



R. Clark Zimmerman, LAc., Lic.#AC00921
Ann Zimmerman, LAc., Lic.#AC00920
Ryder V.K. Johanson, LAc., Lic.#AC180365

Welcome to Middleway

Thank you for choosing Middleway, Acupuncture & Herbs. 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: _____	Home Phone: _____
Email Address: _____	Cell Phone: _____
Employer: _____	Work Phone: _____
Emergency Contact: _____	Relation: _____ Phone: _____
Referred By: _____	Relation: _____

I voluntarily consent to be treated with acupuncture by Clark and/or Ann Zimmerman, and/or Ryder Johanson, 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, 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



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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:

Appointments may 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 or may have to reschedule your appointment, as we have other patients scheduled throughout the day.

Appointment Changes:

We require a **minimum of 24 hours advance notice** to reschedule or cancel 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 the return visit cash fee of \$85.00.

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 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 other 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 #: _____

Insurance Address: _____ Phone: _____

Secondary Ins. Co.: _____ Policy or ID#: _____

MVA / PIP / WC: _____ Date of Accident: _____ Place (state) : _____

Name of Adjuster: _____ Phone/Ext: _____

Claim #: _____

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, 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.

Signature (Patient/Parent/Guardian) Date



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

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

dizziness

tired/low energy

worry/anxiety/nervousness/irritable

sleeplessness/sleep too much

frequent colds

depression

sweating irregularities

loss/gain weight

other:

Skin and Hair

skin rashes

dryness, where?

acne/pimples

hives

oily skin

numbness

hair loss

skin ulcers/sores

bruise easily

cold sores/herpes

flush easily

athletes foot

other: _____

Eyes

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

Ears

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

Nose and Throat

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

Musculo-skeletal

muscle pain or tenderness, if so, where? _____	
swollen, painful, stiff joints	bone pain
tremors, twitches	feet, ankle, calf pain
loss of strength	muscle wasting
restless legs	other: _____

Cardiovascular

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

Respiratory

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

Gastrointestinal

low appetite	constant hunger
bad breath	heartburn/acid reflux
heaviness after eating	gas/belching
bloating stomach, abdomen	tenderness/cramping
If yes, symptoms relieved by eating or worse with eating? _____	
If yes, headache, dizziness, irritable with skipped meals? _____	
Loose stools	constipation
light colored or greasy stool	dark stools
blood in stool	feeling of incomplete evacuation
undigested food in stool	foul odor of stool or gas
hemorrhoids	history of parasites
other: _____	

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

date of last period: _____

date of last PAP smear: _____

type of birth control: _____

pregnancies: _____

ages of children: _____

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

of days _____ length of cycle _____

Was it normal? _____

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: _____

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:
