Acupuncture & Wellness Services Intake Questionnaire

EMERGENCY RESPONDERS HEALTH CENTER

Today's Date: ____/____/____ ☐ **Female** ☐ **Male**

Legal Name: First: _____ Middle Initial: _____ Last: _____

Preferred First Name: _____ **Birth Date:** _____ **Age:** _____

Contact Info: Phone: ( ) _____-_____ ☐ Cell ☐ Landline Email Address: _____

If you wish to receive appointment reminders by text, please include your cell phone number.

☐ I am an established patient of Emergency Responders Health Center. Please use the address on file.

☐ I am not an established patient of Emergency Responders Health Center. Please use the following address:

Street Address: _____

City: _____ State: _____ Zip: _____

Profession: ☐ Fire ☐ Law Enforcement ☐ EMS ☐ Emergency Dispatch

☐ Other: _____
(Note Profession)

☐ Military Service: _____
(Note active duty, reserve, or veteran, and branch of service.)

☐ ***IF* First Responder:** ☐ Active-Duty Responder ☐ Chief/Deputy Chief ☐ Administrator ☐ Retired

Current Employer: _____ **Since:** ____/____
MM YY

Primary Care Physician and Physical Therapist:

☐ I currently see the following ERHC provider(s): ☐ Rob Hilvers, MD ☐ John Wick, MD

☐ Sydney Holmes, MD ☐ Mark Nassir, MD ☐ Rok Holmes, MD ☐ Chelsea Wallace, NP ☐ Shauna Lacow, NP

☐ Mikayla Taugher, PA ☐ Mike Owens, PT ☐ Other: _____

I see the following third-party medical provider:

Physician Name: _____

Practice Phone: ( ) _____-_____

Email Address: _____

How did you hear about ERHC's in-house acupuncture clinic?

☐ Marketing Flyer or Signals e-newsletter ☐ Word-of-Mouth (i.e., another patient)

☐ ERHC 360 Directory Listing ☐ Referral From: _____

Reason for Seeking Care _____

Please describe the primary concern for which you are seeking relief:
(Please ensure all text provided can be read on the lines below):

This form contains a pain index on page 7.

Indicate the severity of this condition, when symptoms are the worst. (How bad does this condition get?)
Check the most appropriate number on the scale below, corresponding with your level of discomfort.

No Discomfort *Most Discomfort*

Indicate the severity of this condition, when symptoms are the best. (What is the least bad this condition gets?)
Check the most appropriate number on the scale below, corresponding with your level of discomfort.

No Discomfort *Most Discomfort*

When did this problem start? (Please ensure all text provided can be read on the lines below):

How often do you experience this problem? Is it constant? Does it come and go? How long are the episodes when you experience it? (Please ensure all text provided can be read on the lines below):

What makes it better? (Please ensure all text provided can be read on the lines below):

What makes it worse? (Please ensure all text provided can be read on the lines below):

Please describe any secondary conditions for which you are seeking relief:
(Please ensure all text provided can be read on the lines below)**:**

Indicate the severity of this condition, when symptoms are the worst. (How bad does this condition get?)
Check the most appropriate number on the scale below, corresponding with your level of discomfort.

No Discomfort *Most Discomfort*

Indicate the severity of this condition, when symptoms are the best. (What is the least bad this condition gets?)
Check the most appropriate number on the scale below, corresponding with your level of discomfort.

No Discomfort *Most Discomfort*

Please make sure all free text answers are fully visible when filling out electronically.

When did this problem start? (Please make sure all text can be read.)

How often do you experience this problem? Is it constant? Does it come and go? How long are the episodes when you experience it? (Please ensure all text provided can be read on the lines below):

What makes it better? (Please ensure all text provided can be read on the lines below):

What makes it worse? (Please ensure all text provided can be read on the lines below):

For your primary and/or secondary complaints, please describe any therapies/treatments you have tried or are currently receiving. Please note how these treatments are working. (Please ensure all text provided can be read on the lines below):

Please note any other problems or concerns you would like to address. (Please ensure all text provided can be read on the lines below):

Medical History

Which of the following pertains to you? *(Check all that apply.)*

- ☐ I have a bleeding disorder.
- ☐ I am currently taking an anticoagulant (blood-thinning medication).
- ☐ I have an electrical implant such as a pacemaker, insulin pump or stimulator.
- ☐ I am pregnant, may be pregnant, or am planning to become pregnant.
- ☐ I have a seizure disorder/epilepsy.
- ☐ I have a history of cancer.
- ☐ I am currently undergoing treatment for cancer.
- ☐ I am currently undergoing treatment for hepatitis.
- ☐ I have had surgeries or hospitalizations. (List Below)
- ☐ I have needling restrictions on areas of my body. (List Below)
- ☐ I have other conditions of which my practitioner should be aware. (List Below)
- ☐ None of these apply.

