Acupuncture, Shiatsu, & Oriental Medicine of New England, LLC

David R. LoPriore Sensei, L.Ac., Director
Felicia Baker, L.Ac MAC • Michelle Minnich, RN • Laura Nichols, LMT

(860) 739-5102 • (860) 739-1844 fax
Sensei@LoPrioreAcupuncture.com • www.LoPrioreAcupuncture.com
Latimer Brook Commons Unit 107 • 339 Flanders Road • East Lyme, CT 06333

Dear New Patient,

Thank you for choosing our clinic for your Oriental medicine treatment. If this is your first such treatment, welcome to the world of acupuncture, holistic wellness counselling, herbal therapy, and much more. Our clinic is uniquely qualified to help you to not only alleviate multiple symptoms, but to help you discover a holistically healthy, balanced lifestyle which will help to prevent these symptoms from ever returning. In your first visit, we will spend about an hour assessing your constitution and physiology according to traditional Asian medicine principles. This will help us understand how your own self-healing resources may be compromised, and how they can be restored to support the elimination of your symptoms, even if they first started many years ago.

Through the treatment process, we may teach you many techniques for self-care of your own symptoms, generating a healthier lifestyle, and eliminating toxic habits, in order to help you to live a longer, happier, healthier life. The patients that follow through on consistently caring for themselves, vs. symptoms and proactively, are always happier and healthier.

We spend more time with our patients than many practitioners. Due to the successful treatment of thousands of patients at ASOMNE over the last 30 years, there may be a waiting list for new patients to get started; if so, we apologize, but rest assured you will get the highest quality care once you are seen. If you need to cancel your appointment, please do so with at least 48 hours' notice to let other patients use the time we have allotted for you.

Acupuncture is the primarily modality used to treat nearly all patients. Over thirty-five years, our Clinical Director, David LoPriore Sensei has refined his acupuncture technique to be gentle and painless for most patients and it is used by all practitioners at ASOMNE. It is an advanced technique by which we do not leave the needles in a patient for more than a few seconds. This allows not only for more comfort and much deeper, pleasant relaxation for the patient, but also allow for more treatment options to create a greater therapeutic effect each visit. Non-acupuncture modalities are available as well.

Many patients prefer to bring their own loose, comfortable pair of shorts to wear during treatment. We recommend you eat a meal or snack before your appointments. Drink some water but ***no caffeine*** and refrain from eating anything spicy, hot, or anything that will affect the color of your tongue on the days we see you.

Following your first treatment, it is optimal if you do not immediately return to work or any other busy, stressful environment. You will likely experience the best results by providing yourself adequate time after treatment. We recommend at least two hours of personal time following your treatment, if possible.

Thank you again for your interest in quality holistic wellness treatment. Be Well, Body, Mind, and Spirit,

The ASOMNE Staff

Know Your Acupuncturist

Practitioners whose educational focus is in Acupuncture & Oriental Medicine receive approximately 80% of their training exclusively in this field, and undergo and extensive clinical internship averaging 3 years. Other healthcare practitioners may use acupuncture, which is one of the many therapies of Oriental Medicine, as an adjunct to their primary practice, with or without any education or training! While both kinds of practitioners also have training in western medical sciences, this chart is designed to illustrate the varying levels of acupuncture training generally undertaken by healthcare professionals. *Authentic* acupuncture can only be administered by a practitioner who has specific training in this field, otherwise, patients risk improper or harmful needling technique, inadequate or no understanding of Oriental medical diagnostic procedures, transmission of disease, actually having new disharmony caused through treatment, or ethical misconduct. Ask for a Licensed Acupuncturist only, when you seek a qualified expert in the field!

