



AIMEE RAUPP  
LICENSED ACUPUNCTURIST  
AND HERBALIST

## PATIENT REGISTRATION INFORMATION

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(Protected Health Information Authorized Access Only)

Date : .....

Name : .....

Street Address : .....

City/State/Zip : .....

Phone (day) : ..... (eve) : ..... (cell) : .....

Email address : .....

Date of Birth : ..... Age : .....

Occupation : ..... Marital Status : .....

Emergency contact : ..... Phone : .....

Physician : ..... Phone : .....

Whom may we thank for referring you? .....

What is the main reason you are seeking treatment? .....

.....

Have you been treated by Chinese Medicine for this condition before? .....

If so, when? .....

Have you sought out other forms of alternative care for this condition? .....

If so, please briefly describe : .....

.....

.....

.....

.....

Have you seen an MD for this condition? .....

If so, please list the following :

MD's diagnosis : .....

Prescribed medications for this condition : .....

Are you currently taking the aforementioned medications? .....

If so, for how long have you been taking them? .....

What is the dosage? .....

Procedures (and dates) you have undergone related to the western treatment of this condition : .....

.....

.....

Please give a brief history of this condition from the onset to the present: .....

.....

.....

Are there any other conditions you would like to address through Chinese Medicine? .....

.....

Please list any Major Hospitalizations you have had, and give approximate dates  
(be sure to indicate births and type of delivery) :

1st Hospitalization :	.....	.....	.....
	Year	Operation or Illness	Hospital

2nd Hospitalization :	.....	.....	.....
	Year	Operation or Illness	Hospital

3rd Hospitalization :	.....	.....	.....
	Year	Operation or Illness	Hospital

Female patients, please list any ART's (assisted reproductive therapy's) you have undergone (be sure to include dates)?

.....

.....

.....

Please list all other *CURRENT* health conditions you have, together with any medications, herbs or supplements you are now taking for the *CURRENT* condition (If you regularly take aspirin and/or ibuprofen, be sure to include it here).

Condition	Western RX (dose/how long)	Other remedies (dose/how long)
1. ....	.....	.....
2. ....	.....	.....
3. ....	.....	.....
4. ....	.....	.....
5. ....	.....	.....

Do you have a family history of any of the following?

- |                   |                  |                         |                            |
|-------------------|------------------|-------------------------|----------------------------|
| <b>Alcoholism</b> | <b>Arthritis</b> | <b>Diabetes</b>         | <b>High Blood Pressure</b> |
| <b>Allergies</b>  | <b>Asthma</b>    | <b>Epilepsy</b>         | <b>Mental Illness</b>      |
| <b>Anemia</b>     | <b>Cancer</b>    | <b>Heart conditions</b> |                            |

Other, please list : .....

Do you:

Exercise? ..... How many times/week? ..... Hours at a time? .....

Type of exercise : .....

Get enough sleep? ..... How many hours/night? ..... Is it restful? .....

Have a stressful job? ..... How many hours/week do you work? .....

Smoke cigarettes? ..... Other tobacco? ..... How many/day? ..... How many years? .....

Drink caffeine? ..... What kind? ..... How many/day? .....

Drink alcohol? ..... How many drinks/day? ..... How many/week? .....

Smoke marijuana? Circle one : **Daily Weekly Occasionally**

Use cocaine? Circle one : **Daily Weekly Occasionally**

Other non-prescribed drugs? Please describe : .....

Eat sugar? Circle one : **Daily Weekly Occasionally Rarely Binge Crave Avoid**

Crave (Circle all that apply): **Sweet Salty Bitter Sour Spicy Carbs Dairy Meat**

Use artificial sweeteners?..... Eat regular meals? ..... How many/day? .....

Please describe what you typically eat :

Breakfast : .....

Lunch : .....

Dinner : .....

Snacks: .....

I prefer: Hot/Cooked foods ..... Cold/Raw foods .....

How much water do you drink daily? .....

I prefer: Hot drinks ..... Cold Drinks .....

Please choose one or two emotions that seem predominant in your life—frequently experienced, difficult to express, or in some way influential (e.g. anger, fear, sadness, joy, excitement, anxiety, worry, etc)

.....  
.....  
.....

Please list recreation, hobbies or pleasure activities and how often you engage in them:

.....  
.....  
.....

