Erin Boedeker, L.Ac.
406.260.5806
Stillpoint Acupuncture | 244 Spokane Ave., Suite 7 | Whitefish

DATE _____

NAME _____

MAILING ADDRESS (STREET/CITY) _____

TELEPHONE (DAY) _____ (EVENING) _____ CELL _____

EMAIL _____ GENDER M F MARITAL STATUS_____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

OCCUPATION _____

EMPLOYER NAME & ADDRESS _____

EMERGENCY CONTACT _____

THEIR PHONE & RELATIONSHIP TO YOU_____

PRIMARY CARE DOCTOR (NAME & CONTACT)_____

INSURANCE PROVIDER _____ PLAN # _____

HOW DID YOU HEAR ABOUT STILLPOINT ACUPUNCTURE? _____

REASON(S) FOR TODAY'S VISIT _____

HAVE YOU SOUGHT TREATMENT FOR ANY OF THESE CONCERNS? IF YES, PLEASE SPECIFY.

_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING:

_____(initials)	I, the undersigned, authorize treatment by Erin Boedeker, L.Ac. I understand that payment is expected in full at the time of service. I have been informed of the fee for treatment, and I agree to pay all fees for such service.
_____(initials)	I have also been informed of the $35.00 fee on all checks returned by the bank for NSF (not sufficient funds), as well as the $25.00 fee for less than 24 hours notice for cancellation of treatment.
_____(initials)	I understand that my practitioner will abide by the Notice of Privacy Practices in accordance with the Health Information Privacy Act, a copy of which I have been given or declined. 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 unless so directed by myself, or my representative, or unless it is required by law and for insurance claim processing reasons.

BY SIGNING BELOW, I VERIFY THAT I UNDERSTAND THIS FORM AND HAVE FILLED IT OUT TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Informed consent

This disclosure is to advise you of the credentials of the practitioner, the scope of practice for Acupuncture and to document your consent for services.

Credentials: Erin Boedeker received a Master's Degree in Acupuncture and Oriental Medicine in December 2009 from Bastyr University in Kenmore, Washington. She passed the National Board Examination by the National Committee for the Certification of Acupuncturists (NCCAOM) and is designated a Diplomat of Oriental Medicine. She is currently a Licensed Acupuncturist in the State of Montana, holding Acupuncture License number 236 since January 2010**.**

Scope of Practice: I hereby authorize Erin Boedeker to perform the following treatments. These treatments include but are not limited to:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.
- **Moxibustion:** A soft woolly mass prepared from ground young leaves, typically in the form of sticks or cones, which are ignited and placed on or close to the skin or used to heat acupuncture needles.
- **Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Dermal-friction Technique (Gua-sha):** Friction is applied topically to the skin using a smooth object to relieve symptoms.
- **Sonopuncture:** The use of sound to stimulate acupuncture points or meridians also called Acutonics.
- **Laserpuncture:** Laser light beams are applied to the acupuncture points to help stimulate the flow of chi and promote healing.
- **Dietary Advice Based on Traditional Chinese Medical Theory:** Suggestions for nutrition and herbal food products.
- **Liniments, Oils, and Plasters:** herbal formulas applied topically to the skin.
- **Cranial Sacral Therapy:** Gentle manipulation of the cranial bones and positive influence of cerebral spinal fluid flow.
- **Reiki:** Hands-on healing therapy that promotes the positive flow of energy in the body.

I recognize the potential benefits and risks of these procedures described below, which include but are not limited to:

- **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.

- **Potential Risks:** Discomfort, pain, some pain following treatment in insertion area, minor bruising, a burn, blistering, bleeding, infection, numbness or tingling at or near the site of the procedure, temporary discoloration of the skin, broken needle, needle sickness, possible aggravation of symptoms existing prior to the acupuncture treatment, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax).

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment

With this knowledge, I voluntarily consent to the above procedures, realizing that Erin Boedeker has given me no guarantees regarding cure or improvement of my condition. I hereby release Erin Boedeker from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

_____

Signature of patient (or guardian if under 18) **Date**

Please complete this form as thoroughly as possible. All answers are strictly confidential. Please ask if you have any questions.

Please list current Medications & Supplement

_____

_____

Please List Any Current Allergies or Sensitivities (environmental/food/skin)

_____

_____

Do you have any reason to believe you are pregnant? Yes No

Do you have a Pacemaker? YES No

Please list any major surgeries or hospitalizations that you have had

_____

_____

Please List any Major Childhood illnesses

_____

_____

Exercise: Days per week_____ Length of workout_____

Type of Activity_____

Typical Diet: Breakfast_____Lunch_____

Dinner _____ Snacks _____

Caffeinated(what/how many) _____

Alcohol _____ Recreational drugs/Tobacco _____

Personal History Please check any conditions or symptoms you have or have had.