Amount of Training in Acupuncture	Practitioner
1363 hours to 4000 hours in Acupuncture (or 2000-3000 hours in Oriental Medicine)* *Licensed Acupuncturist* *Kosho Shorei Ryu Energy Medicine Physician-level Practitioner* *Traditional Chinese Medicine Comprehensively-trained Acupuncturist* *Oriental Medicine Practitioner* *Oriental Medical Acupuncturist*	**Typically a Licensed Acupuncturist (L.A.c.)** or Registered Acupuncturist whose primary training is in Acupuncture and/or Oriental Medicine, and has: (a) Has completed a clinical apprenticeship of at least 4,000 hours, and/or (b) Obtained a 3 to 4-year master's level degree or diploma from a school approved by ACAOM (Accreditation Commission for the Acupuncture & Oriental Medicine), and (c) is awarded the Dipl.Ac. (Diplomate in Acupuncture) designation upon successful examination by the NCCAOM (National Commission for the Certification of Acupuncture & Oriental Medicine) which is the national standard used for licensing in most states ** **- Treatment by these professionals can address a broad range of health issues, including chronic disease, pain, mental–emotional disorders, internal medicine, holistic wellness and prevention based on Oriental medical theory.**
300 hours or less *Medical Acupuncture* *Meridian Balancing/ Therapy* *Chiropractic Acupuncture* *Naturopathic Acupuncture*	**Typically a medical doctor, osteopath, naturopath, or chiropractor** who uses acupuncture as an adjunctive therapy; the World Health Organization (WHO) recommends that medical doctors have 200 hours of training to know when to refer to a more fully-trained Acupuncturist or Oriental Medicine practitioner*** -**Most commonly used for pain and basic ailments. Diagnosis is primarily symptom based (not holistic) and does not employ the Oriental Medicine diagnostic methods traditionally associated with the practice of acupuncture.**
0 to 100 hours *Detox Tech* *Chiropractic Acupuncture* *Medical Acupuncture*	**Typically a detoxification technician or chiropractor** (detox techs should be under supervision of a Licensed Acupuncturist, see above, and are limited to 5 points on the ear) -**Most commonly used for pain management or addiction & detoxification through auricular acupuncture. No Oriental medical diagnosis is used.**

For a list of approved schools and colleges, contact the U.S. Department of Education or:
www.ccaom.org www.nccaom.org www.acaom.org

* Many Acupuncture & Oriental Medical schools exceed 2000 hours. 3000 - 4000 hours are required in apprenticeships.
** Acupuncture/Oriental Medical practitioners are able to obtain a D.A.O.M. doctoral degree from an ACAOM-approved clinical doctoral program. Some states also designate the licensing title (non-degree) as D.O.M. or D.Ac, or Acupuncture Physician. Licensed Acupuncturists may have also obtained and O.M.D., Ph.D., or D.Ac. for non-extensive post-graduate training (from unaccredited programs). Thus, it is important to ask where such a title was received.
***Some medical doctors and chiropractors are trained and licensed in both western and Oriental medical acupuncture. Ask your physician about his or her credentials.

This is an update of a document produced by the Council of Colleges of Acupuncture & Oriental Medicine (CCAOM)). For reprint information contact 301-476-7790 or executivedirector@ccaom.org. For information about the Council please see our web site at: http://www.ccaom.org

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Patient Name			Gender: M F	Primary Language Spoken:
Street Address		City, State Zip		
Date of Birth	Age	Height	Weight	Marital Status: S M W Sep Div
Phone (home, cell, work)		Emergency #		Who will answer?
Patient's E-mail:		Referred By:		
Are you a U.S. Military Veteran? Yes No		Are you a Combat Veteran? Yes No		Service Branch?

Patient Nickname	# Children	# Siblings
Occupation	Description	How long?
Have you ever had a consultation of this type before? (please circle) yes no		
Primary 3 Reason(s) for Consultation: (describe situation and symptoms)		
What other treatments have you tried for this/these conditions? Indicate if you are currently receiving other treatment.		
Date of my last comprehensive physical exam by a primary-care physician: Results, findings and recommendations given:		

Type of Discomfort: (circle or describe) sharp, dull, achy, burning, heavy, distended, etc.		Do you seek treatment for holistic wellness – or- to address symptoms only? (circle one.)
When/how often is discomfort felt?	How long does discomfort last?	When did problem start?
What makes it feel better? (circle or describe) rest, activity, eating, drinking (or not), cold, heat,...	What makes if feel worse? (circle or describe) rest, activity, eating, drinking (or not), cold, heat,...	
Do you have warm or cold sensations? If so, describe.	Is abnormal perspiration (sweating) present?	
Describe appetite, thirst, taste sensations, and cravings	Describe any numbness or tingling sensations	
Describe defecation /urination, if irregular/abnormal.		How many BMs per average day?
Describe pattern of sleep, and normal times of sleep (Is sleep restless, disturbed, broken, or deep, restful, and rejuvenating?) Number of hours actual sleep per night?	How many ounces of caffeine do you consume daily/weekly? CIRCLE: coffee, tea, cola, Monster … (list others)	How much refined sugar (candy, processed foods, etc.) do you eat daily/weekly? What kinds?