Please give approximate dates and briefly describe the nature of any traumatic experiences or injuries you have experienced (e.g. divorce or termination of significant relationship, auto or other accidents, broken bones, change of residence, long-term illness, death of a loved one, bankruptcy, etc)

.....  
.....  
.....

Have you ever had any form of counseling, therapy, etc? If so, please describe what type and when.

.....

.....

.....

Do you feel you have one or more healthy relationships in your life?

.....

.....

.....

Do you have a chronic pain condition? Please describe:

.....

.....

What type of illnesses are you prone towards and how often do you experience them (e.g. monthly, yearly, etc)?

.....

.....

What are your goals and expectations in seeking Chinese Medical treatment?

.....

.....

.....

Please provide any additional information that you feel is significant and was not covered by any of the above questions:

.....

.....

.....

.....

.....

Please indicate, with ONE check mark (✓), any condition that you sometimes experience; TWO check marks (✓✓) for those conditions which occur often; and THREE check marks (✓✓✓) for symptoms that are a major concern for you :

- |                               |                                   |                                 |
|-------------------------------|-----------------------------------|---------------------------------|
| ..... headaches               | ..... irregular heartbeat         | ..... urgent urination          |
| ..... migraines               | ..... chest pain/tightness        | ..... frequent urination        |
| ..... hair loss               | ..... cold hands and feet         | ..... inhibited urination       |
| ..... blurred vision          | ..... shallow breathing           | ..... nighttime urination       |
| ..... poor night vision       | ..... asthma                      | ..... urinary tract infections  |
| ..... decreasing vision       | ..... allergies                   | ..... incontinence              |
| ..... dry eyes                | ..... frequent colds              | ..... mood swings               |
| ..... burning eyes            | ..... frequent sore throats       | ..... depression                |
| ..... eye infections          | ..... lymphatic swelling          | ..... insomnia                  |
| ..... hearing loss            | ..... fatigue                     | ..... restlessness              |
| ..... ringing in ears         | ..... heavy body sensation        | ..... indecision                |
| ..... painful ears            | ..... want to sleep a lot         | ..... poor memory               |
| ..... ear infections          | ..... dry mouth                   | ..... neuropathy                |
| ..... nose bleeds             | ..... strong thirst               | ..... shaking                   |
| ..... sinus congestions       | ..... underweight                 | ..... seizures                  |
| ..... dry skin                | ..... overweight                  | ..... low libido                |
| ..... dry scalp               | ..... strong appetite             | ..... high libido               |
| ..... acne                    | ..... weak appetite               | ..... back pain                 |
| ..... eczema                  | ..... bitter/sweet taste in mouth | ..... weak knees                |
| ..... other skin problems     | ..... heartburn                   | ..... joint pain/stiffness      |
| ..... gum problems            | ..... reflux                      | ..... joint inflammation        |
| ..... mouth/tongue sores      | ..... indigestion                 | ..... too hot                   |
| ..... oral herpes             | ..... stomach ache                | ..... too cold                  |
| ..... cysts/tumors            | ..... bloating                    | ..... nerve pain/shingles       |
| ..... never sweat             | ..... flatulence                  | ..... sciatica                  |
| ..... easily sweat            | ..... belching                    | ..... muscle pain               |
| ..... excessive sweating      | ..... bad breath                  | ..... muscle weakness           |
| ..... night sweats            | ..... ulcers                      | ..... genital herpes            |
| ..... fainting                | ..... nausea                      | ..... gonorrhea                 |
| ..... dizziness               | ..... vomiting                    | ..... other STD's, please list: |
| ..... bruise easily           | ..... diarrhea                    | .....                           |
| ..... difficult wound healing | ..... constipation                | ..... cough                     |
| ..... leg cramps              | ..... hemorrhoids                 | ..... difficulty breathing      |
| ..... swollen feet/ankles     | ..... rectal bleeding             | ..... irritability              |
| ..... high blood pressure     | ..... blood in stool              | ..... rib/flank pain            |
| ..... palpitations            | ..... blood in urine              | ..... shortness of breath       |

Please indicate, with ONE check mark (✓), any condition that you sometimes experience; TWO check marks (✓✓) for those conditions which occur often; and THREE check marks (✓✓✓) for symptoms that are a major concern for you :

**MALE CLIENTS**

..... impotence                      ..... testicular swelling/lumps                      ..... erection/ejaculation difficulties  
..... prostate problems                      ..... burning or discharge                      ..... weak stream  
..... other, please describe : .....