- ❑ Arthritis
- ❑ Anemia
- ❑ Diabetes
- ❑ Stroke
- ❑ Seizures/Epilepsy
- ❑ Raynaud's disease
- ❑ Osteoporosis
- ❑ Asthma
- ❑ Respiratory allergies
- ❑ Hypo/hyperglycemia
- ❑ Food allergies
- ❑ Gastritis/pancreatitis
- ❑ IBS
- ❑ High/Low Blood Pressure
- ❑ Heart disease
- ❑ High cholesterol
- ❑ Chronic fatigue
- ❑ Chronic pain
- ❑ Thyroid disorder
- ❑ Kidney disease/stones
- ❑ Liver/ GB disease
- ❑ Hepatitis
- ❑ Lupus
- ❑ Lyme disease
- ❑ HIV/AIDS
- ❑ Cancer_____
- ❑ Alcoholism/Addictions

Family Medical History Please check any condition that applies to your immediate family.

- ❑ Diabetes
- ❑ Allergies
- ❑ Stroke
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Asthma
- ❑ Seizures
- ❑ Cancer _____
- ❑ Other _____

Please check any of these items listed below that you have experienced in the last 6 months.

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Desire cold/hot drinks
- ❑ Thirst
- ❑ Muscle fatigue
- ❑ Bleed/bruise easily
- ❑ Dental/Gum problems
- ❑ Sudden energy drop
- ❑ General weakness
- ❑ Heavy body
- ❑ Fatigue
- ❑ Gas/abdominal bloating
- ❑ Weight loss/gain
- ❑ Mucous in stools
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Heartburn/acid reflux

- ❑ Sweat easily
- ❑ Allergies
- ❑ Rashes
- ❑ Eczema/Psoriasis
- ❑ Frequent colds
- ❑ Nasal discharge
- ❑ Sinus congestion
- ❑ Dry skin/nose/mouth
- ❑ Cough
- ❑ Shortness of breath
- ❑ Difficult inhale/exhale

- ❑ Eye strain/pain
- ❑ Floaters/Spots in vision
- ❑ Earaches
- ❑ Headaches
- ❑ Dizziness
- ❑ Bad breath
- ❑ Ringing in ears
- ❑ Jaw pain/grinding teeth
- ❑ Difficulty swallowing
- ❑ Irritability
- ❑ Blurry vision
- ❑ Frequent sighing
- ❑ Neck/shoulder tension
- ❑ Cold hands/feet
- ❑ Red eyes

- ❑ Palpitations
- ❑ Insomnia
- ❑ Sores on tip of tongue
- ❑ Anxiety
- ❑ Chest pain
- ❑ Restlessness
- ❑ Disturbing dreams
- ❑ Varicose veins

- ❑ Low back pain
- ❑ Knee pain
- ❑ Premature graying
- ❑ Hair loss
- ❑ Ear/hearing problems
- ❑ Frequently flushed face
- ❑ Night sweats
- ❑ Nighttime urination
- ❑ Frequent urination
- ❑ Urinary incontinence
- ❑ Swollen ankles
- ❑ High libido
- ❑ Low libido
- ❑ Infertility
- ❑ Frequent nose bleeds

- ❑ Foggy head
- ❑ Poor balance
- ❑ Tremors
- ❑ Loss of coordination
- ❑ Taste changes
- ❑ Poor memory/concentration
- ❑ Areas of numbness
- ❑ ADD/ADHD
- ❑ Frequent UTIs
- ❑ Acne
- ❑ Fungal infections
- ❑ Enlarged lymph glands

Gynecological/Reproductive

Women:

- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Endometriosis
- ❑ Fibrocystic breasts
- ❑ Vaginal dryness
- ❑ Infertility
- ❑ Uterine fibroids
- ❑ PCOS
- ❑ Vaginal sores
- ❑ Ovarian cysts
- ❑ Irregular menstruation
- ❑ PMS

Age of first menses_____ Date of last menses_____ # days in cycle _____ # of days of blood flow _____
Pregnancies _____ # Live births _____ # Miscarriages _____ # Abortions _____
Do you use birth control? Y N What type? _____ Duration Birth Control? _____

Men:

- ❑ Prostate issues
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emissions
- ❑ Testicular Pain
- ❑ Male infertility