Ann E. W. Zimmerman, LAc, Lic. # AC00920
R. Clark Zimmerman, LAc, Lic. # AC00921
Ryan Baker, MAcOM, LAc, RPh, Lic. # AC170159

Welcome to Middleway Medicine!

Thank you for choosing Middleway Medicine. Our mission is to provide safe and effective medical care, while helping each individual learn to better care for their own health. Traditional Chinese Medicine is an ancient system of healing that utilizes acupuncture, Chinese herbs, massage and qi gong therapy to bring about balance in the body. It can treat many conditions by itself, but it may also be used as a complementary therapy. We refer and work closely with physicians, medical specialists, other complementary therapists, as well as our patients, in order to offer the best care possible.

In order to serve you most effectively, we will need the following information. All information will be kept strictly confidential.

Name:_____Date:_____

Address:_____Age:_____DOB:_____

City/State/Zip:_____Phone:_____

Email Address:_____

Employer:_____Work Phone:_____

Emergency Contact:_____Relation:_____Phone:_____

Referred by:_____Relation:_____

I voluntarily consent to be treated with acupuncture by Ann and/or Clark Zimmerman, and/or Ryan Baker, Licensed Acupuncturists. I understand that acupuncture is the insertion of small needles into the body in an effort to normalize the body's normal physiological functions. I have been informed that only disposable needles will be used during each treatment.

I have been informed that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible aggravation of symptoms.

I have been informed that heat and electrical current may also be used in my treatments and that these may cause burning or minor electric shock.

I understand that Chinese herbs may be used in my treatment and may cause adverse side effects including, but not limited to: nausea, loss of appetite, stomach upset, or allergic reactions. I understand that if a problem occurs with my herbs, that I should discontinue their use immediately and contact my practitioner.

I have carefully read the above information and grant my consent to be treated.

_____

Signature (Patient/Parent/Guardian) Date

MIDDLEWAY MEDICINE
Acupuncture & Herbal Clinic

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New Patient Form

Name: _____ DOB: _____ Date: _____

Primary care provider: _____

What are your two most important health concerns?

1._____ 2._____

Please circle any of the symptoms listed below that you are currently experiencing and underline any symptoms you have experienced in the past.

General Symptoms

headaches
tired/low energy
sleeplessness/sleep too much
depression
loss/gain weight
dizziness
worry/anxiety/nervousness/irritable
frequent colds
sweating irregularities
other:

Skin and Hair

skin rashes
acne/pimples
oily skin
hair loss
bruise easily
flush easily
dryness, where?
hives
numbness
skin ulcers/sores
cold sores/herpes
athletes foot
other: _____

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Eyes

blurred vision
excessive watering
bloodshot, puffy
floaters
dryness/burning
near/farsightedness
sensitivity to light
other:

Ears

Earaches
loss of hearing
ear discharges
ringing
lots of wax
other:

Nose and Throat

sinusitis/nasal congestion
dry/chapped lips
sore tongue
bleeding gums
nosebleeds
postnasal drip
dry mouth/nose
sore throat
lack of smell/taste
hoarseness
clear throat often
other:

Musculo-skeletal

muscle pain or tenderness, if so, where? _____

swollen, painful, stiff joints
tremors, twitches
loss of strength
restless legs
bone pain
feet, ankle, calf pain
muscle wasting
other: _____

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Cardiovascular

chest pain
high/low blood pressure
cold hands or feet
high cholesterol
heart beats fast or irregular
swollen feet, ankles or legs
varicose veins
other:

Respiratory

difficulty breathing
tightness in chest
shortness of breath
cough frequently
spitting up mucous or blood
other:

Gastrointestinal

low appetite
bad breath
heaviness after eating
bloating stomach, abdomen
constant hunger
heartburn/acid reflux
gas/belching
tenderness/cramping

If yes, symptoms relieved by eating or worse with eating? _____

If yes, headache, dizziness, irritable with skipped meals? _____

Loose stools
light colored or greasy stool
blood in stool
undigested food in stool
hemorrhoids
constipation
dark stools
feeling of incomplete evacuation
foul odor of stool or gas
history of parasites

other: _____

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Urinary

difficulty urinating
incomplete urination
kidney stones
frequent urination
bladder/kidney infection
other:

Female

pain prior to or with periods
painful or swollen breasts
discharge from breasts
symptoms in a monthly pattern
difficulty having orgasm
vaginal discharge
hot flashes
reproductive surgeries
irregular menstruation/peri-menopause
depressed, tense, irritable with periods
lumps in breast
diminished or excessive sexual desire
inability to conceive
pain, discomfort, itching in genital area
history of fibroids or ovarian cysts
menopause

date of last period:_____ # of days_____ length of cycle_____
date of last PAP smear: _____ Was it normal? _____
type of birth control: _____
pregnancies:_____ # of children:_____
ages of children:_____ type of delivery:_____

Male

prostate problems
discomfort or pain in genital area
difficulty maintaining an erection
difficult or unusual urination
diminished or excessive sexual desire
other: _____

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Spiritual Health

What do you do to connect with "SPIRIT"?

Are you satisfied with your spiritual health?

Habits

cigarettes/tobacco _____ packs per day _____

coffee or black tea _____ cups per day _____

sodas per day _____ 8oz glasses of water per day _____

alcohol _____ drinks per week marijuana _____ times per week

other drug use:

Exercise

times per week_____ how long_____

what type _____

Medications & Supplements

Are you currently taking any prescription medication? Please list:

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Are you currently taking any vitamins? Please list:

Allergies

Please list any known allergies:

Surgeries/Hospitalizations

Have you had any of the following removed? Date?

tonsils _____ cysts/tumors _____

appendix _____ uterus/ovaries _____

gallbladder _____ other: _____

Have you ever been hospitalized or had a serious accident or illness?

Please list what, when and where.

Miscellaneous

Have you traveled outside of the USA within the past two years? Where?

Have you ever been diagnosed with:

AIDS Hepatitis HIV

TB Exposed to AIDS

If yes, please give diagnosis/treatment dates:

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Miscellaneous Continued

Have you ever been exposed to significant doses of:

chemicals

radiation

toxins

other:

Family History

cancer

tuberculosis

heart problems

allergies

respiratory problems

psychological problems

urinary tract problems

birth defects

diabetes

thyroid problems

high blood pressure

asthma

migraines

other:

Any additional information that you feel we should know about:

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Office Procedures

Payment of Services:
Payment is due at the time of service unless arrangements are made in advance. Payments can be made with cash, personal check, or credit card.
We have found this policy to be most effective for both patients and providers. Outstanding balances can affect the patient/practitioner relationship and can affect the progress of treatments.

Appointment Scheduling:
Each appointment will involve a detailed intake process, which includes an interview, tongue and pulse observation, and a treatment. It is very important to have the time to perform each of these steps thoroughly in order to achieve the best results. It is therefore necessary to arrive for your appointment on time. If you arrive late, we will only be able to offer a shortened treatment, as we have other patients scheduled throughout the day.

Appointment Changes:
We require a minimum of 24 hours advance notice in order to reschedule an appointment. Failure to do so is considered to be a missed appointment. If a patient misses an appointment without giving the required 24 hours notice, they will be charged half of the total return visit fee.

I have read, understand, and agree to the above statements:

_____
Signature (Patient/Parent/Guardian) Date

Release of Information:
I consent for my practitioner to consult with other practitioners in Middleway Medicine regarding my diagnosis and treatment program.

_____
Signature (Patient/Parent/Guardian) Date

Financial Responsibility:
I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, co-insurance, herbal products and any services rejected or not covered by my insurance company.

_____
Signature (Patient/Parent/Guardian) Date

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Insurance Information

Name of Insurance Co.: _____

Name of Primary Insured: _____ DOB: _____

Policy or ID#: _____ Group #: _____

Address: _____ Phone #: _____

City, State & Zip: _____

Name of Adjuster: _____ Claim #: _____

MVA/PIP: _____ Date of Accident: _____

I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payment, co-insurance, herbal products and any services rejected or not covered by my insurance company.

_____

Signature (Patient/Parent/Guardian) Date

Release of Information

I authorize this office to release any information that is required or necessary for my claim to any insurance company, adjuster, or attorney involved in this case; and hereby release this office of any consequence thereof.

_____

Signature (Patient/Parent/Guardian) Date

Assignment

I hereby instruct and direct my insurance company to pay by check, made out and sent directly to Middleway Medicine, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered by this office.

_____

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Authorization to Disclose Medical Records

I,_____, authorize Middleway Medicine to release a copy of my medical information to the following persons or institutions (name and Address):

1)_____
2)_____
3)_____

The information will be used on my behalf for the following purposes:
_____
_____

The followed items must be individually initialed to be included in the information shared:
_____HIV/AIDS related records_____Mental health information_____Genetic testing information

_____Drug/alcohol diagnosis, treatment or referral information

This authorization is:_____For any time period_____Limited to records from the following time period_____

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire is 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____ Signature
(Patient/Parent/Guardian) Date