Please give any details for the boxes checked above.
(Please ensure all text provided can be read on the lines below):

Which of the following do you experience? *(Check all that apply.)*

HEAD

- ☐ Headaches
- ☐ Migraines
- ☐ Facial Pain
- ☐ TMJ Pain
- ☐ Jaw Clenching/Teeth Griding
- ☐ Concussions
- ☐ Dizziness
- ☐ Vertigo
- ☐ Other (List Below)
- ☐ No problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

SKIN & HAIR

- ☐ Normal Skin
- ☐ Dry Skin
- ☐ Hair Loss
- ☐ Dry/Brittle/Dull Hair
- ☐ Prematurely Gray Hair
- ☐ Psoriasis - Dry
- ☐ Psoriasis - Wet
- ☐ Hives
- ☐ Itchy Skin
- ☐ Scales
- ☐ Rash
- ☐ Eczema
- ☐ Acne
- ☐ Slow-Healing Wounds
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

EYES, EARS, NOSE & THROAT

- ☐ Allergies
- ☐ Sinus Pain
- ☐ Chronic Sinus Congestion
- ☐ Clear Nasal Discharge
- ☐ Yellow/Green Nasal Discharge
- ☐ Chronic Cough
- ☐ Clear Sputum
- ☐ White Sputum
- ☐ Yellow Sputum
- ☐ Dry Eyes
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Red Eyes
- ☐ Gum/Teeth Problems
- ☐ Excessive Thirst/Dry Mouth
- ☐ Sore Throat
- ☐ Feeling as Though Something is Stuck in Throat
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Hearing Problems
- ☐ Ear Pain
- ☐ Ringing in Ears (High-Pitched)
- ☐ Ringing in Ears (Low-Pitched)
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

RESPIRATORY / IMMUNOLOGIC

- ☐ Frequent Colds
- ☐ Frequent Low-Grade Fever
- ☐ Current Fever
- ☐ Chills
- ☐ Asthma
- ☐ Cough
- ☐ Chest Congestion
- ☐ COPD
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Fungal Infection (Respiratory)
- ☐ Immunologic Disorder
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

CARDIOVASCULAR/HEMATOLOGICAL

- ☐ Normal Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Cold Hands/Feet
- ☐ Ankle Swelling
- ☐ Chest Pains
- ☐ Currently Taking R_x Heart Medication (List Below)
- ☐ Pacemaker
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ History of Deep Vein Thrombosis
- ☐ Varicosities
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

NEUROLOGICAL

- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Poor Memory
- ☐ Numbness (List Areas Below)
- ☐ Fainting
- ☐ Twitches
- ☐ Tremors
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Neuropathy
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

GASTRO-INTESTINAL

- ☐ Gas
- ☐ Excessive Gas
- ☐ Foul-Smelling Gas
- ☐ Belching
- ☐ Stomach Rumbling/Digestive Noises
- ☐ Pain when Hungry
- ☐ Pain after Eating
- ☐ Change in Appetite
- ☐ Bloating
- ☐ Distention of Abdomen
- ☐ Pain/Cramping
- ☐ Constant Pain
- ☐ Acid Reflux
- ☐ Burning Sensation when Lying Down
- ☐ Ulcers
- ☐ Nausea
- ☐ Vomiting
- ☐ Fatty Liver
- ☐ Gall Bladder Problems
- ☐ Difficulty Digesting Fats
- ☐ Hepatitis
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

BOWEL MOVEMENTS

- ☐ Well-Formed, Daily
- ☐ Diarrhea
- ☐ Constipation
- ☐ Watery Stools
- ☐ Loose Stools
- ☐ Soft Stools
- ☐ Hard Stools
- ☐ Dry Stools
- ☐ Foul-Smelling Stools
- ☐ With Mucous
- ☐ Blood in Stools
- ☐ Incomplete Feeling
- ☐ Hemorrhoids
- ☐ 1-2 Movements, Per Day
- ☐ 2-3 Movements, Per Day
- ☐ 3-4 Movements, Per Day
- ☐ > 4 Movements, Per Day
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

