 2 3 4 anxiety

2 3 4 floaters in eyes 0 1 2 3 4 heat in palms or soles 0 1 2 3 4 afternoon fever 0 1 2 3 4 night sweats

0 1 2 3 4 flushed face

0 1 2 3 4 chest pain

0 1 2 3 4 disturbing dreams 0 1 2 3 4 restlessness

0 1 2 3 4 palpitations

0 1 2 3 4 dizzy upon standing 0 1

0 1 2 3 4 foggy thinking 0 1 2 3 4
enlarged lymph nodes 0 1 2 3 4
cloudy urine

0 1 2 3 4 feeling of heaviness 0
1 2 3 4 nausea

Urination: Circle all that apply: Burning Urgent Scanty Difficult Profuse Dribbling More than

1 time a night

Bowel movements: Frequency _____

Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

Consistency (circle): Well-formed Hard Loose Alternates Do you ever have
(circle): Undigested food Blood Mucous

Do you prefer beverages that are: Warm Cold Room temperature Do you find that you tend to be particularly hot or cold: _____ How is your energy level in general: _____

Women Only:

Are you currently pregnant: Y N Unsure
# of pregnancies _____ # of live births _____ # of miscarriages _____ How old were you when you had your first period: _____
Have you experienced menopause: Y N When? _____ Are you experiencing peri-menopausal symptoms, please describe: _____

_____

_ Vaginal discharge: Y N Clear/White/Yellow/Green Itch/Burn/Pain/Foul Odor Is your period regular: _____ When was the first day of your last period: _____ Length of cycle (start of one period to start of the next): _____
Average number of days of flow: _____ Flow: Light Normal Heavy Colour (circle all that apply): Pale Normal Dark Bright Red Brown Purple Blood clots: Y N
Cramps: Y N Severe: Y N
Type of pain: Sharp Dull Constant Intermittent Burning Aching Do you

experience any of the following before or during your period:

Breast Swelling/tenderness Water retention Depression Irritability Headaches

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

Men Only:

Circle all that apply:

Groin pain Enlarged prostate Decreased libido Testicular pain Impotence Painful urination
Difficult urination Premature ejaculation Nocturnal emissions Increased libido

Dr. Yuki-S. Itaya, Acupuncture and Moxibustion
www.okyu-do.com

Informed Consent for Acupuncture Treatment

PLEASE NOTE THAT THIS FORM MUST BE SIGND PRIOR TO YOUR FIRST APPOINTMENT

Traditional Chinese Medicine is a system of healthcare that takes a holistic and natural approach to assessment, diagnosis, and treatment with a focus on prevention, restoration and health maintenance.

Traditional Chinese Medicine includes the use of acupuncture, botanical formulas, and dietary changes to eliminate disease and to balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

It is very important that you inform your acupuncturist immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your acupuncturist if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine. These include but are not limited to aggravation of pre-existing symptoms, fainting, pain, bruising or injury from acupuncture needles.

Acupuncture Pricing and Fee Policy

SERVICE	PRICE	DURATION OF VISIT
Initial Visit	£90	60 to 90 minutes
Follow-up Visit	£70	60 minutes

Initial	I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent unless required by law.

Initial	I understand that the acupuncturist will answer my questions to the best of her ability. I understand that the results are not guaranteed. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications.

Initial	I understand that fees are to be paid for at the time of consultation and that I am responsible for submitting all claims to my extended health care provider.

Initial	I understand that a Missed Appointment Fee of £30 will be charged for any missed appointments or cancellations with less than 24 hrs notice. Unforeseen circumstances will always be taken into consideration.

Initial	I understand that NO supplement or herbal recommendations will be made during an acupuncture visit. Supplement and herbal recommendations can only be made during Herbal Consultation visit, and can only be done after an initial visit.

I have read and understand the above-stated policies. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name (please print)

_____ Signature of Patient or

Guardian:_____ Date:_____