Consent to Treatment Form

I, consent to Chinese medical treatment by Bethany M. Leddy. I understand that Chinese Medical treatments involve the use of acupuncture needles, moxa heat therapy, and/or herbal medicines. I understand that I have the right to refuse any treatment at any time and to discontinue treatment whenever I wish.

All information discussed during your treatment is privileged and confidential. I do consent to the release of my medical information to my insurance company or to other Doctors I am seeing regarding my condition. I also consent to the anonymous use of my data for research purposes.

I also understand that it is important to regularly consult my physician regarding my condition and for routine physicals.

Payment is expected at the time of visit in the form of cash, check or credit card. Our office only bills insurance companies with prior authorization where the deductible has been met. I can also provide you with an insurance reimbursement form to assist you in filling out insurance claim forms. The link to verify insurance is contained in your welcome email and also on the website. Because of the reimbursement policies of Blue cross blue shield we do not bill BCBS directly. This office makes no guarantees or claims that insurance will reimburse the patient for treatments.

I agree to give 48 hours notice before cancellation or change of an appointment. If I fail to give 48 hours' notice before cancellation, I agree to pay the full amount of the missed or canceled appointment.

I also certify that I do not have any known Covid-19 symptoms, do not currently have a positive Covid-19 diagnosis, and have not had close contact with anyone recently diagnosed with Covid-19. Covid-19 symptoms include but are not limited to: fever, chills, severe headache, loss of taste or smell, cough, chest pain, shortness of breath, stomach pain, nausea, vomiting, or diarrhea. I must respond to the Covid-19 prescreening email prior to each visit to certify that I do not have Covid-19 symptoms. During this time of Covid-19 any suspected viral or bacterial illness is considered Covid-19 until a negative PCR Covid-19 test is given. The 48 hour cancellation policy is waived if Covid-19 symptoms are present.

Signature_____ Date_____

Fee Schedule

Initial Visit 1 ½-2 hours	$160.00
Follow-up visit 45min-1hour	$130.00

Contact Information

Name:_____ Date of Birth:___/____/_____

Phone: cell: _____ work/home:_____

Address:_____

_____

_____

Email address:_____

Insurance Information:

Employer:_____ Employer Address: _____

Insurance Carrier: _____ Name Of Insured: _____

Policy Number:_____ Member/group#:_____

Name_____

Past Medical History (include date)

_____Cancer _____type of cancer _____Diabetes _____High blood pressure _____Heart Disease

_____ High Cholesterol _____Rheumatic Fever _____Hepatitis _____Thyroid disease(____hypo ____hyper) Seizures _____ Stroke_____ TIA _____

Trauma (include dates)(Auto, biking, skiing, accidents, falls)

Surgeries (include dates)

Your Birth History (prolonged labor, forceps, C-section)

Please list all medications and supplements, include brands and dosages:

Exercise routine and how often:

Family Medical History: Father: _____age _____ Alive _____deceased cause:_____

Mother: _____age _____ Alive _____deceased cause:_____

Sibilings: _____age _____ Alive _____deceased cause:_____

_____age _____ Alive _____deceased cause:_____

_____age _____ Alive _____ deceased Cause:_____

Personal Habits: _____Cigarettes _____Coffee _____ Tea _____Soda _____Alcohol _____THC products _____ Drug Use _____Sugar

Temperature Preferences:

Generally I feel _____always cold _____cool _____comfortable _____warm _____ hot

area of the body that feels hot or cold:

_____

I prefer _____spring _____summer _____fall _____winter My preferred weather temperature is :_____

I dislike _____ weather.

I dislike humidity_____ Humidity makes me feel heavy and lethargic_____

I dislike the wind_____

Sweat:

My perspiration is _____only with exercise _____when I am nervous _____more then other people _____constant _____sweaty hands _____sweaty head _____when I sleep _____if I get stressed

Energy:

My energy level on a 1-10 scale (10):_____ I am a high____ medium_____ or low_____ energy person.

My energy level has changed recently (increased or decreased)_____

I have the most energy at _____time of day.

I have the least energy at _____time of day.

My energy drops suddenly at _____ time of day.

