Matthew Peters Sieradski, MAcOM, LAc ♦ 260 East 15th Avenue Eugene, OR 97401 ♦ 541-579-1153
MatthewSieradski.com

PATIENT INSURANCE/REGISTRATION FORM

Name:		
Street Address:		
City:	State:	Zip:
Email Address:		
Home Phone #:	Cell #:	Work #:
Marital Status/Partner Information: Married _____ Single _____ Divorced _____ Widowed _____ Partnered _____		
Date of Birth:		

Nearest Friend or Relative not living with you in case of an emergency:

Name:	Relationship:	
Street Address:		
City:	State:	Zip:
Home Phone #:	Cell #:	Work #:

Insured Information: Primary

Name:	
Relationship To Patient: Self _____ Spouse _____ Child _____ Other _____	
Subscribers DOB:	
ID #:	Group #:
Employer:	Occupation:
Insurance Co:	Phone:
Send Claims to:	

Insured Information: Secondary

Name:	
Relationship To Patient: Self _____ Spouse _____ Child _____ Other _____	
Subscribers DOB:	
ID #:	Group #:
Employer:	Occupation:
Insurance Co:	Phone:
Send Claims to:	

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Insurance Agreement:

Please remember that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance or any other balance not paid by your insurance. You will be responsible to pay full charge for missed appointments not cancelled 24 hours in advance. Patient's or authorized person's signature: I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits, Medicare, private insurance and other health plans to the party who accepts assignment below.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to a reasonable attorney's fees and cost of collections.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my records.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including; private insurance and other health plans to **Matthew Peters Sieradski, MAcOM, LAc.**

This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ DATE: _____

RESPONSIBLE PARTY: _____ DATE: _____

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HEALTH HISTORY QUESTIONNAIRE

Date form completed:_____

Name:	
Where did you spend most of your childhood?	Place of Birth:
When did you move to the Eugene area?	
How did you find me?	

Main health issue(s) you would like me to help you with:			
How long ago did this become an issue?			
To what extent does this issue interfere with your daily activities (work, sleep, sex, etc…)?			
Have you been given a diagnosis for this issue? If so, what?			
Check the following therapies ever used in past:	Acupuncture ☐	Massage ☐	Herbs ☐
List any therapies you are employing for the current condition:			
When were you last seen by a medical doctor (date or approximate year) (This office will not contact these individuals unless you sign a release of information):			
Name of physician:	Reason for visit:		
Name of physician:	Reason for visit:		
Name of physician:	Reason for visit:		

Past Medical History (include date):	Cancer:	Diabetes:	Hepatitis:
High Blood Pressure:	Heart Disease:	Rheumatic Fever:	Thyroid Disease:
Seizures:	Venereal Disease:	Other:	
Surgeries (type of and date):			
Significant Trauma (auto accidents, falls, etc.):			
Significant Dental Work (type of and date):			
Your birth history (prolonged labor, forceps delivery, etc.):			

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Allergies (drugs, chemicals, foods/result of exposure):					
Medicines taken within the last two months (vitamins, drugs, herbs, etc.):					
Family Medical History (check):		Diabetes □	Cancer □	High Blood Pressure □	Heart Disease □
Stroke □	Seizures □	Asthma □	Allergies □	Other (specify) □	
Occupational Stress (chemical, physical, psychological, etc.):					
Do you have a **regular exercise program?** Yes □ No □ Please describe:					
Have you ever been on a **restricted diet?** Yes □ No □ Please describe:					
What did you have for your most recent:					
Breakfast:					
Lunch:					
Dinner:					
Snack:					
How many **packs of cigarettes** do you smoke **per day?**					
How much **alcohol** do you drink **per week?**					
How much **coffee, tea, or cola** do you drink per day?					
Please describe any use of **other drugs** for **non-medical purposes:**					
What is your work and do you enjoy it?					
If not working, what are your main activities?					
Who do you live with?					
Does that relationship have any significant problems currently?					
What do you consider your current stress level to be (low to high, etc.)?					
What is your greatest source of joy/satisfaction?					
What is your greatest source of sadness/frustration?					
Do you attend a church, synagogue, temple, or other religious institution?					
Do you consider yourself a spiritual person?			Do you practice meditation or contemplative prayer?		

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F or women only: (Please check all that are or have been applicable to you – if past, indicate age or date.)