Patient Name

Are you currently under the care of a physician? please circle: (yes / no) Doctor(s) names? for?
Are you currently on medication? If so, please list names of all medications or supplements (including over-the-counter) you currently take, and the condition your MD/practitioner/(self) prescribed them for. use back of this page if necessary.

Do you drink water daily? (please circle) yes no How many OUNCES?	List allergies or skin problems, if any:
Do you have any current injuries, bruises, infections, or contagious diseases? (please circle) yes no Explain.	
Do you have a history of infection or contagious diseases, such as Hepatitis, HIV, or AIDS? (please circle) yes no Explain.	
* It is important that you answer these questions fully and correctly. Information is STRICTLY CONFIDENTIAL. Do you work in a healthcare field where there is any exposure to blood? (please circle) yes no. Have you ever shared needles? (please circle) yes no. What manner of pregnancy prevention do you use?	

Do you have HIGH blood pressure? (circle) yes no	Do you have LOW blood pressure? (circle) yes no
Circle any/all that apply: I wear: corrective eyewear, dentures, mouthpiece.	
Hospitalization/Surgery History: Please list dates and any types of hospitalization or surgeries you've undergone:	

Reproductive/Sexual Function

Are you sexually active? Circle: Yes No	If yes, have you experienced any sexual performance problems?

Obstetrical/Gynecological History (Females Only)

Are you currently taking birth control pills? yes no		Are you or do you suspect you are pregnant? yes no If yes, how many months? Due date?
First day of last period	Was it normal? yes no	Is your period regular? yes no
Frequency	Average number of days/menstruation	Date of last PAP Smear
Results of PAP Smear		
Number of pregnancies	Number of living children and ages	
Have you ever had a female disorder that required medical or surgical treatment? yes no (if so, please explain)		
Have you noticed any breast changes? (discharges, lumps) yes no (if so, please explain)		
Are you in need of family planning or birth control? yes no		

Patient Name

Lifestyle & Health Status

Do you have tension, migraine, or sinus headaches? (circle) describe:	List other stress impact sites in body	
Do you exercise/play sports? yes no	What kind?	How often?
Do you smoke? yes no -Or use tobacco products?	How many cigarettes/day?	How long? years
Do you drink alcohol? yes no	How often and how much?	

What is the overall stress level in your life? none low intermittent/varies high extreme intolerable
Type(s): emotional time/money issues lack of control responsibilities depression anxiety work family
Which describes you best? worried depressed anxious over-worked angry frustrated obsessive fearful happy
Describe your emotional disposition & predominant "stressors" below:

Historically, how do you deal with conflict, stress?

Do you have any daily or regular practices that promote holistic wellness?

Check off medication types you use:	Never	Occasionally	Frequently	Daily
Laxatives				
Vitamins or Supplements				
Sedatives				
Tranquilizers				
Sleeping Pills				
Aspirin/Tylenol				
Cortizone				
Appetite Depressant				
Thyroid Medication				

Family History

Age & Health Status of the following individuals:

Father Mother Spouse
Children

Please indicate the relationship of any family member having any of the following diseases:

Cancer/Tumor	Epilepsy/Seizures
Diabetes	Asthma/Allergies
Heart Disease	Tuberculosis
High Blood Pressure	Bleeding Disorders/Fibroids/Menstrual
Stroke	Kidney Disease
Anemia	Pneumonia
Arthritis/Gout	Polio
Alcoholism/Drug Abuse	Prostate Disease
Eczema	Thyroid Disease
Emphysema	Scoliosis/spinal disorders
Hepatitis	Ulcers
Migraine	Venereal Disease
Psoriasis	Weight Problems/Eating Disorders