My energy fluctuates through out the day _____

I feel fatigued _____

Sleep:

amount of sleep per night:_____time to bed:_____ time awake:_____ rested when wake up: _____ difficulty to fall asleep:_____ wake in night:____

time awake in the night _____ fall back asleep at_____time

difficulty to fall back asleep:_____

excessive dreams:_____ disturbing dreams:_____ Repeating Dreams:_____

vivid dreams: _____ wake up startled_____ needs more sleep_____

Nutrition and appetite:

I am/can _____hungry frequently _____ can go all day without eating _____often skip meals _____which meals _____have a loss of appetite _____have an increase of appetite _____no interest in food _____food is my life

I feel better after I eat_____ I feel worse after I eat _____

I get hangry/emotional without eating _____

I experience blood sugar fluctuations (dizziness, weakness, headaches, slight sweating, sudden temperature change hot or cold) if I haven't eaten in a long time. _____

I have diabetes _____ type_____

My A1C is _____

I have an eating disorder or have struggled with an eating disorder in the past. _____anorexia. _____bulimia _____over-eating _____ binge eating ____food control

I experience bloating after eating or several hours after eating. How often?

I experience gas _____ How often?

I experience bloating _____ abdominal cramps_____ abdominal pain_____ sensitive abdomen_____

bad breath_____ abdominal distention_____ the sensation that I am larger than I am _____

I find the following foods hard to digest _____

I belch after eating_____

I experience acid reflux_____How often? _____

The following foods trigger acid reflux:_____

I eat breakfast _____ lunch_____ dinner_____ I eat at regular or irregular times:

The first time I eat or drink is _____time

I generally have _____

The next time I eat is _____ time

I generally have _____

The next time I eat is_____ time

I generally have _____

The next time I eat is_____ time

I generally have _____

The last time I eat for the day is_____ time

I generally have _____

I prefer the flavor of sweet____Salty_____Spicey____Sour____ Bitter_____Neutral/bland_____

My favorite food/meal is:_____

The worst thing in my diet is:
_____
_

I do not eat the following foods and
why:_____

_____
_____

_____
_____

Food
allergies:_____
_____

_____
_____

_____
_____

Elimination

I have constipation or difficult to pass stool

____times per week

I have diarrhea or very soft stools

_____times per week

My stools alternate between diarrhea and constipation_____

My stools alternate between soft and hard _____

My stools are like: pebbles _____ long tubes _____ fluffy pieces _____ completely unformed_____

I have blood in my stool_____ black tarry stools_____ hemorrhoids: _____

I am thirsty_____

I drink _____ ounces of water per day

I drink the following other fluids including
alcohol:_____

_____ frequency

I have to urinate frequently _____ My urination equals what I drink_____

I can go a long time without urinating_____ I wake to urinate_____ how often_____

My urination is ____incomplete ____weak stream _____ dribbling _____difficult to initiate _____incontinent _____leakage _____urgent

I have had or have a family history of kidney stones _____

I have had a urinary tract infection _____ number of times

I take urinary supplements such as cranberry or probiotics _____

Respiratory/ Immune system (Lung)

I get sick easily_____
with_____

I never get sick_____

Then last time I was sick was_____ with
_____

I have or have had sinus problems_____ asthma_____ weak voice_____ pneumonia_____ bronchitis_____ lung cancer_____ production of phlegm_____ post nasal drip_____ tight chest_____ difficulty breathing lying down_____ loss of taste or smell___

frequent or chronic cough_____ dry cough_____ wet cough_____ fever_____ chills_____ body aches_____

frequent antibiotic use:_____ which antibiotic_____ when taken_____

I have had (check mark) or been vaccinated (write a V) against ____mononucleosis _____ Epstein-Barr-virus ____measles _____chicken pox _____shingles _____mumps _____polio _____meningitis

_____malaria _____tetanus _____pertussis _____influenza

I am allergic to:
_____
_____

_____
_____

_____
_____

_____
_____

I get my allergies in: _____Spring _____Summer_____Fall_____Winter

My Allergy symptoms are: _____runny nose _____stuffy nose _____sneezing_ ____watery eyes _____red eyes _____itchy eyes _____itchy skin _____hives_ ____

stomach discomfort _____itchy mouth _____swollen mouth _____swollen tongue _____

dry mouth _____

Dermatology:

I have _____eczema _____psoriasis _____dry skin _____oily skin _____combination skin_____ pimples_____

cystic acne_____ itchy skin_____ rashes_____ dandruff _____hair loss_____ alopecia_____

brittle hair____ dry hair_____ oily hair_____ weak nails_____ strong nails_____ unusual ridges in nails_____

Cardiovascular (Heart):

palpitations_____ anxiety_____ insomnia_____ shortness of breath_____ chest pain_____ fainting or LOC_____ facial color:_____

high blood pressure_____ low blood pressure_____ dizziness_____ irregular heart beat_____ mitral valve prolapse_____ blood clots_____

clotting disorder_____ swelling in hands_____ swelling in feet _____both or _____

one foot _____ phlebitis _____ difficulty breathing_____

Musculoskeletal:

I have the following injuries:
_____
_____

_____
_____

neck pain_____ shoulder pain_____ Midback pain_____ lumbar pain_____

pain in hips and gluts_____ pelvic pain_____ knee pain_____

ankle pain_____ elbow pain_____ wrist pain_____ carpal tunnels syndrome_____ tendon or connective tissue disorder_____

fibromyalgia_____ knee weakness_____ numbness_____ where_____ tingling_____ where_____

arthritis_____ where: _____ Rheumatoid_____ or Osteo_____

My pain level is a 1-10 (10 is high) _____
where_____

My pain is better with ice_____ heat_____ rest_____ elevation____

Movement_____ stretching_____ exercise_____

My pain is worse when I:
_____
_____

_____
_____

Head, Eyes, Ears, Nose, Throat:

dizziness_____ concussions_____ migraines_____ glasses_____ contact lenses_____ near sighed_____ far sighted_____ eye strain_____

eye pain_____ poor vision_____ night blindness_____ cataracts_____

macular degeneration_____ detached retina_____ color blindness_____

blurry vision_____ floaters_____ earaches_____ itchy ears_____ ringing in ears _____ pitch high_____ low_____

loss of hearing_____ poor hearing_____ history of frequent ear infections_____

tubes in ears_____ nose bleeds_____ mucus_____ dry throat_____ sore throat_____ sensation of something stuck in throat_____dry mouth_____copious saliva_____

teeth problems_____ Loss of teeth_____ gum bleeding_____ sores in mouth_____

sores outside of mouth or lips gum recession_____ jaw clicks_____ TMJ_____

jaw pain_____ grinding teeth_____ recurrent sore throats_____

Headache_____ how frequently_____ where temporal_____ frontal _____ behind eyes_____ back of head_____

Menstrual: If you are trying to conceive or undergoing treatment for IUI or IVF please request the separate fertility intake

Menstrual Cycle: amount of flow_____ color of flow_____

clots during cycle_____ pain/cramps during cycle_____ where_____ dull or sharp pain_____ age at first menses_____ date of menopause_____ first day of last menstrual cycle_____

Regularity of cycle_____ days of cycle_____

Discharge_____ Birth control history type and duration:_____
____

PMS /changes before/during cycle:__ fatigue ___breast tenderness ___irritable ___weepy ___anxious _____bloating _____trouble falling asleep _____waking in the night _____mood fluctuations _____more energy

fibroids_____ polyps_____ ovarian cysts_____ endometriosis_____

vaginal discharge_____ vaginal sores_____

history of STDs:_____
HIV/AIDS_____

_____ Number of Pregnancies _____ Births _____ vaginal _____cesarian _____

premature births_____ miscarriages_____ terminations

uterine prolapse_____

Neuro psychological:

Depression_____ past or current_____ anxiety_____ past or current_____ thoughts of suicide_____

attempted suicide_____ bi-polar disorder_____ type_____

obsessive compulsive disorder_____ schizophrenia_____ depression_____ vertigo_____

high stress_____ Cause of stress_____

anger easily_____ bad temper_____ easily stressed_____ poor memory_____ forgetfulness_____ worry a lot_____ obsessive thoughts_____ over thinking_____ difficulty concentrating_____ ADD_____ ADHD_____

currently undergoing psychological therapy_____

type of therapy_____

Name of Therapist:_____
_____

currently undergoing psychiatric treatment
_____

Name of Psychiatrist:
_____
_____

Psychiatric Medication include dosage and frequency_____

_____
_____

Anything else you would like to share: