Jaime Kahn Gordon, P.O.M.
1014 Bethlehem Pike, Erdenheim, PA 19038
610-834-8755 - Jaime@InnerLandscapeAcupuncture.com
www.InnerLandscapeAcupuncture.com
Pa. License #OM 000029

Dear New Patient,

Welcome to Inner Landscape Acupuncture. I want to thank you for choosing me as your acupuncturist. I send this letter to welcome you to my practice and assist you in gathering the information that I need in order to best serve you at your first appointment.

On the following pages you will find a new patient information sheet, a cancellation agreement form, an informed consent form, and a new patient intake form. Please read these thoroughly and sign where applicable or fill in your answers. Please bring the three completed forms with you to your first appointment. Additionally, if you have any relevant medical records, recent test results or other diagnostic information I ask that you also bring these with you so I may make copies as necessary.

Please feel free to call my office if you have any questions or need directions, and do arrive on time. Also, it is best to come to your appointment with enough in your stomach so that you are neither too hungry nor too full.

I look forward to meeting and working with you soon!

Sincerely,

Jaime Kahn Gordon

Cultivate your Qi, Grow into Wellness!

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New Patient Information

Welcome to Inner Landscape Acupuncture. Please take a few minutes to read through the following topics that will help to prepare you for your first visit. Also, make sure you print and fill out the forms that follow and bring them with you to your first visit. If you have any questions or concerns you can call the office or we can discuss them at the beginning of your appointment.

Appointments

If possible, when your treatment is finished please schedule your next appointment(s) in advance. This will ensure that you receive and retain the time slot that is best for your schedule. If you need to make changes to an already scheduled appointment, please do so as soon as possible. Remember, it is your responsibility to cancel any unwanted appointments. If you are unsure of your appointment, please call the office phone number: 610-834-8755.

Cancellation Policy

We require **at least 24** hours notice to cancel an appointment. If you miss or reschedule an appointment with less than 24 hours notice, you will be held responsible for the entire office visit fee. Our cancellation policy is waived for emergencies and acts of nature. We run a very tight schedule so if you find that you are running late please give the office a call to avoid making an unnecessary trip. Arriving even 10 minutes late may compromise your treatment plan resulting in a missed appointment. We will however always do our best accommodate your circumstances whenever possible.

Payment and Insurance

We accept cash and personal checks. Payment is due at the time of your visit, and receipts are available upon request. Although we do not bill insurance companies, we can provide you with the proper documentation that you may need to submit for your own reimbursement or application towards your deductible, flex spending or health savings account.

Needles

This office exclusively uses sterile, disposable needles.

The Day of Your Visit

On the day of your appointment please refrain from eating or drinking anything that will change the color of your tongue (ex: hard candy, coffee, grape juice, etc.) for several hours before your appointment begins. If possible you should wear loose, comfortable clothing (i.e.: pants that you can push up above your knee, and shirt sleeves that can roll up above your elbow.) You are welcome to bring a change of clothing, and draping is provided to ensure modesty. Please do not wear strongly scented perfume, oils and/or lotions on the day of your visit. Unscented or lightly scented are fine.

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Cancellation Agreement Form

Dear New Patient,

Because I often have a waiting list and time slots are very tightly scheduled, a missed appointment is both a loss to me and another person that I might have treated in that time slot. Cancellations must be received by 2:00pm for the following day's morning appointments, and by 6:00pm for the following day's afternoon appointment. If you are unable to reach me directly you may leave a voice mail message for delays or cancellations, so except for cases of extreme emergencies you will be billed for any session that you miss. This office cancellation policy is waived for extreme emergencies (your own or an immediate family member) and acts of nature.

It is also very important that you arrive on time for all appointments. With each scheduled visit a certain amount of time is allotted for your treatment. If you find that you are running late (i.e.: in excess of 10 minutes past your scheduled time), please call the office to avoid making an unnecessary trip as the remaining time may or may not be sufficient for your treatment and you may need to schedule another appointment. Please understand that if you are late I will certainly do my best to work you back into my schedule, but regardless of whether I am able to accomplish this you are still responsible for the full office visit fee.

Please sign and date below to indicate your understanding and consent to this policy.

Thank you in advance for your consideration,

Jaime

_____

Patient's Name

_____ _____

Patient's Signature Date Signed

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Informed Consent for Acupuncture and Chinese Medicine Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Chinese medicine procedures, including various modes of physiotherapy, on me by Jaime Kahn Gordon, P.O.M., who is a licensed acupuncturist and practitioner of Oriental medicine.

I understand that methods or treatments may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), gua-sha, Chinese or Western herbal medicine, and nutritional counseling.

I understand that herbs and nutritional supplements are traditionally considered an important and safe part of the practice of Chinese Medicine. I understand that Jaime Kahn Gordon, R.O.M. may recommend that I take a Chinese herbal formula(s). I am always free to decline herbal treatment if I do not wish to utilize it at any time. I will immediately inform Jaime Kahn Gordon, P.O.M. if I experience any adverse reaction to the herbs and/or nutritional supplements.

I have been informed that I have a right to refuse any form of treatment. I have read or have had read to me the above consent. I have also had an opportunity to ask questions about the content of the consent, and by signing below I agree to receive treatment from Jaime Kahn Gordon, P.O.M. I also understand there is always a possibly of an unexpected complication, and I understand that no guarantee can be made concerning the results of the treatments given to me by Jaime Kahn Gordon, P.O.M. I intend this informed consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Jaime Kahn Gordon, P.O.M.

I understand that it may be necessary for Jaime Kahn Gordon, P.O.M. to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives Jaime Kahn Gordon, P.O.M. permission to release any medical records for the reasons set forth in this paragraph.

_____
Patient's Name

_____ _____
Patient's Signature Date Signed

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Patient Information & Health History

Note: This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released to any person without your written authorization.

Patient Information

Name: _____ Today's Date: _____

Street Address: _____

City, State and Zip: _____

Home Phone: _____~_____~_____ Work Phone: _____~_____~_____

Cell Phone: _____~_____~_____ *{Please circle the best phone for leaving messages}*

E-Mail Address: _____

Age: _____ Birthdate: ___/___/___ Birthplace: _____

Height and Weight: _____ Relationship Status: _____

Occupation:_____ Employer's Name: _____

Family Physician: _____ Physician's Number:_____

Emergency Notification: _____ Phone: _____ Relation: _____

Referred By: _____

Please answer the following questions:

Yes	No	
❍	❍	Are you nervous about needles?
❍	❍	Do you have tendency to faint?
❍	❍	Do you bruise easily?
❍	❍	Women: are you pregnant?
❍	❍	Have you ever had acupuncture? When & for what? _____

Yes	No	
❍	❍	Do you have hepatitis or HIV?
❍	❍	Have you ever had hepatitis?
❍	❍	Do you have a pacemaker?
❍	❍	Any bleeding disorders?

Present Health

Chief Concern(s): _____

_____

_____

Date of onset (when you first noticed your problem): _____

Is there Pain? (Please describe): _____

To what extent does this problem interfere with your daily activities? _____

Is your condition getting: ☐ Worse ☐ Constant ☐ Comes & goes

What makes it worse? _____What makes it better? _____

Have you had this in the past? ☐ Yes ☐ No When?_____

Have you been given a diagnosis for your problem? If so: what, when, and by whom? _____

_____

What kinds of treatment have you tried? _____

_____

Medical History

- ❍Anemia
- ❍Arthritis
- ❍Asthma
- ❍Cancer
- ❍Chronic Fatigue
- ❍Diabetes
- ❍Epilepsy
- ❍Gall Stones
- ❍Heart Attack/Disease
- ❍High Blood Pressure
- ❍Rheumatic Fever
- ❍Seizure
- ❍Stroke
- ❍Thyroid Disease
- ❍Ulcer
- ❍Venereal Disease
- ❍Kidney/Bladder Disease

Other significant illnesses (include dates): _____

_____

_____

Allergies (drug, chemical, food): _____

Surgeries (type and date): _____

_____

Trauma (type and date): _____

_____

Medications currently being taken (include drugs, vitamins, & herbs): _____

_____

_____

_____

Family History

	Father	Mother	Siblings	Children
Age if living				
Cause of death & age				
Health: Good/Poor				
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Stroke				
Epilepsy				
Mental Illness				
Asthma, Hay Fever				
Kidney Disease				
Tuberculosis				
Hepatitis				
Other, please list				

Lifestyle

Employment activities: _____

_____

Exercise (kind, frequency): _____

_____

How much sleep do you average each night? _____ Do you have difficulty getting to or staying asleep? (Please describe) _____

Energy level: Highest at what time of day? _____ Lowest at what time of day? _____

Are you satisfied with your current diet (explain): _____

_____

Please describe your average daily diet and time of day you eat:

Morning: _____

Afternoon: _____

Evening: _____

Do you eat "on the go" or sit down to a meal? _____ Do you eat when you're not hungry? _____

Do you snack often? (How much and what) _____

How much water do you drink each day? (In 12 oz. Glasses) _____

How much coffee, tea, or soft drinks do you consume a day? _____

How much alcohol do you consume a day/week? _____

Do you smoke? If yes, how many cigarettes each day? _____

Did you quit smoking? When? _____

Other non-pharmaceutical/recreational drugs used now or in the past, and how often? _____

_____

Review of Systems

Please check any that you are experiencing now or have experienced in the past three months.

