

One River Medicine

P.O. Box 1538, Meadow Vista, CA 95722
(530) 878-4828

Welcome to One River Medicine! Before you become an acupuncture patient of ours we would like to let you know some details to make your treatment more successful.

Caffeine: Try not to drink caffeine within 12 hours before your visit because it will stay in your system and alter your pulse. Pulse diagnosis is an integral part of Chinese medical diagnosis and helps insure more effective treatment.

Tongue: Please do not brush your tongue before a visit because the quality of your tongue's coating also provides important information for your treatment. Please avoid anything that may stain your tongue prior to your appointment.

Eat: During your acupuncture treatment, you will usually become very relaxed, and may feel a little light-headed afterwards. Make sure that you have eaten beforehand so that your blood sugar stays level, and you will be much less likely to experience light-headedness.

Herbal Tinctures: Your herbal tincture is custom made for you and your condition only. Please do not give this tincture to anyone else. If you bring your tincture bottle back for refill, you will get \$1.50 off your next tincture. *Bottles should be clean, label-free, and placed in a bag with your name on it.*

Preparation: Place the recommended dosage of tincture in some boiling water and let it simmer for the recommended length of time to evaporate off the alcohol. This can be done in either a very small amount of water to get it down quickly, or in a larger amount of water so that it doesn't taste so strong. Often times the herbs taste fine if they are diluted. You can also add the evaporated tincture to some juice to make it more palatable. You may want to prepare the whole day's worth of tincture in the morning so that you can take it with you for the day. **Please do not microwave** your tincture, as it may change the chemistry of the herbs.

For Your Information:

1. Sometimes, after receiving an acupuncture treatment, you may feel slightly light-headed. If this is the case, please sit for a while in the waiting room.
2. Occasionally you may get a small bruise after an acupuncture needle is removed. This is not cause for concern. It will go away in a few days.
3. Herbal prescriptions are intended only for the person for whom they are prescribed.
4. For your protection, I use only pre-sterilized, disposable needles in my practice.

OFFICE POLICY – PATIENT'S COPY

Fees: *All fees are due at the time of service.* Unpaid balances will be charged 18% interest, assessed monthly.

Payment Options: For your convenience, we accept cash, personal checks, Visa, Discover, or Mastercard.

Cancellations: **There is a \$75.00 cancellation fee for appointments not cancelled or changed at least 1 full business day in advance.**

Scents: Because many people have severe chemical sensitivities, please do not wear any type of scent to this office (including essential oils, colognes, and scented lotions). The use of nano-particles in cosmetics and bath products has resulted in severe and sudden respiratory distress and migraine headaches in many people.

Time: Because we try to run on schedule from patient to patient, please arrive on time. If you think you are unable to make it on time, please call at least 1 full business day ahead of time to avoid the cancellation/no show fee. This policy is in place because we have turned other patients away in order to reserve your appointment for you. (If you are changing to an *earlier* appointment, the cancellation fee does not apply.)

Welcome to *One River Medicine!*

Congratulations, you have just embarked upon a journey to optimal health and vitality using ancient wisdom and natural medicines. My goal is to assist patients in obtaining and maintaining **optimal health and vitality**, physically, mentally, emotionally and spiritually. To obtain the best results, I offer all five branches of Chinese medicine: acupuncture, herbs, diet, manual therapies and medical Qi Gong. Patient education is an integral part of this process, and I encourage everyone to attend my classes on Chinese medicine and the Health and Longevity series. In addition, Qi Gong classes are held here to teach you how to keep your energy flowing between treatments.

Many patients come here for quick relief of pain or discomfort, or for the treatment of a chronic disease. Most are unaware that the ultimate goal of Chinese medicine is to keep you healthy, balanced and free from illness on an ongoing basis. Because it is difficult to judge the health of your body simply by your immediate symptoms, regular treatments and evaluations are recommended to alleviate any minor problems before they become major concerns. **Good health is not just the absence of disease or pain.**

The first step on your journey to optimal health is **Relief Care**. This type of care allows you to feel better faster. Each visit builds on previous visits, paving the way toward eliminating your initial problems. Treatments are scheduled close together over a few weeks or months to further reduce your symptoms. Your condition, age, lifestyle, and quality and quantity of your energy, called Qi (pronounced “chee”), are all factors in your treatment frequency.

The next phase of your journey is **Corrective Care**. After signs and symptoms have been significantly reduced or eliminated, your visits become less frequent. The focus during this phase is on maintaining and supporting the changes you have achieved, thus providing a foundation for deeper healing and addressing the underlying imbalances or deficiencies.

The third phase is **Maintenance & Wellness Care**. These are less frequent visits that help preserve all the progress you have made, and keep you tuned-up for optimal health. These visits keep your energy flowing smoothly, further strengthen your body’s resistance to disease, and minor problems can be quickly resolved.

***To help you make a commitment to your health and wellbeing,
we offer significantly reduced rates for those who pay in advance for a set of treatments.***

I look forward to assisting you on your journey.

Sincerely,

Linnie O’Flanagan, L.Ac.