GYNECOLOGICAL/FERTILITY

- ☐ Light/Scanty Menses
- ☐ Moderate/Normal Menses
- ☐ Heavy Menses
- ☐ Dysmenorrhea - Moderate Pain
- ☐ Dysmenorrhea - Heavy Pain
- ☐ PMS Symptoms (List Below)
- ☐ PMDD Symptoms (List Below)
- ☐ Cycle Every 20-22 Days
- ☐ Cycle Every 23-25 Days
- ☐ Cycle Every 26-27 Days
- ☐ Cycle Every 28-30 Days
- ☐ Cycle Every 30-39 Days
- ☐ Cycle > 40 Days
- ☐ Irregular Cycles
- ☐ Amenorrhea (Missing Cycles)
- ☐ Spotting – Before Menses
- ☐ Spotting – After Menses
- ☐ Spotting – Between Menses
- ☐ Menstrual Discharge with Clots
- ☐ Excessive Vaginal Discharge
- ☐ Birth Control
- ☐ Inability to Conceive
- ☐ History of Failed IUI
- ☐ History of Failed IVF
- ☐ Currently Seeing Reproductive Endocrinologist
- ☐ Frequent Miscarriages
- ☐ Full-Term Delivery
- ☐ C-Section
- ☐ Miscarriages: _____
- ☐ Pregnancies: _____
- ☐ Deliveries: _____
- ☐ Prior D&C
- ☐ Menopause
- ☐ Hormone Therapy
- ☐ Pain with Intercourse
- ☐ Hysterectomy - Total
- ☐ Hysterectomy - Partial
- ☐ Oophorectomy - Partial
- ☐ Cysts/Breast Lumps
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

ENDOCRINE

- ☐ Hypo-Thyroid Disease
- ☐ Hyper-Thyroid Disease
- ☐ Pre-Diabetes
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

UROLOGICAL

- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Painful Urination
- ☐ Incomplete Urination
- ☐ Pale Urination
- ☐ Dark Urination
- ☐ Scanty Urination
- ☐ Copious Urination
- ☐ Dribbling Urination
- ☐ Decreased Urine Flow/Pressure
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Enlarged Prostate
- ☐ Erectile Dysfunction
- ☐ Male Hormone Therapy
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

SLEEP

- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Frequent Waking due to Disturbances (partner/child/pets)
- ☐ Restlessness
- ☐ Pain Interfering with Sleep
- ☐ Waking Early
- ☐ Disturbing Dreams
- ☐ Night Sweating
- ☐ Snoring
- ☐ Night Shift Work
- ☐ Waking to Urinate 1-2 Times
- ☐ Waking to Urinate 3-4 Times
- ☐ Waking to Urinate > 4 Times
- ☐ Sleeping 8-10 Hours
- ☐ Sleeping 6-8 Hours
- ☐ Sleeping 4-6 Hours
- ☐ Sleeping < 4 Hours
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

PERSPIRATION/BODY TEMPERATURE

- ☐ Normal Perspiration
- ☐ Does Not Perspire
- ☐ Easily Perspires
- ☐ Excessive Perspiration
- ☐ Hot Flashes
- ☐ Usually Feeling Cold
- ☐ Usually Feeling Chilly
- ☐ Usually Feeling Warm
- ☐ Usually Feeling Hot
- ☐ Night Sweating
- ☐ Profuse Night Sweating
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

PSYCHOLOGICAL, MOOD & ENERGY

- ☐ Brain Fog
- ☐ Low Energy
- ☐ Fatigue
- ☐ Lethargy
- ☐ Exhaustion
- ☐ Always Tired – Waking
- ☐ Always Tired – Afternoon
- ☐ Better in the Morning
- ☐ Better in the Evening
- ☐ Jitteriness
- ☐ Anxiety
- ☐ Worry
- ☐ Fears/Phobias
- ☐ Depression
- ☐ Crying
- ☐ Mood Swings
- ☐ Irritability
- ☐ Bad Temper
- ☐ Low Sex Drive
- ☐ High Sex Drive
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

MUSCULOSKELETAL/PAIN

- ☐ Joint Pain - Multiple Sites
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Hand Pain
- ☐ Wrist Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Elbow Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot Pain
- ☐ Arthritis
- ☐ Low Bone Density
- ☐ Osteoporosis
- ☐ Visceral (Internal) Pain
- ☐ Other (List Below)
- ☐ No Problems

Details for any boxes checked above, or other non-listed problems: (Please ensure all text provided can be read on the lines below):

Social, Family & Personal History

Please provide a description for each of the following.