- ☐ Irregular period
- ☐ Scanty period
- ☐ No period
- ☐ Heavy period
- ☐ Tender breasts before period
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sweet cravings
- ☐ Breast pain
- ☐ Breast lumps
- ☐ Took birth control pills
- ☐ Nervousness
- ☐ Fluid retention
- ☐ PMS
- ☐ Mood swings
- ☐ Habitual miscarriage
- ☐ Vaginal discharge
- ☐ Difficulty breastfeeding
- ☐ Uterine fibroids
- ☐ Uterine hemorrhage

Age when started menses: _____ Age when started menopause: _____

Pregnancies: _____ Age: _____

Miscarriages: _____ Age: _____

Abortions: _____ Age: _____

For men only: (Please check all that are or have been applicable to you – if past, indicate age or date.)

- ☐ Decreased sex drive
- ☐ Low sperm count
- ☐ Difficult urination
- ☐ Scanty ejaculation
- ☐ Loss of force when urinating
- ☐ Impotency
- ☐ Exhaustion after sex
- ☐ Nighttime urination
- ☐ Premature ejaculation
- ☐ Dribbling after urination

For All: (Please check all that are or have been applicable to you – if past, indicate age or date.)

General:

- ☐ Poor appetite
- ☐ Localized weakness
- ☐ Strong thirst (for hot or cold)
- ☐ Poor sleeping
- ☐ Poor balance
- ☐ Cravings, for what: _____
- ☐ Weight loss
- ☐ Fevers
- ☐ Bleed or bruise easily
- ☐ Thirst, but no desire to drink
- ☐ Chills
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Sweat easily
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop
- ☐ Tremors
- ☐ Night sweats
- ☐ Weight gain

Skin and Hair:

- ☐ Rashes
- ☐ Change in hair or skin
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Itching
- ☐ Ulcerations
- ☐ Hives
- ☐ Other, please specify: _____
- ☐ Dandruff
- ☐ Eczema
- ☐ Pimples

Head, eyes, ears, nose and throat:

- ☐ Dizziness
- ☐ Cataracts
- ☐ Teeth grinding
- ☐ Night blindness
- ☐ Nose bleeds
- ☐ Migraine
- ☐ Earaches
- ☐ Sores on lips or inside mouth
- ☐ Other, please specify: _____
- ☐ Glasses
- ☐ Ringing in the ears
- ☐ Teeth problems
- ☐ Blurry vision
- ☐ Facial pain
- ☐ Eye pain
- ☐ Spots in front of the eyes
- ☐ Headaches, where on head: _____
- ☐ Poor vision
- ☐ Sinus problems
- ☐ Eyes strain
- ☐ Poor hearing
- ☐ Jaw clicks, aches
- ☐ Color blindness
- ☐ Recurrent sore throats

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Cardiovascular:

☐ High blood pressure ☐ Irregular heartbeat ☐ Cold hands and feet
☐ Blood clots ☐ Low blood pressure ☐ Dizziness
☐ Swelling of hands ☐ Phlebitis ☐ Chest pain
☐ Fainting ☐ Swelling of feet ☐ Difficulty breathing
☐ Other heart or blood vessel problems: _____

Respiratory:

☐ Cough ☐ Bronchitis ☐ Difficulty breathing lying down
☐ Coughing or blowing nose w/ phlegm: what color? _____ ☐ Coughing blood
☐ Pneumonia ☐ Asthma ☐ Pain on breathing
☐ Other lung or breathing problems: _____

GastroIntestinal:

☐ Nausea ☐ Constipation ☐ Diarrhea
☐ Black stools ☐ Bad breath ☐ Abdominal pain or cramps
☐ Chronic laxative use ☐ Vomiting ☐ Gas
☐ Blood in stools ☐ Rectal pain ☐ Belching
☐ Indigestion ☐ Hemorrhoids
☐ Other stomach or intestinal problems: _____

Genito-Urinary:

☐ Pain on urination ☐ Urgency to urinate ☐ Decrease in flow
☐ Unable to hold urine ☐ Blood in urine ☐ Kidney stones
☐ Sores on genitals ☐ Other kidney or urogenital problems: _____

Musculoskeletal:

☐ Neck pain ☐ Back pain ☐ Hand/wrist pain
☐ Muscle pain ☐ Muscle weakness ☐ Shoulder pain
☐ Knee pain ☐ Foot/ankle pain ☐ Hip pain
☐ Other: _____

Neuropsychological:

☐ Seizures ☐ Areas of numbness ☐ Concussion
☐ Bad temper ☐ Dizziness ☐ Lack of concentration
☐ Depression ☐ Easily susceptible to stress ☐ Loss of balance
☐ Poor memory ☐ Anxiety ☐ Other: _____

Please rate the degree of severity of your problem right now (mark an X):

0 ——————————————————————————————————— 10

None Worst Imaginable

Comments: (please tell me about any other issue(s) you would like to discuss):

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PRIVACY POLICY:

All information divulged on the intake questionnaire or during the course of your treatments is privileged and kept strictly confidential in accordance with the Board of Medical Examiners and HIPAA guidelines. By signing below, I indicate that I have also read the Notice of Privacy Policy as provided by the office of Matthew Peters Sieradski, L.Ac.

DESCRIPTION OF THERAPEUTIC MODALITIES:

Acupuncture entails the insertion of needles that are sterile, single-use, very fine, and solid (unlike a syringe) into specific locations (acupoints) along the body to a depth that averages around ⅛ to ¼ inch, but varies from very superficial (less than 1 mm) to deeper (1 or more inches). Acupuncture sometimes entails a momentary pricking sensation, which ceases once the skin has been breached. After insertion, a dull, achy sensation is often elicited through manipulation of the needle – this indicates the activation of the patient's qi. Occassionally, **electro-acupuncture** will also be employed, usually in the case of stubborn pain conditions. This entails the use of small voltage current between two or more needles, most commonly producing a small buzzing or tickling sensation.

Often acupuncture is combined with **heat therapy**, most commonly the use of an infrared emitting lamp that deeply penetrates the body's tissues to promote circulation and healing. Also, **moxibustion**, the burning of small amounts of the herb mugwort, (artemisia vulgaris) on or near the skin may be recommended.

Cupping is the placing of glass suction cups on the skin, and is used to draw out toxins from the deeper tissues into the bloodstream where they can be properly eliminated. It effectively and efficiently increases qi and blood circulation locally and can result in reddening or bruising of the skin.

Chinese Massage, or *tuina*, is similar to Western therapeutic massage but emphasizes balancing the circulation of qi and utilizes unique techniques and tools. It is employed for specific conditions of musculoskeletal imbalance as a complement to acupuncture.

Craniosacral Therapy is a healthcare modality in line with Chinese traditional models of health and healing that uses very light touch to resolve subtle imbalances in the skeletal, visceral, and neurological tissue. It provides powerful relief to difficult health conditions and promotes balance of mind, body and emotions.

Herbal Medicine employs specially formulated decoctions (teas), powders, and pills – composed of plant, mineral, and animal substances. Herbal decoctions are usually the strongest smelling and/or tasting, and are the most effective form of administration. Powders and pills are simpler to prepare and often useful for chronic ailments that require long-term therapy. A branch of herbal medicine treats external problems such as injuries and skin ailments using pastes, plasters, and liniments. I have over 220 bulk herbs in my pharmacy.

Diet Therapy involves restrictions and additions to the patient's daily food intake. Chinese diet therapy employs an understanding of how various types of foods are helpful or harmful for different constitutions and health conditions.

INFORMED CONSENT TO TREATMENT:

I understand that any of the above therapeutic modalities may be recommended to me by Matthew Peters Sieradski, a Licensed Acupuncturist in the state of Oregon. Furthermore, by signing below, I voluntarily consent to be treated by Mr. Sieradski by one or more of the above therapies, as they fall under the scope of his licensure. I also understand that acupuncture and the above modalities of health care are generally safe, but do carry a small risk of side effects including, but not limited to, bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burns are a possible side effect of moxibustion. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that other side effects may occur. I will notify Matthew Peters Sieradski if I am or become pregnant or if I have any questions or concerns regarding any of these treatments at any time.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and description of therapeutic modalities, have been told about the risks and benefits of acupuncture and the other procedures, and have had an opportunity to ask questions. I have also read the Notice of Privacy Practices and understand a copy is available upon request. 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.

_____ _____

Signature of Patient or Guardian Date

_____

Print Name