



Lightwave Healing Arts

Encouraging Transformation for the Body, Mind, & Soul

1951 Downingsville Road, Lincoln, VT 05443

(802) 453-4943 lightwave@gmavt.net

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

DAY PHONE: _____

EVENING PHONE: _____

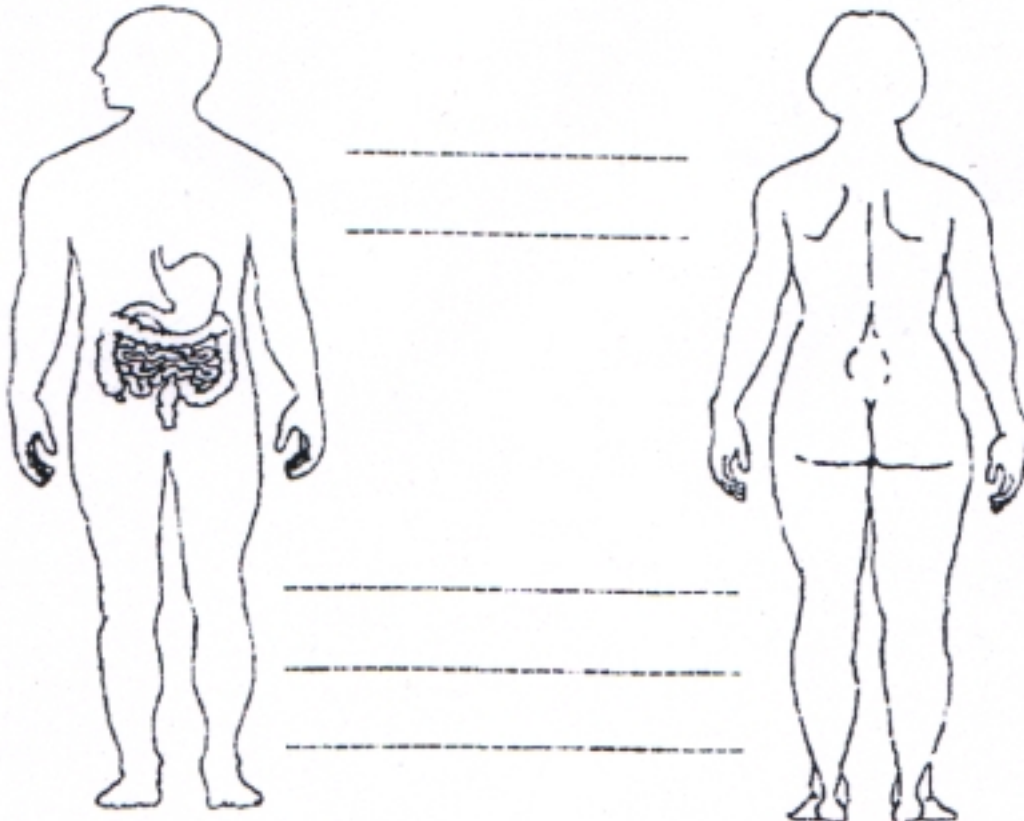
CELL PHONE: _____

What is the main condition you would like to have treated?

When did you first become aware of it?

Please list whatever treatments and/or consultations you have received for this condition, and approximate dates of treatment.

In the pictures below, please mark any areas of pain, discomfort, or dysfunction that you experience on a regular basis. You may include conditions other than your main complaint—please describe them briefly near the area of involvement.



Acupuncture, Rolwing®, Movement Education, Herbal Medicine

Please describe any significant events in your medical history (hospitalizations, accidents, etc.):

Describe illness or conditions in your family:

Mother:

Siblings:

Father:

Grandparents:

What do you do for pleasure?

In an average week, how many hours do you play? _____

Is your sleep restful? _____

How many hours per night? _____

Do you have regular eating habits?

Describe what you would typically eat for...

Breakfast:

Lunch:

Dinner:

Snack:

Do you have any dietary restrictions?