Living Situation:

○ Live Alone ○ Live with Roommate(s) ○ Live with Spouse/Partner ○ Live with Family

○ Other (Please Describe)

History of Significant Illness in Parents or Siblings? (Please ensure all text provided can be read on the lines below):

Diet:

○ Vegetarian ○ Vegan ○ Pescatarian ○ Gluten-Free ○ Paleo ○ Other (Please Describe)

Food Allergies or Sensitivities: (Please ensure all text provided can be read on the lines below):

Exercise – Types and Amount per Week: (Please ensure all text provided can be read on the lines below):

Alcohol Use: (Please ensure all text provided can be read on the lines below):

Tobacco Use/Smoking: (Please ensure all text provided can be read on the lines below):

Recreational Drug Use: (Please ensure all text provided can be read on the lines below):

Meditative Practice: (Please ensure all text provided can be read on the lines below):

Diet/Lifestyle Goals: (Please ensure all text provided can be read on the lines below):

Please list any Medications, Vitamins or Supplements you are taking. *(Required.)* (Please ensure all text provided can be read on the lines below):

Please list any other questions or concerns not covered above. (Please ensure all text provided can be read on the lines below):

Emergency Contact Name: _____

Cell Phone: ( ) _____-_____ Relationship: _____

_____ _____

Patient Signature Today's Date

_____ _____

Patient's Legal Guardian Name (if patient is a minor) Relationship

_____ _____

Patient's Legal Guardian Signature Today's Date

Thank You!

Acupuncture & Integrative Healing

Informed Consent Agreement

Practitioner: Dr. Stacey Whitcomb, DAcHM, LAc

By signing the following page, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named, for whom I am legally responsible) by the acupuncturist named above.

I understand that acupuncturists practicing in the state of Idaho are not primary care providers, and that regular primary care by a licensed medical provider is recommended by Emergency Responders Health Center. I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, Gua sha, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, and Qi Gong.

ADVERSE EVENTS and RISKS: Acupuncture involves the insertion and stimulation of fine, sterile, single-use needles through the skin. Acupuncture is considered a generally safe method of treatment. Treatments can occasionally produce a mild but temporary discomfort, achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and may occasionally leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 2 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve irritation, organ puncture, pneumothorax and infection. These risks have an extremely low incidence, especially when acupuncture is administered by a Licensed Acupuncturist.

_____

CONTRAINDICATIONS: Contraindications for acupuncture treatment and certain herbs may include a history of a bleeding disorder or current anticoagulant therapy; an implanted pacemaker or prosthetic heart valve; use of certain medications; or pregnancy. I will inform my practitioner if any of the above apply to me at any time. I will also inform my Licensed Acupuncturist of any and all medications I am using.

_____

TRADITIONAL CHINESE HERBAL MEDICINE: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs such as rashes, hives and tingling of the tongue. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop using the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting to conceive or suspect I may be pregnant. With all herbal treatments, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

_____

HEAT TREATMENT (TDP Lamp): The TDP lamp is a specific electromagnetic lamp that produces far-infrared (below visible light) emissions. The lamp is used to increase microcirculation, loosen fascia and muscles, relieve menstrual cramping and pain, and to accelerate the natural healing processes of the body. Every precaution is taken to prevent over-warming, but the rare possibility of burns exists.

_____

CUPPING: Cupping is a traditional Chinese therapy technique that involves placing glass, ceramic, bamboo or plastic cups on the skin and using heat or negative pressure to create suction. The use of heat causes the air inside the cup to expand and create a vacuum, which pulls the skin and underlying tissue into the cup. Cupping promotes blood flow, reduces pain and inflammation, and promotes relaxation. It is often used for conditions such as back pain, respiratory infections, and digestive issues. Cupping often creates painless bruising marks on the skin. There is also a rare risk of burning and scarring, and uncommon occurrences of blisters that are not burn-related.

_____

Informed Consent Agreement Continued

GUA SHA: Gua Sha is translated as "scraping" or "rubbing." A smooth-edged instrument (often a Chinese soup spoon) is used to gently scrape the skin. This treatment is useful to release fascial restrictions, but is also used to resolve a common cold. This therapy often results in bruising, which is not painful and typically resolves in 3 to 7 days.

_____

ELECTRO-ACUPUNCTURE: A mild electric micro-current (similar to a TENS treatment) may be used to stimulate the acupuncture points. During electro-acupuncture, a mild tingling or tapping sensation will be felt during treatments. Occasionally, a mild achiness or soreness will be felt at the areas treated, for up to one day after the treatment. I understand that I must inform my practitioner if I am using a pacemaker, or have any heart or neurological condition, prior to undergoing this treatment.

_____

ACUPRESSURE and MASSAGE: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms that existed prior to the treatment, which may occur during or after massage.

_____

I understand that ERHC clinical and administrative staff may review my patient records and lab records, but all of my records will be kept confidential and will not be released without my written consent.

_____

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture. I understand that there may be other treatment alternatives, including treatment offered by a licensed medical provider, as Dr. Stacey Whitcomb DAcHM, LAc is not a primary care physician.

_____

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Patient Name	Date of Birth
Patient Signature	Today's Date
Patient's Legal Guardian Name (if patient is a minor)	Relationship
Patient's Legal Guardian Signature	Today's Date

EMERGENCY RESPONDERS HEALTH CENTER

Acupuncture Insurance Verification Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

It is the responsibility of each patient to verify that acupuncture benefits are included in their personal insurance policy.

I acknowledge Emergency Responders Health Center has informed me (the responsible party) of my financial responsibility should my insurance not cover my acupuncture initial evaluation and subsequent treatments.

I assume full financial responsibility for the balance of charges not covered by insurance.

Additional Benefit Information- Manual Therapy Acupuncture services, such as cupping, may be considered Physical Therapy with your insurance. If so, it will count as a Physical Therapy appointment toward your allotted number of visits per year. Resp Party initials: _____

Self-Pay Rates

- Initial Evaluation and Treatment: 60 minutes, $200
- Follow-up Sessions: 45-60 minutes, $110

Patient or Responsible Party Signature: _____Date: _____

Front Office Signature: _____ Date: _____

EMERGENCY RESPONDERS HEALTH CENTER

Appointment Late Cancel & No Show Policy Acknowledgement

Patient Name: _____ Date of Birth: _____

PLEASE BE ADVISED:

→ Late Cancellations & No-Show Appointments significantly impact our ability to provide all patients with quality care.

→ The demand for ERHC's specialized services has continued to grow in recent years.

→ An increase in Late Cancellations & No-Shows has resulted in longer wait times for patients to see our specialized providers.

→ Our providers experience significant personal financial losses from missed appointments, during a time of nationwide healthcare personnel shortages. This jeopardizes the clinical and financial viability of our Health Center.

IN ORDER TO AVOID INCURRING CHARGES OR HAVING YOUR APPOINTMENT REMOVED FROM OUR SCHEDULE:

✓ Confirm that our Front Desk has your current cell phone number and email address on file for appointment reminders.

✓ Provide us as much advance notice as possible, and at least 24 to 48 hours depending on visit type,* to cancel or reschedule any appointment.

(208) 229-8433 | Mental Health, Acupuncture & Massage Appointments

✓ Respond to our convenient text messaging prompts to confirm your next visit.

✓ Avoid scheduling appointments during a work shift or while on-call, when possible.

✓ Review our full policy found at https://er-hc.org/patient-forms and let us know if you have any questions.

- Acupuncture Late Cancellation / No Show Fee: **$100.00**

Patient or Responsible Party Signature: _____ Date: _____

Acupuncture F.A.Q.

How does acupuncture work?

Acupuncture is a traditional Chinese medicine practice that involves inserting thin needles into specific points on the body to stimulate various physiological responses. The exact mechanism by which acupuncture works is not yet fully understood, but there are several theories that attempt to explain its effects.

One theory suggests that acupuncture stimulates the release of natural painkillers, such as endorphins and enkephalins, which can help reduce pain and promote relaxation. This may explain why acupuncture has been effective in treating chronic pain conditions.

Another theory suggests that acupuncture works by affecting the autonomic nervous system, which regulates various bodily functions such as heart rate, digestion, and breathing. By stimulating specific acupuncture points, the nervous system may be influenced to promote healing and balance in the body.

Acupuncture may also help to reduce inflammation, boost immune function, and improve circulation, which can all contribute to improved health and well-being.

Overall, while the exact mechanisms behind acupuncture are not yet fully understood, there is evidence to suggest that it can be an effective complementary therapy for a range of conditions, including chronic pain, stress, and anxiety.

Does acupuncture hurt?