Nervous breakdown or other psychiatric disorder

Comprehensive Personal Medical History

Which symptoms apply to your health among the following? (circle applicable symptoms AND time-frames below) --			
Periods of passing out	In past	Present	Never
Dizziness	In past	Present	Never
Visual changes	In past	Present	Never
Chest pain or irregular heartbeat or heart disease (circle your symptom(s) at left)	In past	Present	Never
Heart Palpitation or other chest/heart symptoms (circle)	In past	Present	Never
High blood pressure	In past	Present	Never
Low blood pressure	In past	Present	Never
Shortness of breath or difficulty breathing (circle)	In past	Present	Never
Coughing of blood, or vomiting of blood (circle)	In past	Present	Never
Heartburn or ulcers (circle)	In past	Present	Never
Diarrhea, constipation, incontinence, stool color change (circle)	In past	Present	Never
Frequent or painful urination, bloody urine, or weak stream (circle)	In past	Present	Never
Night sweat or other abnormal perspiration (circle)	In past	Present	Never
High blood sugar or frequent urination, excessive thirst or sweating (circle)	In past	Present	Never
Swollen or painful joints (circle)	In past	Present	Never
Chronic back, neck, or muscle pain (circle)	In past	Present	Never
Loss or partial loss of use of arms, legs, speech, hearing (circle)	In past	Present	Never
Difficulty sleeping	In past	Present	Never
Depressed or sad most of the time, hopeless outlook (circle)	In past	Present	Never
Weight loss or gain of 10 or more pounds recently (circle loss or gain, list lbs.)	In past	Present	Never
A sore that is not healing properly	In past	Present	Never
Difficulty swallowing	In past	Present	Never
Nagging or persistent cough or hoarseness (circle)	In past	Present	Never
Obvious change in warts/ moles (circle)	In past	Present	Never
Unusual bleeding or discharge (circle)	In past	Present	Never
Masses or lumps in breasts or discharge (circle)	In past	Present	Never
Libido changes or sexual dysfunction (circle)	In past	Present	Never
Black or tarry stools (circle)	In past	Present	Never
Smoker, consistent drinker of alcohol, user of chemical substances (circle)	In past	Present	Never
Enlarged/swollen glands (circle)	In past	Present	Never
Liver, Gall Bladder, Kidney, Thyroid, Bladder, Prostate, Bowel, Lung disease (circle)	In past	Present	Never
Hepatitis A, B, C, or other, HIV, or AIDS (circle)	In past	Present	Never

Do you have any other medical condition we should be aware of before beginning the consultation? yes no
Describe:

I, (print name:) take full and sole responsibility for any food supplements, herbs or plant products that I/my child may decide to ingest or apply as a result of this consultation and treatment process. I am aware that these herbal products or supplements may not work as efficiently, or might produce unwanted side effects if taken in conjunction with other herbs, supplements or medications, or if taken improperly. I understand that David LoPriore, L.Ac., Felicia Baker, L.Ac., and Michelle Minnich, RN (ASOMNE practitioners) do not diagnose illness, disease, or any other physical or mental disorder within the realm of western medicine. Likewise, ASOMNE practitioners do not prescribe medical treatment or pharmaceuticals. I understand that an Acupuncture and Oriental Medicine consultation is not a substitute for a medical examination or western medical diagnosis, and that it is recommended that I seek the care of a primary care physician in conjunction with acupuncture treatment. I understand that if I am presently under the care of a physician and/or currently taking medications, I may consult my physician before making any changes in my current medical regime. I certify that I understand no claims or guarantees are given regarding particular medical outcomes of treatment by ASOMNE practitioners. Understanding that ASOMNE practitioners must be aware of all of my existing health conditions, I have stated all my known health and medical conditions and take it upon myself to keep ASOMNE practitioners updated on my physical health and medical status. I hereby agree to have this consultation and hold the practitioners and ASOMNE harmless for any problems that might arise after this consultation and treatment.

Signature: Patient, parent, or guardian date

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Personal Vitality Assessment Form

"Health" is not merely the absence of pain or disease, but True Personal Vitality— Living life to the fullest each day, not simply existing, managing our symptoms, getting by, … or waiting to die.

Most illness can ultimately be traced back to constitutional, psychological and behavioral disharmony. Resolve, diligent holistic self-care, and a good relationship with our own mind are often the differences between the perpetuation of self-imposed suffering, and great holistic health and happiness.

How are you doing in these areas?

1. On a Scale of One to Ten, one being extremely unhealthy, ten being maximum health, how would you rate your overall health, and how happy are you with your rating?

2. If you could wake up tomorrow having changed one thing about yourself, what would it be? Why?

3. What are the three most important things you have left to accomplish in your life?
   1.
   2.
   3.

4. Please describe a time/situation in your life when you expended a great amount of effort in order to accomplish a goal related to your health:

5. Name six specific holistic wellness goals: Two physical, Two mental/emotional, and Two spiritual or Character-development-oriented ones:

   Physical Wellness: 1.

   2.

   Mental/Emotional: 1.

   2.

   Spiritual/Character: 1.

   2.

6. In your Life, are there more things you're doing because you feel that you "Have To" (obligations imposed by others), or more things you're doing because you "Want to" (volitional choices)?

Make two lists here. Use the back of the page if necessary.

Have To	*Want To*

7. If you knew you were going to die in one year, would you change anything about how you are living now? If so, what?

8. Is there something you have dreamed of doing for a long time? If so, why haven't you done it?

9. Personal Insights: What do I notice about myself as I review my answers to these questions?

Many people become very upset when they answer these questions. That is because these questions have been inside of them for a long, long time. They are frustrated. They have reached this age and still have yet to do much...

These questions are behind the symptoms many people run from doctor to doctor to resolve. Whether or not this is true on a large scale for you, it is always a good idea to take stock once in a while; To get back to the basics of what holistic health is.

Do you really want just not to be sick? Or do you want to LIVE A VITAL LIFE? Start now. Give yourself permission to be fully healthy. You have the power to move mountains. Use it!

10. Based on this assessment, what advice would you give yourself to help you become as holistically healthy and well as you want to become?

11. Based on your own advice, what commitment are you making for today?

This week?

The next month?

The next year?

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NOTICE OF PRIVACY PRACTICES

Effective July 15, 2003

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At Acupuncture, Shiatsu and Oriental Medicine of New England, LLC, we respect the privacy and confidentiality of your health information. We understand that health care information about you and your health is personal and we are committed to protecting this information. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices describes how we may use and disclose your health care information, and how you can get access to this information.

WE ARE REQUIRED BY LAW to maintain the privacy of your health care information and provide you with notice of our legal duties and privacy practices. We are also required to comply with the terms of our notice that is currently in effect.

WE MAY USE AND DISCLOSE your health care information for the following reasons:

Treatment: We may use health care information about you to provide you with treatment and services. We disclose health care information to our employees and others who are involved in providing the care you need. For example, those who work here may share information with each other in order to coordinate the services you need, such as acupuncture treatments, herbal prescriptions, Naturopathic treatments, supplement, or wellness recommendations.

Payment: For payment purposes, we may disclose your health information to your insurance provider or worker's compensation. This information would be disclosed to request that you or we be reimbursed for services received. In this case, your health care information would be disclosed to determine whether your plan would cover the diagnosis and treatment. In the case where you have paid us and are filing a claim for insurance benefits yourself, we will be happy to provide the necessary procedure and treatment codes at your request.

Appointment Reminders: We use and disclose health care information to contact and remind you about appointments. If you are not home, we may leave this information with the person answering the phone or on your answering machine. **IMPORTANT:** If you have given us a phone number at work (and it is your direct line) we may leave a message. If you do not wish to be called at work, please make us aware of that. If you have given a cell phone or home telephone number, we may leave a message on your voice mail. If you provide us with a phone number that you do not want us to call except in an emergency situation, please tell us and we will respect your wishes. We generally call patients on the day before the treatment, to remind you of treatments scheduled. If there are phone numbers you have given us where you do not want us to leave a message, please tell us.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your heath care or

payment for your care, with your permission.

To Avert a Serious Threat to Health or Safety: We may use and disclose health care information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person; for example, for reporting victims of abuse, neglect or domestic violence. We may also release health care information if asked to do so by a law enforcement (civil or military) official(s), or as required by law. In addition, special regulations may apply to disclosures of health information relating to care for psychiatric conditions, substance abuse or HIV-related information.

YOUR WRITTEN AUTHORIZATION IS REQUIRED before we can make use of or disclose any of your health information other than for any reason other than those described above. You may revoke a written authorization at any time but such revocations must be made in writing. Such requests will be honored immediately except where actions have already been taken on your authorization.

WE RESERVE THE RIGHT TO USE AND DISCLOSE your health care information without your written authorization in the following situations: to advise you of treatment alternatives and health-related benefits; for marketing purposes (without your name or other identifying information), to provide others with testimonial letters you have given us for this express purpose; for educational purposes during Wellness Talks or other instructional events (**please note:** under these circumstances ONLY information about health care may be used or disclosed; your name will never be used except in testimonial letters, as you sign them); as required by local or federal law; for public health investigations; in response to a court order; for coroners or medical examiners; as required by military command authorities (for military and veteran patients only); or for health oversight activities (such as audits, investigations and licensure necessary for the government in its responsibilities of monitoring the nation's health care system).

YOU HAVE THE FOLLOWING RIGHTS regarding your health information: Right to Request Special Privacy Protections, Right to Request Confidential Communications, Right to Inspect and Copy, Right of Access to Personal Health Information, Right to Request Amendment, Right to an Accounting of Disclosures, Right to a Paper Copy of this Notice.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, change our practices and make new provisions in the future. Should we do so, we will notify you when it is applicable. In addition, if the ownership or directorship of this clinic changes, your health care information may be transferred to the new owner. Should such a change occur, you maintain the right to request that copies of your health care information be transferred to another health care provider. If a practitioner who has been treating you leaves our employ, your medical records will remain in this office. However, you may request a copy of them.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Ave SW, Room 509p, HHH Building, Washington, DC 20201. You will not be penalized for filing a complaint.

Thank you.

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WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received a copy of the **Notice of Privacy Practices** that describes how my health care information may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the office.

I also understand that I am entitled to receive updates upon request if Acupuncture, Shiatsu, and Oriental Medicine of New England, LLC's Notice of Privacy Practices is amended or changed in a material way.

_____
Signature

_____
Printed Legal Name

_____
Relationship to Patient

_____
Date

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I hereby request that any communications by Acupuncture, Shiatsu, and Oriental Medicine of New England, LLC to me be made to:

Please check all that apply and fill in the appropriate telephone numbers or address, as applicable:

- [ ] Home Phone _____
- [ ] Work Phone _____
- [ ] Cell Phone _____
- [ ] Mailing address _____

_____

_____

[ ] I would like to receive a copy of the ASOMNE Newsletter via the following email address:

_____

May we speak to or leave messages with:

- [ ] Parents
- [ ] Children
- [ ] Spouse, boyfriend, or girlfriend: _____
- [ ] Other people: _____

_____

_____

[ ] A person answering the phone other than above:

- [ ] At Home
- [ ] At Work
- [ ] On Cell Phone (Continued on reverse)

[ ] I give permission for appointment and scheduling information to be left on the answering machine/voicemail on my:
(please circle all that apply) home / work / cell phone

[ ] I give permission for information regarding herbal prescriptions or other self-treatment information pertaining to me or my child to be left as a message.

[ ] I give permission for *any* information regarding my health to be left as a message with the above-named people.

[ ] Please do not call to remind me of appointments. I understand that I will be charged the normal treatment fee for an appointment that I miss without 48 business hours' notice.

I request that all future communications to me to be made in accordance with my wishes as expressed above. I understand that if I refuse to specify an alternate address or to provide information as to how payment will be handled, that Acupuncture, Shiatsu, and Oriental Medicine of New England, LLC may deny my request.

_____
Signature of Patient, or Personal Representative if under 18 years old

_____
Printed Name of Person Signing Above

_____
Relationship to Patient (if applicable)

_____
Date

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Patient Reminders:

Please consider the following before each treatment:

- **Bring a loose, comfortable pair of shorts**
- **<u>No coffee</u> at all the day of your initial assessment. (It will compromise your pulse diagnosis).**
- **Do not eat or drink anything excessively hot or cold, or anything which might color your tongue for at least 90 minutes before your treatment. These foods will interfere with your diagnosis.**
- **Do not wear perfumes or colognes to the treatments, out of consideration for others who may be allergic to these items.**
- **It is best if you don't plan to do anything active 2-4 hours after the 1st Acupuncture treatment. Patients can enhance their results this way.**

Thank you.