**FEMALE CLIENTS**

Age at onset of menstruation ..... Age at onset of menopause .....  
Interval between periods(days)..... Duration of flow(days)..... Date of last period .....  
..... infertility                      ..... irregular menstruation                      ..... excessive menstrual bleeding  
..... menstrual cramps                      ..... absent menstruation                      ..... bleeding between periods  
..... PMS, please list symptoms: .....

..... vaginal discharge                      ..... blood in discharge                      ..... vaginal/yeast infections  
..... fibroids                      ..... vaginal dryness                      ..... pain with sex  
..... positive PAP                      ..... Date of last PAP  
..... breast lumps/cysts                      ..... ovarian/uterine cysts  
..... Are you pregnant now?                      ..... could you be?  
..... # of Pregnancies                      ..... # of children  
..... #of miscarriages                      ..... #of abortions  
..... Menopause or perimenopause, please list symptoms : .....

## PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and have been provided an opportunity to review it (available in treatment room).

.....  
**Signature**

**Print Name**

**Date**

## INDIVIDUAL PATIENT'S AUTHORIZATION

I give my authorization to use or disclose my (PHI) Protected Health Information to my doctors, insurance companies, and attorneys (with a signed written release). This office will permit only trained, authorized employees to have access to my PHI. I understand that this office will not reveal my information to any external organization other than those previously mentioned. This office has assured me that my information will be safeguarded according to strict standards of security and confidentiality any information shared with them. I give my permission to be called to reschedule appointments, to be sent post cards and be sent newsletters for health information purposes.

## FEE SCHEDULE

Initial Treatment with Aimee E. Raupp, MS LAc: \$250 (includes initial consultation and treatment)

Follow-up Treatment with Aimee E. Raupp, MS LAc: \$150

Facial Rejuvenation Treatments with Aimee E. Raupp, MS LAc: \$175

**I do not directly bill insurance companies. I will furnish you with a superbill, which you can submit to your insurance company for reimbursement. In some cases, reimbursement may be available. But, keep in mind that plans vary greatly. Please check with your insurance company to verify Acupuncture benefits.**

## PAYMENT POLICY

Payment is expected in full at the time of service, unless other arrangements have been made in advance. We accept cash, checks and credit cards.

## CANCELLATION AGEEMENT

I understand that Aimee E. Raupp, M.S. L.Ac, LLC. holds my appointment solely for me, even when others request my time. Consequently, I realize there is a one-day prior cancellation policy. I acknowledge it is my responsibility to notify Aimee E. Raupp, M.S. L.Ac. of my inability to keep any appointment time being held for me. If for any reason I am unable to call in this information on the prior day, I understand I am responsible for half of the visit fee.

## LATENESS POLICY

Life happens!! And we cannot all be perfectly on time... However, we need you to understand that you are scheduled for a visit lasting one hour. If you are unable to be on time, you must realize that your visit with the therapist may be limited to your scheduled hour, so as not to inconvenience others scheduled to work with the therapist after your appointment time.

On the other hand... Infrequently, you may need to wait a few minutes before I can see you. Please understand that this will not affect the duration of your appointment. If you have special time constraints, please let me know at the time of your arrival, or upon scheduling your appointments. Thank you, in advance, for your courtesy in upholding these policies with Aimee E. Raupp, M.S. L.Ac, LLC.

.....  
**Signature**

**Print Name**

**Date**

## INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

**I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.**

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a coming side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I (We), the undersigned, do affirm that, ..... (Patient Name) has been advised by, Aimee E. Raupp M.S., L.Ac., to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

*By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.*

.....  
**Print Name of Patient**

.....  
**Print Name of Acupuncturist**

X  
.....  
**Signature of Patient (or Representative)**

X  
.....  
**Signature of Acupuncturist**

.....  
**(Print Name of Patient Representative)**

.....  
**(Print Name of Witness/Translator)**

X  
.....  
**Date Consent Completed**

X  
.....  
**(Signature of Witness/Translator)**