Please describe your daily or weekly consumption of the following:

Coffee/tea/soda: _____

Alcoholic drinks: _____

Sweets: _____

Cigarettes: _____

Recreational drugs: _____

Other: _____

List the medications and supplements you currently take:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have regular bowel movements? _____

How many times per day? _____

Are your stools well formed? Dry? Loose?

Do you urinate regularly? _____

How many times per day? _____

How many times per night? _____

WOMEN, PLEASE FILL OUT THE FOLLOWING:

Do you menstruate regularly? _____

How long is your cycle? _____

How many days does your flow last? _____

Is your menstrual blood dark? Light? Bright red? Clotted?

Do you experience pain or other symptoms before your period? During? After?



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NOTICE OF PRIVACY PRACTICES

Our office is dedicated to providing respectful and confidential service. Protecting your privacy and healthcare information is fundamental to our practice, and is also mandated by law.

Please be advised that we may gather personal and health information about you in several ways:

- Directly from you, our patient
- From other healthcare providers
- From third party payers (i.e., insurance companies)

Note that we may use and disclose medical information about you (without your specific consent or authorization) for the following reasons only:

- To confer with other healthcare practitioners to better understand the optimal course of treatment
- To facilitate payment from insurance companies for the treatment and services you receive from us
- To share our findings with your referring primary care practitioner

We may disclose your medical information to any other medical practitioners, friends, or family only with your written consent. You may request a medical information disclosure consent form from our office.

Communication:

We routinely communicate with patients over the phone to schedule appointments, address concerns, or answer questions. If we leave a message, we will identify ourselves by name and mention we are from Lightwave Healing Arts. *If you prefer to **only be contacted at work, home or other phone number**, please write that number here:* _____.

Patient Rights:

- Upon written request, you have the right to access, review or receive copies of your healthcare records.
- Upon written request, you have the right to request that we place restrictions on the disclosure of your protected health information. In your request, you must indicate what information you want to limit. We are not required to agree to this request.
- You are entitled to a copy of this notice.
- Upon written request, you have the right to a summary of what we have disclosed about you and to whom.

Complaints:

If you have questions or complaints, please contact Gail Reichstein Rex at 802-453-4943. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Ave., SW
Room 509F HHH Building
Washington, D.C. 20201

- By signing below, I acknowledge that I have read, reviewed, understood, and agreed to the statement of Privacy Policy for healthcare services with Lightwave Healing Arts. I also confirm that this office has attempted to provide me with a copy of the statement of privacy policies.

Patient Signature

Date

Acupuncture, Rolwing[®], Movement Education, Herbal Medicine



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INFORMED CONSENT

I, _____, hereby consent to be treated by Gail Reichstein Rex, L.Ac. with acupuncture and/or other Oriental medical procedures, which may include acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, or nutritional and lifestyle counseling.

I understand that acupuncture is performed by the insertion of pre-sterilized acupuncture needles through the skin, with or without the addition of heat or electrical stimulation, to certain points on the body, with the intent of improving bodily functions, relieving pain, and treating certain diseases or bodily dysfunctions.

I have been informed that acupuncture, when performed by qualified licensed practitioners, is a safe method of treatment, but rarely, some side effects do occur. The most common of these are bruising or tingling near the needling sites for a few days, fatigue, or temporary aggravation of pre-existing symptoms. Other theoretically possible, though extremely rare, side effects may be fainting, spontaneous miscarriage or pneumothorax. If I experience any symptom I believe may be a result of treatment, I've been advised to contact my acupuncturist promptly for guidance.

I understand that I should inform my acupuncturist prior to being treated if I believe that I might be pregnant.

I accept the fact that no guarantee is made concerning the outcome of my acupuncture or herbal medicine treatments and that I may stop treatment at any time.

PATIENT'S NAME _____

PATIENT'S SIGNATURE _____ DATE _____

I, _____ (patient's or patient's representative's name printed), have been advised by Gail Reichstein Rex, L.Ac. to consult a physician regarding the condition or conditions for which such patient seeks acupuncture/herbal medical treatment.

Patient's or patient's representative's signature

Date

Acupuncturist's signature

Date