Skin and Hair:
- ❍ Dry
- ❍ Oil
- ❍ Itchy
- ❍ Moist/Clammy
- ❍ Rashes/Hives
- ❍ Pimples
- ❍ Bruise easily
- ❍ Hair loss
- ❍ Sores/Ulcers

Cardiovascular:
- ❍ High blood pressure
- ❍ Low blood pressure
- ❍Chest pain/pressure
- ❍Blood clots
- ❍Cold hands or feet
- ❍Swelling feet/hands
- ❍Fainting
- ❍Varicose veins
- ❍Pain or cramping in legs

Neuropsychological:
- ❍ Poor memory
- ❍Seizure
- ❍Depression
- ❍Fear/anxiety
- ❍Bad temper
- ❍Crying spells
- ❍Overwhelming joy
- ❍Concussion
- ❍Easily stressed

Respiratory:
- ❍ Daily cough
- ❍ Cough with blood
- ❍ Asthma
- ❍ Bronchitis
- ❍ Difficulty breathing
- ❍ Shortness of breath
- ❍ Tight chest
- ❍ Frequent chest colds
- ❍ Pneumonia
- ❍ Production of phlegm/sputum. What color?_____

Ears, Eyes, Nose Throat:
- ❍ Dizziness/Vertigo
- ❍ Headaches/Migraine
- ❍ Facial pain
- ❍ Ringing in ears
- ❍ Earaches
- ❍ Poor hearing
- ❍ Teeth grinding
- ❍Gum bleeding
- ❍ Poor vision
- ❍ Eye pain/strain
- ❍ Night blindness
- ❍ Nose bleeds
- ❍ Nasal stuffiness
- ❍ Constant head colds
- ❍ Loss of smell
- ❍ Sores on lips/tongue
- ❍ Frequent sore throats

Gastrointestinal:
- ❍ Nausea
- ❍ Vomiting
- ❍Poor appetite
- ❍ Belching
- ❍ Indigestion
- ❍ Bad breath
- ❍ Abdominal pain
- ❍ Flatulence
- ❍ Loose stools
- ❍ Constipation
- ❍ Diarrhea
- ❍ Hemorrhoids
- ❍ Blood in Stool
- ❍ Mucus in Stool
- ❍ Black Stool
- ❍ Rectal Pain

Musculoskeletal:
- ❍ Joint pain/stiffness
- ❍ Muscle pain
- ❍ Numbness/tingling
- ❍ Neck pain
- ❍ Back pain
- ❍ Shoulder pain
- ❍ Hip pain
- ❍ Knee pain

Genito-Urinary:
- ❍ Burning urination
- ❍ Blood in urine
- ❍ Urgency to urinate
- ❍ Frequent urination
- ❍Difficulty urinating
- ❍Incontinence
- ❍Kidney stones
- ❍Venereal disease
- ❍Wake at night to urinate

Women Ob/Gyn:
Age first menses:_____
Time between menses:___
Date last menses:___/___/__
Duration:_____ days long
Blood color: _____
Quantity of blood (circle):
Excess/Normal/Scanty?
- ❍ Clots in menses blood
- ❍ Pain with menses
- ❍ PMS

Pregnancies: #_____
Births: #_____
Miscarriages: #_____
Abortions: #_____
Last Pap:_____
- ❍ Vaginal discharge
- ❍ Vaginal Sores
- ❍ Breast lumps
- ❍ Nipple discharge
- ❍ Birth control?

What kind: _____

General:
- ❍ Chills/fever
- ❍ Sweat easily
- ❍ Night sweats
- ❍ Weight loss/gain
- ❍ Strong thirst (hot/cold)
- ❍ Tremors
- ❍ Fatigue
- ❍ Sudden energy drop.

What time of day?____
- ❍ Swollen glands
- ❍ Unusual tastes or smells?

What?_____