Everyone experiences acupuncture differently. Some people don't feel anything, while other people may feel a deep heavy ache upon needle insertion that quickly goes away. Dry needling can be painful, but a fully trained acupuncturist doesn't rely heavily on these types of techniques to get desired results. We will make your treatment as comfortable as possible, and you are always encouraged to let us know if you are ever in pain.

The needles used in acupuncture are very thin (about the width of a human hair) and are inserted just beneath the skin at specific points on the body. Your acupuncturist will adjust the depth and angle of insertion based on treatment technique and your individual needs.

Most people find acupuncture to be a relaxing and calming experience, and many patients even fall asleep during their treatment. Some people may experience a temporary feeling of heaviness or soreness in the treated areas after the session, but this usually subsides within a few hours.

How many treatments will I need?

The number of treatments required to see change in a pattern or symptom is dependent on several factors. Conditions that have been in place for many years can sometimes be stubborn, and take more treatments to resolve than an acute situation. We also factor in your overall health, constitution and lifestyle choices. Most conditions should see significant change in 6 to 12 treatments. As part of your first appointment, we will discuss your health in-depth in order to plan an appropriate treatment schedule for your specific needs.

How long does acupuncture take?

Your initial evaluation will take 75 to 90 minutes; follow-up visits are 45 to 60 minutes. The duration of time you will spend on the treatment table, with needles inserted, will depend on your diagnosis. A longer needle retention time is not always superior. Depending on your diagnosis and constitution, your practitioner will determine the appropriate treatment duration for you.

Can you combine acupuncture with other medical services?

Absolutely! Examples of successful concurrent treatments include those for fertility, post-surgical rehabilitation, addiction recovery, and mental health challenges. Chinese medicine contributes greatly in almost all medical conditions to help reduce symptoms, speed healing and improve mental well-being. If you have questions about whether acupuncture can help you, feel free to reach out using the contact information below.

Does acupuncture work for treating Mental Health conditions?

Acupuncture has a tremendous effect on the nervous system, which makes it a great addition to your current treatment plan. Patients who receive regular treatments often report that their sleep improves, they have more energy, and they just feel better overall. By utilizing even very simple specific auricular acupuncture protocols, such as Battlefield Acupuncture and the NADA protocol, patients can benefit from drug-free alternatives to pain management and a decrease in withdrawal symptoms during drug and alcohol detox.

Acupuncture & Integrative Healing Modalities

Congratulations on taking this important step toward total wellness!

What to Expect During your First Appointment

Your first visit will be much longer than follow-up visits, to enable your provider to gain a clear picture of your total health, and make an informed diagnosis and treatment plan.

First, you will be asked to fill out an extensive intake form, followed by a thorough discussion of the primary condition for which you are seeking relief (chief complaint). Your practitioner may also ask you several questions, some of which may seem unrelated to your condition. As a form of Chinese medicine, acupuncture is a holistic practice. Therefore, your practitioner will consider every possible related consideration. In order to get a clear diagnosis, you and your practitioner may explore all physical systems. Your practitioner will feel your wrist pulse, and take a look at your tongue as part of the diagnostic process.

Then, your practitioner will explain your diagnosis and present a treatment plan. In most cases, this plan will call for 6 to 12 treatment sessions, depending on your diagnosis, the amount of time you have had this condition, your overall constitution, and your lifestyle. Your practitioner will explain all of the modalities they may use, to include acupuncture, electro-acupuncture, cupping, and Gua sha.

Following this explanation, your practitioner will provide your first treatment, by inserting sterile acupuncture needles.

Integrative Healing is a Process

Acupuncture is very rarely a one-time “miracle” cure. The positive impact of each individual treatment will build over consistent sessions, much like physical therapy or working out. You should not expect to be symptom-free after your first visit. However, you might begin to experience a deep sense of relaxation beginning with your initial visit. You might experience a decrease in your pain level or modest relief from other symptoms following your first visit, or you may experience no change at all for some time. The main purpose of your first visit is to get acquainted with your practitioner, and for them to offer an initial treatment and observe how your body responds.

Before your first visit:

1. Be sure you have eaten something within 2 hours of treatment.
2. Dress comfortably and wear loose-fitting clothing. You will usually have to push your sleeves past your elbows, and your pants up over your knees. Don’t worry if you show up in your skinny jeans. We can provide appropriate draping with sheets and towels if needed.
3. Try not to have anything stressful planned prior to, or just after, your visit. It’s common to feel a little “spacy” after treatment.

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