ONE RIVER MEDICINE

P.O. BOX 1538, MEADOW VISTA, CA 95722

(530) 878-4828

PATIENT INFORMATION

Today's Date _____

Name _____ Gender _____ Birthdate _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home (_____) _____ - _____ Work (_____) _____ - _____ Other (_____) _____ - _____

What is your preferred method of contact for appointment reminders? _____

Any restrictions on information left in a message? _____

Do you need any assistance getting undressed/dressed, on/off the table? _____

E-mail Address _____

Emergency Contact _____ Relationship _____ Phone: (_____) _____ - _____

How did you hear about us? _____

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Please initial:

_____ I authorize the professional staff of One River Medicine to treat me with Therapeutic Massage & Advanced Bodywork.

_____ I authorize Linnie O'Flanagan, L.Ac. to treat me with Acupuncture & Chinese Medicine.

I have read this document and indicate agreement by my signature below.

Print Name of Patient

Print Name of Parent or Legal Guardian

Signature of Patient, Parent, or Legal Guardian

Date

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

Occupation _____ Employer _____ Marital Status _____ No. of Children _____

What is your main reason for visit? _____

Other minor concerns? _____

Symptoms Check (✓) symptoms you have had problems with recently

General

- Chills
- Fever
- Sweats
- Anxiety
- Depression
- Grief
- Irritability
- Nervousness
- Tension
- Dizziness
- Fainting
- Fatigue
- Headaches
- Loss of balance
- Loss of sleep
- Tire easily
- Weight loss
- Weight gain

Muscle/Joint/Bone

Pain, weakness, numbness in:

- | | |
|--------------------------------|------------------------------------|
| <input type="checkbox"/> Arms | <input type="checkbox"/> Elbows |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrists |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Hips | <input type="checkbox"/> Groin |
| <input type="checkbox"/> Legs | <input type="checkbox"/> Jaw |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulders |

Gastrointestinal

- Appetite poor
 - Bloating
 - Bowel changes
 - Constipation
 - Diarrhea
 - Excessive hunger
 - Excessive thirst
 - Gas
 - Hemorrhoids
 - Indigestion
 - Nausea
 - Persistent ab. pain
 - Rectal bleeding
 - Stomach pain
 - Vomiting
 - Vomiting blood
- ## Cardiovascular
- Chest pain
 - Cold hands or feet
 - Flushed face
 - High blood pressure
 - Irregular heart beat
 - Low blood pressure
 - Poor circulation
 - Shortness of breath
 - Swelling of ankles
 - Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums
 - Blurred vision
 - Crossed eyes
 - Difficulty swallowing
 - Double vision
 - Earache
 - Ear discharge
 - Hay fever
 - Hoarseness
 - Inflamed throat
 - Loss of hearing
 - Nosebleeds
 - Persistent cough
 - Ringing in ears
 - Sinus problems
 - Tightness in throat
 - Vision- Flashes
 - Vision- Halos
- ## Women only
- Abnormal Pap Smear
 - Bleeding between periods
 - Breast lump
 - Extreme menstrual pain
 - Hot flashes
 - Nipple discharge
 - Painful intercourse
 - Vaginal discharge
 - Other

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash _____
- Scars
- Sore that wont heal

Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Men only

- Breast lump
- Erection Difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

Conditions Check (✓) conditions you currently have or have had in the past.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia

- Cancer _____
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Gall Bladder Problems
- Glaucoma
- Goiter
- Gonorrhea

- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Lymes Disease
- Measles

- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate Problems
- Psychiatric Care
- Rheumatic Fever

- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

All information is strictly confidential

Current Medications & Supplements	How long?	Reason?

List Allergies

Have you ever had a blood transfusion?
 ___ Yes ___ No
 If yes, please give give approximate dates.

Year	Injuries, Procedures, Operations, & Serious Illnesses	Reason &/or Outcome

Pregnancy History

Year of Birth	Gender	Complications if any

Health Habits

Check	Habit	Frequency
	Caffeine	
	Tobacco	
	Street Drugs	
	Sugar	
	Alcohol	
	Exercise	
	Meditation/ Prayer/ Relaxation	

Describe current pain & location	Pain level 1-10	How long?

Occupational Concerns: Check (X) if your work exposes you to the following

	Stress	Your occupation:
	Hazardous Substances	
	Heavy Lifting	
	Other	

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	Health Problems	Age at Death	Relation	Age	Health Problems	Age at Death
Father				Mother			
Brothers				Sisters			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my practitioner if I, or my minor child, ever have a change in health.

 Signature of Patient, Parent, Guardian or Personal Representative

 Date

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

One River Medicine

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, the office of One River Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that the office of One River Medicine maintains a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that One River Medicine reserves the right to change their notice and practices at anytime. A revised *Notice of Information Practices* may be obtained by forwarding a written request to One River Medicine P.O. Box 1538, Meadow Vista, CA 95722.

With my consent, the staff of One River Medicine may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations (TPHO), such as appointment reminders, insurance items, and any call pertaining to my clinical care.

With my consent, the office of One River Medicine may mail to my home or other designated location any items that assist the office in carrying out TPHO, such as appointment reminders cards and patient statements.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that One River Medicine is not required to agree to the restrictions requested.

By signing this form, I am consenting to One River Medicine's use and disclosure of my protected health information to carry out TPHO. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. If I do not sign this consent, One River Medicine may decline to provide treatment to me.

Print name of Patient

Print name of Parent or Legal Guardian

Signature of Patient, Parent, or Legal Guardian

Date